July 17/97

To: Bill

From: Joan

Re: Draft #4 - Non-nominal Testing

1) Important to ask that they be consistent in using language of

medical officer of health **or his/her designate**

It is used in the last paragraph (1.4) a) but not in preceding sections. Important to legitimize the role of the designate since they are usually community health nurses with more counselling skills.

2) b)...there is another circumstance not covered here, that is, the voluntary use of public health. when a patient doesn't feel prepared to do their own notification, a physician may ask the patient for their permission to refer to public health to help with partner counselling/follow-up. This happens where the physician may be reluctant to do the initial partner counselling themselves and offers the service of public health to the patient and the patient wants help. More often a heterosexual partner situation where the patient needs counselling and coaching to be prepared to tell a partner or wants someone else to do the notification. Would read something like:

> the patient gives the physician permission to disclose her/his name to a medical officer of health or his/her designate to receive help with notification.

3. (1.2) has a first step missing which may not be that important given the overall strength of this section.

the physician shall attempt to clarify and resolve issue directly with their patient or refer for more in-depth counselling as needed.

4. And the big question is ..what is sexual intercourse? Will the Act define sexual intercourse? if someone gets another STD that is transmitted more easily by oral sex (say the PHA goes down on someone with an STD.) will public health declare them "unwilling"?. I've attached the section of the newly published CAS safer sex guidelines which is relevant to the discussion.

In terms of strategy, discussing potential problems tomorrow will be helpful. And sounding out whether or not we can get a specific reference to anal and vaginal intercourse which is the best solution. There's no question that in public health, sexual intercourse is going to be interpreted as including oral sex. However, whether most health units would worry unduly about follow up on oral sex contacts given the workload is another matter. Ian Gemmil in Ottawa would certainly take the most conservative approach.

SECTION 1

An Approach to Safer Sex:
Consistent and Coherent Advice

This *Safer Sex Guidelines* document: (1) offers a framework for judging levels of risk for transmitting HIV infection through various sexual activities; (2) summarizes the implications of the medical and scientific evidence currently available on transmission; and (3) discusses some practical considerations of safer sex.

These guidelines are not intended as a complete "how to" guide for educators and counsellors, but they offer a place from which to start. Many important educational topics are not addressed here. Other sources need to be consulted to learn more about the means of equipping people with the understanding, motivation, skills, resources and social support to adopt this advice.

The document is intended as a resource tool to assist in the delivery of **consistent and coherent advice**.

How the Document was Produced

The first edition of the guidelines originated in 1988 from a request by member organizations of the Canadian AIDS Society (CAS), who were concerned by the confusion resulting from the distribution of inconsistent safer sex advice across the country.

In response, CAS brought together a group of scientific experts and educators to produce the approach that appeared in the highly successful first edition of these guidelines. This second edition results from a three-part process: (1) an exhaustive review of the literature; (2) a national consultative gathering of medical, scientific and education experts to assess the continuing accuracy of the original document, how it had been used and how it could be improved; and (3) reviews of draft versions of the final document by a diverse group of educators, counsellors, health professionals, and researchers.

Affirming Sexuality and Health

Since the beginning of the HIV epidemic, it has become a truism that prevention education represents our best hope of controlling the effects of this virus. Despite the importance of HIV prevention messages, however, the public has not always been given basic, complete and easily understood information which distinguishes sexual practices that place individuals at risk for HIV infection from sexual practices they can enjoy without worry of infection.

Social disapproval and discomfort about sexuality have often led either to unhelpful coyness and innuendo or to self-censorship and official silence. The HIV epidemic too often has been used, either consciously or haphazardly, to reinforce notions of "good" and "bad" sexual behaviour.

The perspective of the Canadian AIDS Society is that effective prevention and sexual pleasure are highly compatible. Research has shown that individuals will voluntarily practise safer sex if they feel good about themselves and the preventive measures they are taking.

In order to achieve and to reinforce positive behaviour change, it is important to affirm sexuality and to acknowledge the key role it plays in

personal health. Enhancing sexual health, which includes freedom from diseases and disorders that interfere with sexual functioning, is increasingly recognized as an integral part of health promotion.

Healthy sexuality, of course, will mean different things to different people, depending on their experiences, values and customs. Rather than attempting to get diverse groups of people to conform to a specific moral code or lifestyle norm, we are more likely to bring about changes by presenting risk-reduction options most appropriate to the sexual practices and desires of different individuals. That is why the emphasis of these guidelines is on behavioural advice that can be applied to everyone and that respects individual differences and the circumstances in which people engage in sexual activity.

It is hoped that the guidelines will encourage sexual practices that individuals feel comfortable with, that bring them pleasure, and that promote their health and the health of others. A health promotion approach makes safer sex a more realistic and achievable goal.

Safer Sex and Other Sexually Transmitted Infections

Sometimes it may appear that the problems of other sexually transmitted diseases (STDs) have been overshadowed by increased attention to the prevention of HIV transmission. Recently, in fact, there have been high levels of infection rates of sexually transmitted infections such as chlamydia, gonorrhea, and genital warts (caused by human papilloma virus) reported in Canada, particularly among youth.

Research into the interactions of STDs and HIV disease is still in its early stages, but the complex relationships of the disease syndromes, sometimes called an "epidemiological synergy," is a new focus of concern. There is some evidence, for example, that syphilis and gonorrhea could contribute to progression of HIV illness. There is also some indication that STDs can have more pronounced effects, and be harder to treat, in men and women living with HIV. Furthermore, genital ulcer disease (lesions from syphilis or herpes) can create a more susceptible point of entry for HIV.

Many public health departments and community-based agencies are now working to integrate their STD and HIV/AIDS strategies more effectively. We are aware of this shift but have opted to keep the primary focus of this document on HIV transmission. Although there are some differences, most safer sex advice for preventing HIV is equally effective in preventing other sexually transmitted infections. *(See Appendix 2 for an application to other STDs of the model of risk used in this document.)*

The Problems of Providing Accurate Safer Sex Advice

The safer sex advice with which we are now familiar was developed before HIV was identified as the underlying cause of AIDS. The earliest AIDS-specific safer sex guidelines date from 1983 and were modelled on precautions to reduce the transmission of hepatitis B, then prevalent in communities becoming affected by AIDS. In the decade since those first prevention messages, a considerable amount of research has been conducted that confirms much of the initial advice and clarifies different levels of risk for different sexual practices.

It is not an easy task for educators to bring about voluntary change in human behaviour that is as complicated and as culturally charged as sexuality, particularly in the context of a virus as complex and illusive as HIV. We cannot hope to remove all degrees of ambiguity from our messages. This is why many educators and counsellors have stopped using the term "safe sex" in favour of the more accurate "safer sex."

The word "safer" implies that a level of safety can be achieved, but that absolute guarantees do not exist. This lack of certainty can lead to anxieties that inhibit people's ability to adopt or maintain safer sex practices.

Uncertainty has also led to the wide variation in safer sex advice offered by different sources. Those wishing to educate themselves about HIV transmission have often been confused by conflicting advice, differences in emphasis, and inconsistent terminology. For example, the same sex act could be described in one pamphlet as "probably safe" and in another as "possibly dangerous."

The goal of this document is to offer a logical approach to the theory and evidence of HIV transmission, and to provide a consistent framework for realistically assessing the risk represented by various sexual activities.

Levels of Risk

Because of the uncertainties in safer sex, educators and counsellors need to appeal to a difficult abstract concept: levels of risk. The model used in these guidelines places sexual activities into categories according to their level of risk for HIV transmission.

We negotiate risk in our lives every day and make decisions, both conscious and unconscious, about the level of risk taking we can cope with. Every time we ride a bicycle, walk on city sidewalks, drive a car, or get on an airplane, we are taking a risk. We hear a great deal about the health risks of drinking coffee, smoking cigarettes or drinking alcohol — risks that may eventually shorten our lives — and our actions show how we deal with that knowledge. The more we feel that we are in control of the risk, the better we are able to choose our actions. Sexual choices, despite being uniquely laden with personal and cultural meanings, should be placed in the context of those other risks we face in our lives.

Safer sex advice should acknowledge the options that can be exercised by people who feel comfortable with some risk, as well as validate the more cautious approaches of those who want greater assurances. There are "no-risk" options for engaging in sex and some will choose them. For many people, however, some level of risk is probably either acceptable or unavoidable, making it necessary to include a broad range of risk reduction choices in safer sex education.

What is an Acceptable Risk?

Among the "grey zones" of uncertainty in safer sex advice, one of the most frequent difficulties facing educators and counsellors is the question of what to say about the practices of oral sex (fellatio and cunnilingus).

As outlined in later sections, the different ways of practising fellatio and cunnilingus have all been assessed as sex acts with theoretical or low risk of HIV infection, as they were in the first edition of these guidelines. This classification became the most debated aspect of the 1988 edition of the *Safer Sex Guidelines*, and was seen as the major departure from earlier, more cautious, safer sex advice.

Since the mid-1980s, there has been a significant amount of research to show that oral transmission of HIV can happen, although it seems to occur rarely. Similarly, with protected vaginal or anal intercourse, even though we know that a properly used condom greatly reduces risk, condoms sometimes do fail and transmission can occur.

The question of what constitutes an acceptable risk lies at the heart of the challenge of safer sex. Should we be encouraging people to reduce risk, or to totally eliminate it?

From the broader perspective of public health strategy, this document is guided by a commitment to risk reduction as the most achievable goal in behaviour change. From the point of view of the individual, the document

assumes that it is better to provide advice for both options: reducing risk and eliminating risk. This way individuals can determine which choice is appropriate for themselves.

With vaginal and anal intercourse, for example, individuals who are not comfortable with the possibility of condom failure can take further steps to protect themselves. In addition to using a condom, they can stop intercourse before ejaculation, or a female partner can use a vaginal spermicide. If individuals want to reduce risk even further, they can avoid vaginal or anal intercourse altogether.

During oral sex, there is also a series of options that individuals can choose: they can avoid cunnilungus during menstruation, they can stop fellatio before ejaculation occurs, they can use a condom or other latex barrier, or they can avoid the practice altogether.

Ultimately, it is up to individuals and their partners to choose to make a voluntary change in their sexual behaviour. Therefore, their wish to reduce or to eliminate risk is central to effective adoption of prevention measures. If they are given complete information, positive motivation, and a chance to develop social skills related to sex, individuals will usually act in their own best interests. The challenge for educators and counsellors is to find ways to help people feel good about the behavioural changes they choose to make.

If educators and counsellors focus on individual behaviour exclusively, without reference to social context, it will blind us to a complete picture of how people adopt safer sex practices. Recent research has confirmed the importance of social environment. We cannot forget that other factors can limit a person's capacity for choice. For example, power imbalances in sexual relationships, particularly between men and women, may prevent individuals from acting freely in their own health interests.

Positive or Negative: Safer Sex is for Everyone

There are two social reactions that pose problems for people living with HIV, and that make widespread adoption of safer sex practices more difficult to achieve.

One reaction is that people living with HIV are often made to feel they can no longer enjoy sex and intimacy. The other reaction is that people engaging in sex with someone they know to be HIV-positive often experience an irrational fear that is absent when they don't know their partner's serostatus. Even if they rationally understand the principles of barrier protection, they may ignore them and insist on additional precautions.

Whether or not HIV-infected individuals have a greater responsibility to inform their sex partners about their status, even if they take appropriate precautions, has become an explosive legal issue. Several cases have occurred in which individuals have faced criminal charges for failing to inform their partners. There are strongly held views on either side of this issue, with public health departments and community-based organizations often in disagreement.

For the purposes of these guidelines, sexual practices have been assessed for risk based on actual evidence of HIV transmission. That means the guidelines are consistent and valid for everyone, including people who are living with HIV. To put a different burden of responsibility on those who are HIV-positive would create a double standard in our messages: practise one set of safer sex guidelines with those who are infected and practise another with those who are not infected. In fact, a large percentage of people who are HIV-positive do not even know they are infected.

The media have tended to highlight lurid stories of individuals who have knowingly infected unsuspecting sex partners. However, the great majority of people who know their

serostatus behave responsibly and ethically and practise safer sex. There is no evidence that more than a very small minority of HIV-positive people will recklessly endanger others.

Most people in a growing, trusting relationship will find it desirable to share information about their serostatus with their partners. The circumstances and timing under which people living with HIV will want, and feel able, to tell others they are HIV-positive will vary greatly. Some may want to tell all their sex partners immediately, while others may find that revealing such information creates greater difficulties for them. Some women, for example, may perceive themselves to be in physical danger if they tell their male sex partners. Gay men may fear their community will reject them. Support and counselling should be available to such people to enable them to consistently practise safer sex and/or to communicate openly with their partner(s).

Consistency and coherency are the essential features of the risk model presented here. An expectation that people living with HIV should have to exercise additional precautions appears to remove the burden of responsibility from the other partner. It would send contradictory messages about the validity of the precautions recommended.

All people who are sexually active should take precautions against HIV infection. At the same time, we should not forget the complex emotional issues that sex raises for people once they have been tested and told they are HIV-positive. That is why testing must be accompanied by empathetic and intelligent counselling. People living with HIV should be supported to make positive decisions about their sexual behaviour that balance their emotional needs with the health and safety of themselves and others. Sexuality counselling should be part of ongoing follow-up support for people living with HIV and their partners.

Enhancing the Health of People Living with HIV

Although these guidelines apply equally to people who are living with HIV and those who are not infected, there are further considerations for the health of those who are HIV-positive. Making sex healthier can be part of a broadly based health promotion approach for people living with HIV. Just as they need to consider a wide range of treatment and other options for improving and maintaining mental and physical health, people living with HIV should be aware of possible exposure to other infections.

Because the focus of this document is on sexual activity, the infections of primary concern here are sexually transmitted diseases (STDs). People with HIV should be aware that other sexually transmitted infections could affect the immune system and could trigger the progression of HIV from an asymptomatic seropositive state to illness. There is also some indication that STDs can have more pronounced effects, and be harder to treat, in men and women living with HIV.

People living with HIV should also be aware of the potential risks in having unprotected sex with someone who is also HIV-positive. Although there is no clear evidence yet to show that further exposure to HIV is either harmful or neutral, two points should be considered.

First, any infection affects the immune response and may activate cells that HIV targets. Second, different strains of HIV may produce illness at varying rates or may affect different systems in the body. Infection with a new strain may cause new problems. Given these possibilities, it would be prudent for men and women already infected to practise safer sex at all times.