Death Anus Ad from NYC Dept of Health

January 3, 2011 By Sean Strub

This is a long blog post about an important issue. I know I'm supposed to keep blog posts short, but not all issues lend themselves to 300 words. HIV is complex and understanding the challenges we face--especially in prevention--requires reading more than headlines. So I apologize for the length, but I hope readers with the interest and patience will find this useful. Thanks, Sean

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The New York City Department of Health's "It's Never Just HIV" advertising campaign, targeted to encourage HIV negative gay and bisexual men to use condoms, has prompted a conversation that is profoundly important and speaks directly to the heart of the problems with HIV prevention.

The ad features doleful, frightened or ashamed young men who are so attractive they look like characters from the television program *Lost* , set against a sound track appropriate for a horror film. The ad's message is that HIV doesn't exist in isolation; it also brings other serious health problems.

X-rays of badly broken bones, an MRI of an atrophied brain and, most shocking, a close-up photograph of a man's cancer-encrusted anus graphically make the point. The voiceover sounds like a poor man's Don Lafontaine (he's the legendary "voice of God" who often starts movie trailers with "*In a world*..."), evoking an apocalyptic end-of-the-world feeling.

GMHC and GLAAD share the concern of many people with HIV, prevention experts and activists and rightly issued a press release calling for the ad to be pulled, asserting it is sensationalistic and stigmatizing.

UK-based journalist Gus Cairns, who has HIV, commented on Michael Petrelis' blog, "***I hate this ad because it's sadistic and bullying... It's horrified by gay men and gay sex in general, using images of bodily corruption and disease to ram home things that -despite 50 years of gay lib--we still feel about ourselves: look at the suicide, depression and drug use statistics. The message it gives--not factually, but with all the visceral power of that 5-frame shot of a ruined ass--is that if you're out on the scene, death and decay are stalking you and serves you right if they get you.***"

Others have questioned its presentation of facts. The horrible conditions noted are typically found only in some older people with HIV, or those who are not diagnosed until later stages of the disease; anal cancer is caused by an entirely different virus, osteoporosis is likely as much a function of anti-retroviral treatment as it is HIV itself, etc.

The lion of AIDS activism, Larry Kramer, loves the ad, has congratulated the NYC Department of Health and called for even more frightening ads to be produced. Larry has written: "***...these nyc department of health public service announcements are in fact not strong enough! How about trying this one on for size (pun intended): LETHAL WEAPON men, what you carry between your legs is a potential lethal weapon! it can murder people. Before you stick it anywhere PUT A CONDOM ON IT! i bet you'll get better results with this one.***"

Larry believes in fear as a strategy to change people's behavior; he cites it as key to the success of ACT UP and other community-mobilizing efforts. There are many who share this view, as is clear by reading comments posted online in response to coverage of the controversy.

Many of those comments express concern that gay men are complacent, unaware of how awful HIV can be and, at least in Larry's case, too concerned with their own pleasure to worry about protecting their partners.

The debate over these ads has largely been amongst people who have devoted much of their lives to combating the epidemic, which makes me hesitant to write in terms of the different "sides" of the issue. Everyone is on the side of finding the best ways to reduce HIV transmission, but we have differing thoughts on whether this particular campaign will help reach that goal.

I think this advertising campaign is terrible, mostly because it may contribute to further spread of the virus. The only good it has accomplished is that it has provided a brief moment when a few more people are thinking about and paying attention to HIV prevention issues. That is an opportunity that I hope we will not waste.

Supporters of these ads claim HIV prevention has been a failure and they are angry that the epidemic has disappeared from the media and fallen off the list of priorities for LGBT organizations and others who once were leaders in the fight against AIDS.

I share that anger. It is profoundly frustrating, disempowering and, quite frankly, depressing to see so many one-time activists, caring friends and neighbors, concerned journalists, political and public policy leaders disappear like a puff of smoke once combination therapy brought a relative

cure to those with the privilege of healthcare access.

As the epidemic settled into communities of poverty, communities of color and amongst the young, the milieu that once made combating AIDS their priority has acquired a collective amnesia.

Nowhere do we feel that frustration more than when we see young gay and bisexual men put themselves at risk, either unknowing or uncaring about the consequences.

At times I want to shake and scream, Larry Kramer-style, to young gay and bisexual men: "***You don't want to get this virus! It screws up your life, creates a never-ending series of health battles, makes it vastly more difficult to have intimate relationships, decimates your self-esteem and stigmatizes you beyond what anyone who is HIV negative can ever understand!***"

At the same time, I proselytize to those who do have HIV: "***You may have HIV, but you can still lead a happy, productive, and vital life, you can fall in love, pursue a career and find purpose, and with careful attention, stay mostly healthy, even while managing the tremendous burden of a life-long viral infection***."

We can and should tell young people that HIV is very bad and they don't want to get it, but we can do that without condemning or stigmatizing people who already have HIV. And we can and should tell people with HIV that a diagnosis is not the end of their lives, that they still pursue their dreams and seek everything anyone else can extract from life without sending a message to young people that HIV is no big deal.

We need to convey both of these messages, at the same time, and not let one negate or diminish the other. That requires a more nuanced messaging, one that doesn't assume the intended audience can be manipulated by over-the-top fright messages, doesn't speak down to them and doesn't assume they are presently not caring whether or not they get HIV.

The messaging must also be fact-based. That means including the difficult truths about what untreated HIV can do to one as well as about what is and is not known about the side effects of long-term anti-retroviral therapy. And it means talking honestly and practically about risk-reduction techniques rather than rely on the overly simplistic "use a condom every time" message to which few gay and bisexual men adhere.

Much of the support for the NYC DOH campaign is an expression of frustration, a desire to see the

epidemic discussed, to get the attention of young gay and bisexual men and others at risk. Many of my generation recall how terrified we once were and how that fear affected our behaviors. There is a sense today that *"nothing else works, so let's try terrifying them"* as the epidemic did to our generation.

Gus Cairns also noted on Petrelis Files that **"*The problem is not that young gay men are 'complacent' and don't fear HIV: the problem is that they do fear HIV, but don't fear it enough. And the reality is that, no matter how horrifying the ads, they are never going to fear it enough again.*"**

I agree with Gus, young gay men who have the comfort of knowing they can access treatment if they get ill will never fear HIV the way my generation feared it. Manufacturing fear through media manipulation is tricky and the research indicates it can just as easily compound as help the problem.

Another poster on Mike Petrelis' site noted **"*Here's the problem fear-based tactics face. They are countered each and every time you meet someone with HIV who's leading a normal, happy and productive life and not wallowing in a pit of despair and disease and clothed in sackcloth bemoaning his former, evil ways. In the modern gay community, that happens all the freaking time. Which means that people you are trying to scare will write you off as a lying hysteric. And your safe sex message gets tarred with the same brush. As a bonus, all of the people who don't know people living with HIV (basically, most of the population) actually will get your message loud and clear: that people with HIV are scary, disease-ridden lepers who must be shoved out of society.*"**

This is what the DOH ads accomplish. They certainly will instill fear, but they do so at the expense of further stigmatization of people with HIV, and at the expense of turning off the young gay and bisexual men whose sexual behavior they seek to change.

As AIDS advocates, we have demanded evidence-based approaches; this is what I ask for in considering HIV prevention efforts. There are a number of credible and serious studies of the use of fear-based messaging in the context of HIV; it is not an unexamined topic. I hope those who have instinctively felt favorably towards the DOH ads will take a look at several of them. If they do, I suspect their opinion on the matter may evolve.

Fear in the Context of HIV

Two studies summarize research on the use of fear in the context of HIV. One is by London-based

Sygma Research, a part of the faculty of Humanities and Social Scientists at the University of Portsmouth. Sygma have earned an international reputation as one of the most important and innovative sources of new social scientific information in the area of sexual health and HIV. Their six-page brief, **The Role of Fear in HIV Prevention**, is clear, concise and spot-on relevant to the "It's Never Just HIV" campaign in question.

The other study is **Applying Persuasion Strategies to Alter HIV-Relevant Thoughts and Behavior**, by Loraine Devos-Comby and Peter Salovey at Yale University. This one is especially important because Larry Kramer claims its author supports Kramer's enthusiastic endorsement of the DOH campaign while I cite it in support of my position, which is quite different from Larry's.

Salovey's research and response is important. He endorses "loss-framed" messaging (in effect, fear-based) for "early detection behaviors" (ie: HIV testing). However, despite repeated requests for clarification, he has declined to endorse "loss-framed" messaging in pursuit of long-term changes in sexual behaviors.

His published research notes that **"...fear arousal does not necessarily lead to the adoption of health recommendations. In some cases, it can produce the reverse effect, as illustrated by a study in which a cohort of Australian gay men exposed to the "grim reaper" advertisement subsequently reduced safer sex behaviors."**

Salovey's Yale study specifically addresses the defensive avoidance or resistance triggered by messages that cause a high level of fear, noting that the stronger the emotional reaction following threat appeals, the greater the resistance to persuasion that results in behavioral change.

Fear-based messaging is more supported by those who are older and who already practice the desired behaviors (in this case, safer sex). Fear-based message can be effective at increasing HIV testing (although it may not increase testing amongst those at greatest risk).

The Sygma study notes that **"...fear appeals are more favored by individuals who are already engaging in the desired, health-protective behavior than they are for individuals not already doing so...there may be a role for fear to help reinforce existing safer sex behavior, but that arousing fear is not necessarily an effective means of facilitating change among those who engage in risky behaviors."**

The bottom line is that fear-based messaging is more effective in raising awareness, changing attitudes and behavioral intent and possibly reinforcing existing safer sex behaviors than it is in actually changing sexual behaviors amongst those who engage in the riskiest behaviors.

More from the Yale study: “campaigns that focus solely on the negative consequences of HIV infection may serve to disempower men with HIV by making them appear weak, helpless or diseased; depictions of visible symptoms reinforce commonly held beliefs…” The NYC DOH campaign certainly focused solely on the negative consequences.

Sygma also notes “it is important not to always present target populations with the ’worst case scenarios’ that are in fact unlikely to arise for the majority of individuals”; yet presenting the worst case scenario is exactly what the NYC DOH campaign does.

The studies also indicate that the targeted audience--those whose behavior the campaign is seeking to affect--can feel threatened by fear-based messaging, which triggers avoidance (ignoring the fear-arousing message), denial (believing the harmful consequences are unlikely), counter-arguing (rejecting the risk presented, believing it to be exaggerated by authorities) or deflecting (believing the message is intended for someone else).

When experiencing fear-based HIV prevention messaging, older gay men believe it is intended for younger gay men. Younger gay men believe it is intended for “scene-oriented, promiscuous gay men”. These reactions lead to rationalizing or defending one’s present behaviors, rather than a change in behavior.

Loss Framed vs. Gain Framed Messaging

The Yale study makes an enormously important distinction between “loss framed”, focused on what one has to lose (getting sick and being miserable) vs. what they call “gain framed”, focused on what one has to gain (being healthy, and happy).

“…participants expressed greater intentions to engage in the preventive behaviors when the information was gained framed than when it was loss framed; loss framed messages were more effective at encouraging the detection behaviors.”

The DOH ad is clearly “loss framed”, which is not the strategy proven most effective for actually changing sexual behaviors amongst the targeted audience.

Further more, “threat appeals” that lack ways to avoid the negative consequences depicted in the message produce a “boomerang effect, in that participants were less likely to adopt the recommended behavior.”

Use a Condom Every Time?

The only part of the DOH ad that suggests a way to avoid the negative consequences is the generic and, at this point, largely useless "Use a condom every time" message tacked onto the end of the ad. The ad does not provide the information young gay men need and want to help them avoid contracting HIV.

I call "use a condom every time" message largely useless because at this point in the epidemic repeating this to young gay men is as helpful as hectoring teenage girls to "don't get pregnant". Young gay men know they don't want to get HIV and they know condoms are effective at preventing its transmission. Like virtually every young woman who suffers an unwanted pregnancy; they know exactly how not to become pregnant.

What enables gay men to protect themselves and young women to avoid unwanted pregnancies is not hectoring them with a catch-phrase, but providing empowering information, practical strategies and solutions that they can integrate into the reality of their sex lives and cultural milieu.

For the NYC DOH to base a campaign on the slogan "Use a Condom Every Time" is likely to be as effective as Nancy Reagan's "Just Say No to Drugs" campaign.

All sexual behaviors are not of comparable risk of HIV transmission. We know that receptive anal intercourse accounts for the vast majority of new infections amongst gay men and is exponentially riskier than other sexual activities.

Sharing the truth about the relative risks of different kinds of behavior will do more to help young gay men avoid acquisition of HIV than will hitting them over the head with "Use a Condom Every Time".

Focusing our prevention efforts on these riskiest activities, rather than generic messages that have become part of the background noise to our lives, will result in greater success.

We also need to stop saying that using a condom every time is the only way to avoid acquiring HIV. Most gay men have already permanently rejected the "use a condom every time" message. At the peak of the crisis, many were willing to forego skin-to-skin contact for a period of time. But over the long haul, many gay men (and perhaps most younger gay men), have identified situations where the risk of transmission is so low or non-existent that sex without condoms

becomes, for them, an acceptable risk.

If they feel certain someone is of the same sero-status, if they are engaging in oral sex, or as the active partner in anal sex, or if they are certain an HIV positive partner is on treatment and has an undetectable viral load, or in other circumstances, they may skip the use of condoms. We need to recognize that different individuals will tolerate different levels of risk.

Some of those people will make decisions most of us might find foolish, but our task is to give gay men is the education and tools to make their risk assessment processes as informed as possible. Those who will accept no risk can choose abstinence. Everything else involves some level of risk and where the line is drawn is ultimately a personal decision.

The Role of Treatment in HIV Prevention

We also have failed in recognizing the role treatment plays in reducing risk. A person with HIV on treatment who has been undetectable for six months or more is unlikely to transmit the virus. It is not impossible, but the chance of transmission is dramatically reduced, for many that chance is reduced to the extent they are comfortable having unprotected sex with a person who is undetectable.

Our community's failure to have an honest discussion about this has resulted in people making judgments that are often poorly informed. We need to recognize the reality of how treatment does reduce transmission risk, even while also communicating that it does not eliminate such risk.

Condoms sometimes fail--the most responsible studies generally put the failure rate between 2% and 8%--but we as advocates have been slow to acknowledge this fact, in part because we have had to fight the Catholic Church's propaganda that claims condoms "don't work".

But it may be that the risk of transmission due to condom failure is comparable to, or even greater than, the risk of transmission from a person with HIV on treatment with an undetectable viral load. That discussion is happening in my quarters of the community, in bars and at dinner tables, but it has not been undertaken by our public health establishment or AIDS service providers and that silence is damning.

Post-Exposure Prophylaxis

Another damning silence concerns post-exposure prophylaxis. The culture of the epidemic, amongst gay men, was based in a time when most people who got ill did not know when or by whom they were originally infected. Many of us assume we were infected more than once.

Today that is much different. Young gay men who are diagnosed often know exactly when and by whom (the individual, if not their name) they were infected. I have been struck by how often I have been told by recently infected gay men that they knew at the time they had just been potentially exposed, either because a condom broke or they did something in a weak moment that they quickly came to regret.

But what is appalling--and the blame for this must rest with the public health and AIDS service establishment--is how few of them knew that there was something they could do shortly after the potential exposure to avoid sero-conversion.

Post-exposure prophylaxis (PEP) has been a standard procedure for persons in a healthcare setting who accidentally get stuck with a needle. They are put on a 28-day course of anti-retrovirals immediately (it must be within a couple of days to be effective) and in almost all circumstances that prevents them from becoming HIV positive.

For several years, the Centers for Disease Control has recommended post-exposure prophylaxis in a non-occupational setting (read: sexual context) as well. So why don't gay men know about PEP and why can't they access it easily?

One big reason is that PEP is seen by some as a potential "disinhibitor" and will enable gay men to be sexually irresponsible and use PEP as a sort of "morning after" pill. The research doesn't support this premise, but that doesn't stop those who are uncomfortable with gay male sexuality, especially anal intercourse, to operate from a conscious or subconscious desire to discourage sexual expression.

The truth is that those who go to the effort to access PEP--and it is not easy--are the guys who really do not want to get HIV. They aren't those who don't care or are indifferent to risk; they are those who will go to a lot of effort to avoid acquiring the virus.

Last year, I helped launch a site to provide information about accessing post-exposure prophylaxis; now we're trying to get providers to register their information so it is available.

And for several years, I have been giving out "starter kits" to young gay men that include three

days of anti-retroviral treatment and some instructions for use. I tell them to put the kit in their medicine chest or dopp kit so it is available in the event they need it. The kit buys them some time, to give them a chance to talk to their doctor or another expert to evaluate their risk and whether they should pursue the 28-day treatment protocol.

Risk episodes most often happen at night or at a time when one can't quickly reach a medical professional to assess one's exposure risk; the starter kit gives them the chance to start treatment immediately and not lose the opportunity to avoid infection. Emergency rooms, in theory, should provide this service but in practice they remain a nightmare.

Hospitals are often are unfamiliar with PEP for use in a sexual exposure or the cost is prohibitive; typically $1500 or more, which isn't a practical consideration for most young men who have sex with men. When faced with the long wait typical at most emergency rooms in New York, and the uncertainty of whether or not they really need or will ultimately receive PEP from the ER as well as the enormous expense, it is easy to say "nuts to it" and just cross one's fingers and hope for the best.

If the Department of Health wanted to provide a real tool to young gay men to avoid infection, they would educate the community about PEP and make it convenient and available without cost. That goes for hospitals, AIDS service organizations, physicians and others.

The Whitman Walker Clinic, in Washington, DC, has a "red carpet" program for people who think they might have been exposed to HIV. Upon presentation at the clinic, they are processed on an expedited basis. They promote this service throughout the community so people know that if a condom breaks or they do something they regret that they can go to Whitman-Walker and quickly and discreetly have their risk assessed and, if necessary, put on the 28 day preventive treatment without cost.

Educating about the relative risks of various sexual activities, for those who are negative, and those who are positive on treatment or not on treatment, and promoting PEP are practical and useful strategies that will do much more to prevent new infections than a scare-mongering campaign that may ultimately drive new infections rather than avoid them.

HIV prevention is a process, not an advertisement or given campaign. We can alert people to the dangers of HIV without resorting to fear that risks losing the very audience we most need to reach.

Respecting the Rectum

Our success in preventing HIV transmission has been hampered by an unwillingness to recognize and celebrate sex between men as something beautiful, admirable and morally equivalent to sex between men and women.

In 1983, very early in the epidemic, Joseph Sonnabend, MD, famously and courageously said, “the rectum is a sexual organ and it deserves the respect a penis gets and a vagina gets.” Eric Rofes, Walt Odets and other pioneering thinkers about gay male health and sexuality have subsequently explored similar themes.

I couldn’t help but think of this when I saw the close-up image of a man’s anus, covered in cancerous lesions, in the NYC DOH ad. Anal cancers are preceded by genital warts, which are caused by strains of HPV, the Human Papiloma Virus. Last year, 4,000 women in the U.S. died of cervical cancer; in virtually every case the cancer was caused by HPV.

If the NYC Department of Health pursued a campaign to combat transmission of HPV, does anyone think they would, for a moment, consider using a close-up image of a horribly diseased vagina?

The bodies and sexuality of gay and bisexual men are seen as dangerous and our sexuality as threatening. We are so little respected that it is acceptable to show an exceptionally intimate part of a gay man’s body, one visibly riddled with cancerous lesions, and put it on television as a tool to frighten us.

We need to respect anal intercourse and recognize the important role it plays in the sexuality of many gay and bisexual men.

In this context, “gain-framed” could communicate how protecting one’s self and one’s partner from HIV transmission can provide peace of mind, is socially responsible and enable the person to live a long, healthy and happier life, free of the tremendous burdens that come with an HIV diagnosis. In this context, risk reduction strategies have more meaning and will resonate more strongly with gay and bisexual men, resulting in the behavioral changes that will reduce HIV transmission.

That’s HIV prevention messaging that may not please Larry Kramer and those who are hell-bent to use fear to bludgeon the psyches of young gay and bisexual men--and in the process, further stigmatize those of us with HIV--but it will change sexual behaviors and result in less HIV transmission.

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