Looking to the Future: Eradication by 2030?

Introduction

The primary objective of this volume was to provide insights into the clinical, social and psychological aspects of HIV—both its prevention and care—among gay men. Given that HIV is a clinical issue with significant social, psychological and behavioural underpinnings, it is clear that all of these aspects will need to be closely examined if we are to achieve the zero-infections target by 2030. It is also clear that, in order to prevent HIV, we must focus on optimising HIV care and ensuring that all people living with HIV are able to access it.

In this volume, we have discussed many distinct facets of the HIV epidemic in the UK, including its history, science and epidemiology; its biological and social and psychological risk factors; HIV diagnosis and treatment options; the mental health burden of HIV; and the role of identity in relation to HIV-related cognition and behaviour. The multitude of topics covered in this book are testimony to the complexity of HIV—both its prevention and treatment. The impact of gay history on the sexual behaviour of gay men may not seem immediately obvious to the outside observer. Yet, our analysis demonstrates that a history
characterised by prejudice, rejection and identity concealment has clear implications for how gay men think about their identity and express it in the heteronormative contexts that they inhabit. Furthermore, the short-sighted attempt to manage HIV by silencing the voices of young gay adolescents, with the damaging Section 28 legislation, probably had counter-productive effects on the epidemic in the UK.

It is essential to learn from these historical lessons and to ensure that the potential future implications of today’s policy remain at the forefront of our thinking and serve to reduce health inequalities. Only a serious consideration of all these issues will enable us to achieve the ambitious zero-infections target by 2030.

A key aim of this volume was to address three specific questions which were posed in the introduction:

- What are the major clinical and social psychological challenges associated with HIV risk, prevention and treatment among gay men?
- How can theoretical, empirical and methodological tools from the clinical and social psychological sciences be bridged in order to address some of these challenges?
- What are the next steps for HIV research, theory and practice among gay men?

This is not the type of book in which neat conclusions can be drawn in relation to these questions. However, the discussion that has unfolded in this volume does highlight the key debates that we should be having in order to realise the zero-infections target by 2030. It elucidates the gaps in our knowledge, in policy and in practice, which may curtail our ability to prevent HIV in the future. As the epidemic progresses, identifying new cases does remain a challenge—1 in 10 gay men is unaware of his diagnosis despite the best efforts of public health campaigns. More research is needed in order for us to close this gap in diagnoses. In order for this to be a well-informed debate, there are some key components that must not be overlooked by researchers, clinicians and policymakers.
The Key Components of HIV Prevention and Treatment

Our discussion of HIV in the preceding chapters suggests that the following seven factors, which are the key theoretical building blocks for understanding social psychological issues (Breakwell, 2007; Jaspal, 2019), must be considered in order to provide reliable responses to these questions.

• The physical/biological context includes the physiological aspects of HIV. Some sexual behaviours are riskier than others. Substance use can create both physiological and psychological conditions for HIV transmission to occur. One may fail an ART regimen requiring more intensive support. At the most basic level, one may not physically be able to access HIV prevention services. The list is not exhaustive, and there are of course many other examples of how the physical and biological context is important.

• The socio-historical context determines the individual and social attitudes that exist today. Gay men have acquired a sense of self on the basis of previous experiences, that is, their socio-historical context. Similarly, heterosexual people base their perceptions and understandings of HIV on the socio-historical context of the epidemic. This context must therefore be understood.

• The ‘macro’ level includes societal and institutional structures, such as ideology, legislation and policy. Gay men are more likely to engage with healthcare if the institutional approach to gay men’s health is characterised by acceptance and inclusion. A good example of this is the recent initiative for NHS staff to wear rainbow badges to signal that LGBT people are welcome. Furthermore, individuals can access PEP, PrEP and TasP only if health policy provides access to them. State ideology determines whether HIV should be a health priority and how it should be dealt with. All of these ‘macro’ level issues have significant implications for both HIV prevention and treatment.

• Social representations are key. As outlined in Chap. 7, these collective understandings inform how gay men think, feel and act in relation to
HIV and its prevention methods. Their level of access to particular social representations will develop in social context.

- **The intrapsychic level** must be acknowledged. This refers to the psychological aspects of HIV, such as how gay men think about themselves in relation to the epidemic, their perceived risk of infection, stigma and so on. Identity, cognition and emotion are three examples of the intrapsychic level.

- Gay men’s **interpersonal relationships** matter, since relationships with other individuals and groups provide access and exposure to particular social representations and constitute a source of social support. However, particular interpersonal relationships may also expose an individual to stigma or to situations of risk. All these factors shape HIV prevention.

- Gay men’s **behaviour** is at the heart of HIV prevention. Ultimately, it is behaviour that determines one’s level of risk. Moreover, effective behaviour change can result in reduced risk. It is likely that all of the aforementioned factors shape behaviour, which remains a central focus of HIV research and subsequent public health campaigns.

**The Importance of Combination HIV Prevention**

It is evident that we now possess sophisticated clinical tools for the effective prevention of HIV, which include condom use, PEP, PrEP, TasP and other emerging methods, such as a potential vaccine against HIV. These approaches have varying degrees of efficacy and are characterised by some pitfalls, and each will be acceptable to only some gay men. For instance, while condom use is one of the most effective prevention options and has been promoted since the very beginning of the epidemic in the UK, it has not been consistently observed by all gay men. Moreover, although PrEP performs even more efficaciously than a condom, not all gay men personally endorse this method for themselves due to stigma and other issues. There are many reasons why an individual may reject one method over another and these reasons must be explored and understood. This is especially important in a
clinical setting where these factors must be examined in order to ensure the best outcome for the patient. Assumptions about the acceptability of certain methods may prove to be erroneous.

Potential barriers to these prevention methods must be removed. In the meantime, it is important to refrain from favouring any single approach at the expense of another. It is short-sighted to focus only on the pitfalls of any particular method and to discard it altogether. As highlighted in this volume, this has been a recurrent theme in discussions about PrEP since it is sometimes feared that PrEP use will lead to the abandonment of condoms by all gay men. It appears that all possible prevention options must all be included within a broad and inclusive ‘toolbox’ of HIV prevention approaches so that the clinician (and indeed patient) can draw upon a particular method or set of methods at any given time.

Another important point is that sexual risk-taking can be in flux—some who go through periods of risk behaviour (e.g. chemsex as a consequence of recent psychological trauma) may find PrEP acceptable. If they were to settle with one partner, their acceptability of PrEP may subsequently reduce. This is why it is vital to engage with gay men in clinic (and in fact in all healthcare appointments). Their HIV prevention package should be modified accordingly. The effective engagement with communities (led by culturally competent healthcare workers) lies at the very heart of our ability to deliver excellent care to those who are at risk of HIV.

In this volume, the fundamental importance of patient-centred care has been emphasised in the battle against HIV. An adequate understanding of the patient’s identity, social context and cultural norms is crucial to ensuring that patients from all backgrounds are engaged in prevention and treatment. The inextricable relationship between sexual health and HIV has been illustrated. Psychological services must complement sexual health services, and vice versa. These are just some reasons why it is essential for the adequate funding of sexual health and HIV services in the UK. Although the UK has made enormous strides in preventing HIV, resulting in a recent continued decline in new infections, there remains much work to be done, especially in some groups, such as ethnic minority gay men and those of lower socio-economic status. It would be
counter-productive to deprive sexual health services of the funding required to perform adequately in order to realise the zero-infections target. The target can be achieved only if combination prevention remains a reality, not an aspiration.

Yet, at the time of writing, the UK is in the grip of a significant global challenge. The outbreak of COVID-19 precipitated a nationwide lockdown and the enforcement of social distancing (Jaspal & Nerlich, 2020). Giving the rising number of infections, hospitalisation and deaths associated with the disease, the main focus of the NHS has understandably been on the treatment of COVID-19. Clinicians from all specialties, including sexual health and HIV, have been redeployed to join the fight against COVID-19. This in turn has meant that many other services, including sexual health and HIV services, have been curtailed and that the roll-out of PrEP to those at risk of HIV has been delayed. We must ensure that sexual health and HIV does not fall off the policy agenda across the world as we deal with the aftermath of COVID-19. In fact, the COVID-19 outbreak may well provide the ideal conditions for detecting more early infections than ever before. In short, it will be vital to continue to work collaboratively with HIV charities and activists in order to promote sustainable change in relation to HIV prevention.

Consistent with the social distancing measures, gay men have been strongly advised to avoid meeting casual partners for sex—advice that has been reiterated on gay mobile social networking applications, such as Grindr. However, the extent to which gay men adhere to this policy is unclear. Therefore, it is possible, but not yet known with certainty, that the unprecedented public health emergency of COVID-19 may translate into poorer HIV and sexual health outcomes in gay men. There may also be an accentuation of poor mental health, especially in vulnerable groups, as a result of the outbreak (Lopes & Jaspal, 2020). The closure of ‘non-essential’ sexual health services may have a deleterious effect on health and wellbeing, and will need to be closely monitored. Furthermore, there are broader questions about the future of HIV prevention and care in the UK. There is of course much uncertainty about the economic, social and political landscape that awaits us after the COVID-19 pandemic. Will the economic challenges ahead lead to decreased funding for sexual health services? Will funding for all communicable diseases be increased in the
future? How will any possible austerity measures impact on HIV incidence among gay men? What will this mean for the zero-infections target?

The Future of HIV Prevention

Notwithstanding the unsettling challenges posed by COVID-19, each chapter in this volume highlights the tremendous advances made in HIV prevention and care over the last four decades. Collectively, these steps have resulted in a significant reduction in HIV incidence in gay men which continues to fall each year. The UN 90-90-90 target has of course already been achieved in the UK. Yet, the assessment of performance in relation to HIV depends on the measure that it used. Psychological wellbeing is a recurrent theme in this volume. The available evidence suggests that gay men face challenges to psychological wellbeing, which can lead to increased risk-taking, and that those living with HIV also face poor psychological health outcomes. Yet, psychological wellbeing and living free of side effects of ART and of HIV stigma are not currently one of the measures in the 90-90-90 target. They should be.

The goal of HIV medicine has traditionally focused on the physical health of those at risk of, or living with, HIV. In the case of HIV prevention, the focus has been on keeping people HIV-negative, and in the context of HIV care, the principal aim has been to get people undetectable and to keep them physically well. Psychological health is inextricably entwined with both risk and wellness—those who are not psychologically well are more likely to take risks and to experience poorer physical health outcomes. Although over 90% of people living with HIV have received a diagnosis, are on ART and are undetectable, it is unlikely that the same proportion of individuals experience a high level of psychological wellbeing. Indeed, much of the existing evidence on psychological wellbeing among gay men living with HIV suggests a very high prevalence of anxiety, depression and other forms of psychological adversity. Although a ‘fourth 90’ focusing on quality of life has been discussed, a specific emphasis on psychological wellbeing (which does indeed encompass quality of life) would be fruitful for future research, policy and practice.
This should also be formally included in the UNAIDS targets (see also Jaspal & Lopes, 2020).

Both effective HIV care and HIV prevention are important in their own right. They are also are inextricably entwined. If a person living with HIV is not engaging with care, they will not be able to achieve viral suppression through the use of ART and may therefore transmit HIV to others. If a person is experiencing poor quality of care, they are more likely to disengage or to interrupt ART, yielding the same risks for onward transmission. In this volume, a series of clinical and social psychological barriers to effective care and prevention have been described. These include lack of HIV knowledge, inaccurate risk appraisal, actual and anticipated side effects, stigma and many others. Moreover, it is clear that not all of these barriers affect all groups in society in quite the same way. In Chap. 7, the impact of ethnicity and culture on both HIV prevention and care were explored. Individuals from ethnic and religious minority groups also appear to be at disproportionately high risk of poor outcomes than the general population. Thus, it is necessary to ensure that our approach to prevention and care is underpinned by cultural competence, identity awareness and robust evidence.

It is evident that a variety of disciplines have contributed to HIV research evidence. While clinical scientists focus on the physiological aspects of HIV, its treatment and prevention, social scientists are grappling with empirical questions concerning human behaviour. Both are essential for the zero-infections target. The future of prevention and treatments for HIV is an exhilarating story that is now turning to the prospect of two- or three-monthly injectable medication and sub-dermal implants negating the use of daily pills and dramatically improving adherence to medication. These methods should also be just as effective for prevention with the tantalising prospect of protection lasting months with ART administered in this fashion. A ‘functional cure’ whereby people remain undetectable without the use of drugs is also an exciting chapter in the story of HIV—researchers are eagerly trying to unlock this puzzle which would have life-changing results for millions of people.

The research outlined in this volume has been driven by many theoretical approaches—some focusing on the individual, others on societal and institutional structures. The research studies have been underpinned
by a multitude of methodological approaches, including randomised control trials, phylogenetics, behavioural experiments, surveys, qualitative interviews, media analyses and others. Moreover, the data generated by this research have been analysed using a similarly diverse range of methods, including structural equation modelling, multi-level modelling, interpretative phenomenological analysis and discourse analysis. In order to provide nuanced analyses of the seven aforementioned dimensions of HIV, it will be necessary to use the full plethora of methods of data generation and analysis at our disposal (see Breakwell, Wright, & Barnett, 2020). Our repertoire of theories and methods grows as we bridge disciplinary approaches, as we have attempted to do in this volume. It is hoped that future research into HIV will be theoretically, methodologically and analytically eclectic.

At the beginning of this volume, two case studies were illustrated, which explored various social psychological issues peripherally related to HIV risk. Throughout the chapters of this volume, it has been shown how these issues—body image, sense of community, friendship, the digital world of gay dating, identity and culture—may impinge on HIV risk. Clearly, more social psychological opportunities and challenges will emerge in the future. In order to achieve the zero-infections target, these must be continually monitored and addressed in the research questions we pose in the future.

Future research into HIV among gay men must focus on those groups in society in which there remain significant barriers to effective HIV prevention and care. There are significant lacunae in our knowledge about the HIV prevention and care needs of some subgroups of gay men, such as those who do not consistently self-identify as gay but have sex with men, gay men from ethnic and religious minority communities, and those with poor mental health. Although individuals in these subgroups are often deemed to be ‘hard-to-reach’, it is necessary to use the full plethora of tools available to us to attempt to reach and to engage them in research. It has unfortunately been shown that their rates of participation in research appear to be lower than other groups, which means that their specific needs may not be captured in the data that this research generates.
Final Thoughts

There is much to be gained from bridging clinical medicine and social psychology in the context of HIV prevention. This volume is an attempt to do just that. There must be a reciprocal relationship between these fields of study but also between key communities in the area of HIV prevention among gay men—researchers, practitioners, policymakers and, of course, gay men themselves. By working in partnership, using clinical practice to establish research questions and drawing on that research to inform clinical practice, we will be better positioned to achieve the ambitious goal of ending all HIV transmissions by 2030. We will need to use the lessons learned from history to shape our future. We will need to think creatively and to take some risks to reduce risk. This is a goal worth pursuing since the end of HIV is clearly in sight.

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