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Advancing biosocial pedagogy for HIV education

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Abstract

This article develops the concept of biosocial pedagogy in HIV education for this era of expanding biomedical forms of HIV control. With reference to critical pedagogy and teaching and learning materials addressing HIV treatment and prevention, I explain how HIV education can problematize its own role in HIV control. I also discuss how educational practice can be informed by the ethical and political dilemmas that face people affected by HIV. I argue that through biosocially aware HIV pedagogy, individuals and communities can be assisted to act on the opportunities and drawbacks of biomedical HIV control.

Introduction

This paper argues for a biosocial approach in HIV education. The mixing of the biomedical and the social has become a feature of HIV control. Epidemiologists have advocated for universal HIV testing and rapid HIV treatment [1], or 'test and treat', as a way of 'rendering HIV-infected people not infectious' [2]). Researchers have not only recognized different biomedical prevention approaches [pre- and post-exposure prophylaxis (PEP) with antiretroviral drugs; vaginal and rectal microbicides; condoms for men and women; rapid and universal antiretroviral treatment of people with HIV; circumcision and vaccination, when available] but also cautioned that these need to be carefully used and evaluated [3]. Such developments reflect the more general technologizing tendency in health care [4], especially in this era of transformations in reproductive and regenerative medicine related to new genetic technologies. These transitions, which I frame as 'biosocial', form the backdrop to my argument here.

Researchers have addressed this accentuation of the biomedical in HIV control. Race [5] examined how viral load blood testing has expanded the surveillance of the sexual practices of gay men with HIV, with both opportunities and drawbacks. Wilbraham [6] identified the racing, classing and westernizing effects of education materials developed in South Africa to encourage parenting practices assumed to protect younger people from HIV. Research such as this reveals how communities assert their own interests in HIV control and resist and modify its coercive elements.

While ascendent biomedical HIV control has been examined in research, implications for HIV educational practice is not well understood. HIV education is often shaped around how sexual cultures engage with biomedical technologies, such as in campaigns addressing mistaken assumptions regarding HIV serostatus among gay men. However, less attention is given to how HIV education materials, procedures and rationalities are themselves 'technologies' worthy of examination. Biomedical technologies appear to have a fetish status through their novelty and promise to exact (or interrupt) HIV control. The apparently more prosaic work of HIV education fades into the background, becoming in effect the invisible, taken-for-granted technology of HIV control. I argue that this

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approach characterizes much research that justifies itself in terms of informing HIV education. Such research can end with hand-wavy statements about what HIV educators should do in light of research findings.

I am concerned therefore not just with the 'what' of HIV education in relation to biomedical HIV control but the 'how'. My approach borrows from Freire's theory of critical pedagogy [7]. Freire developed perspectives on literacy education and social change in Brazil and other post-colonial states in South America. Freire held that education could assist people to become reflexive with social conditions and therefore to free themselves from simply being subject to them. Such critical consciousness is formed when people develop the capacity to recognize themselves as subject to tensions and contradictions associated with their social situation, a kind of awakening of the spirit for emancipatory action. These effects are produced when the material and social conditions of existence become intelligible through pedagogy engaged with its own limits and possibilities. Campbell and MacPhaill [8] have taken critical pedagogy into their evaluation of why it is that HIV education in South Africa can fail to engage its participants. They argue that, among other reasons, ineffective education is attributable to the omission of authentic critical consciousness for social change among educators and those affected by HIV alike. I argue that critical pedagogy is useful in this present era of biomedical HIV control. The conditions on the lives of those affected by HIV are not always escapable, including the opportunities and drawbacks of biomedical forms of HIV control. But these conditions can be taken as objects in pedagogy and educators and affected communities can therefore be assisted to reflect on how, and the extent to which, they are subject to them. In this view, HIV education does not only try to influence what people do so that HIV is better controlled but also helps expand the capacity of communities to assert their own interests and be in a better position to question and negotiate the limits placed on them. An illustration is the 'negotiated safety' approach to HIV prevention [9]. This approach overturned the previous 'condom every time' HIV prevention paradigm through research that revealed how gay men used knowledge of the serostatus of them and their partners to manage the risk of HIV transmission.

This focus on the how of HIV education was a focus of a teaching and learning module I wrote for an international capacity building project (see acknowledgements). In this module, I made connections between critical pedagogy and critical research on the biomedical in HIV control, including Race and Wilbraham noted above. Learning activities included analyzing research texts and interview transcripts; examining education materials; reflecting on the ethics of HIV control exhibited in, for example, online dating profiles, and holding classroom debates on biopolitical controversies, such as the 'test and treat' strategy. I frame this module as a 'biosocial toolbox'. The discussion and examples that follow derive from the module.

My paper therefore takes this as its problematic: How can critical self-aware HIV education engage with what I am calling the biosocial framing of HIV control in ways that can be helpful for educators and affected populations? The following defines what I mean by biosocial, shows how HIV education is itself biosocial and therefore that it does not stand outside HIV control. On this basis, I discuss how HIV education can be reflexive with its own role in the production of social relations that make HIV control possible. I point out the ethical dilemmas related to biomedical HIV control and how these can inform HIV education. And I argue for taking the contentious issues of HIV control, such as test and treat, not as problems to be resolved at a distance from educators and affected communities but as the starting points for HIV education understood as critically and biosocially self-aware.

The biosocial properties of HIV education

It is important to recognize how I am defining biosocial. Discourse on HIV control makes reference to the relationship between the social and the

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biomedical. For example, a UNAIDS-meeting on 'Antiretroviral treatment for prevention' was summarized in this way:

> Antiretroviral therapy will play several roles in combination prevention strategies, along with other key strategies including, but not limited to, social and behavioral [sic] change communication to delay sexual debut, promote mutual fidelity and reduction of the number of sexual partners, promote safer sex including correct and consistent male and female condom use, harm reduction programmes for people who use drugs, prevention of vertical transmission, and other biomedical, behavioural and structural prevention programmes [10].

It is implied here that HIV control has multiple facets including biomedical ones. Social and biomedical researchers are encouraged to sensitize one another to their respective expertize to effect greater influence over HIV, which is laudable. Implied here, too, is the action of HIV education in relation to the promotion of safer sex, among other matters.

But I am using biosocial in a way that goes beyond a happy parliament of the social and biomedical sciences. The particular use of biosocial I am advocating derives from the work of researchers such as Race and Wilbraham. It also takes up insights in the work of writers such as Rose and Rabinow who have suggested that analysis of the relationship between biomedicine and society has three elements: 'knowledge of vital life processes, power relations that take humans as living beings as their object, and the modes of subjectification through which subjects work on themselves qua living beings' [11]: 215). For them, biosociality refers to the manner in which people are made alike and not alike in terms of biomedical knowledge and how they are therefore encouraged to form alliances and oppositions fashioned around the protection and production of life. Treatment activism by people living with HIV is an example of collective practice produced in this way. Both Rabinow and Rose have examined the new genetics, among other matters, from this biosocial viewpoint, debunking simplistic notions of genetic determinism but also examining the novel contradictions and challenges emerging for social relations under increased knowledge and capacity to manipulate the biological basis of human existence.

The argument I make here is informed by these perspectives. For instance, HIV education circulates knowledge generated in social and biomedical research concerning the prevention and treatment of HIV. An example is advice appearing in printed and online media on how and when to access PEP. HIV education helps constitute the regulation of behaviour and thus circulates forms of power in the lives of affected individuals and communities. Advertizing campaigns focusing on increasing HIV testing in affected communities stand as examples of the expansion of biomedical power in HIV control. HIV education also encourages people to take up the social and biomedical technologies of HIV control as self-regulation, to subject themselves to the imperatives of HIV treatment and prevention. Safer sex education is self-regulatory because it asks people to take up condom use, for example, as a matter of personal action. HIV education, therefore, does not stand apart from HIV control or simply mediate its effects. Via the biosocial framing I am exercising here, HIV control rests on HIV education and by reversal, HIV control is educational in that, it seeks the shaping of behaviour to produce its effects. But it is my argument that by taking critical pedagogy seriously, HIV education can interrogate itself and therefore HIV control and, relatedly, the implications of the ways and means by which subjects are influenced to care for themselves and others.

Biosocial pedagogy?

What then might a biosocial pedagogy look like? I argue that the biosocial approach provides HIV educators with a different relationship with their own work. Through the biosocial 'toolbox', practitioners can step back from their practice and

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interrogate their own work as the basis for assisting affected communities to engage with the conditions on their own action, including the new possibilities and constraints concerning HIV biomedical technologies. I note that HIV educators do employ reflective practice and there are notable examples of reflexive dialogue between social science and HIV prevention [9]. Here, I am discussing critical pedagogy under biosociality in the interests of expanded opportunities for the action of educators and the communities they engage. In the following, I discuss the subjects of HIV education, the ethical tensions associated with biomedical prevention and critical engagement with biosocial challenges.

HIV education and its subjects

Biosociality draws attention to the assumptions of human agency in HIV control. A useful example is the 'onelove: talk, respect, protect' (see: onelove southernafrica.org). This Internet-based education is sponsored by HIV organizations from countries across southern Africa, including 'Soul City Institute for Health and Development' in South Africa. It is focused on 'multiple concurrent partners' (MCP) and risk for HIV infection. The website includes information, video, online polling and reader contributions. The focus on MCP is rationalized by the notion that, all things being equal, not only do individuals with more than one partner have an increased risk of HIV infection due to an opportunity effect, there is also heightened risk for an individual who is not aware that they have a partner who has other partners.

The website thus addresses the risks of MCP. It does more, however, than circulate information because it encourages readers to reflect on their sexual lifestyle choices. This focus on the choice-making power of the reader is amplified by the user-driven quality of Internet practices in general [12]. One of the main pedagogical strategies of the website is to pose questions, for example: 'Who and how should we love?'. Questions like these create a pedagogical space for reflection on HIV and sexual practices. They appeal to an actuarial subject, weighing up the pros and cons of different choices in terms of their risks. This is most clear where the website asks:

> Are you in a multiple concurrent partnership? Send us your story; share the life lessons that you have learnt with our readers. Tell us why and how you came to have more than one sexual partner at a time. What are the benefits for you? What are the challenges? Does your main partner know that you have other sexual relationships? What does he/she think of this decision? Anything else you want to add?
>
> Or maybe you made the decision to have one love only, and to be faithful to your partner? If that is the case, tell us why you choose to have one love at a time. When did you make this decision? How long have you lived like this? What are some of the challenges that you have faced since you made this decision?

These questions are biosocial in the sense that they are figured around the imperative of reducing the transmission of HIV. Here, too, personal stories become the medium for reflecting on one's life choices, reinforcing the educational force of the questions through the subjectifying properties of narrative [13]. In another part of the website, the reader is invited to complete an online survey in response to this question: 'Is testing for HIV with your partner a romantic gesture?', making a connection between sexual partnering and knowledge of HIV serostatus.

The point of the 'onelove' example is that HIV education is implicated in self-regulation in all its complexity. There is an assumption here that MCP is associated with HIV transmission, but this is not translated into an instruction, perhaps because this would be too outrageous a contradiction of liberal notions of the free agent, on which, actually, the website and the MCP campaign depend. It is also possible to argue that this liberalizing approach to sexual choice is offered in ways that may be beneficial to some readers, for example, younger women who may not ordinarily be supported in the choices they make with regard to their sexual partners. Critical, biosocial analysis of HIV education allows

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us to reflect on such benefits and limitations. Key here is constraint. Not all people will have the material and symbolic means to change their lives in ways that accord with, for example, the requirements of MCP campaigns. It is reasonable to ask, then, what can such HIV education offer them?

Ethical dilemmas

The foregoing has suggested how HIV education is implicated in HIV control subjectivity. HIV education can also engage with the ethical dilemmas related to biomedical HIV control. Consider this example from interview research:

> … the reason that I'm confused at the moment is because of a remark made to me by [my doctor] when I actually raised my sexual behaviour as an issue during the clinical session …. … He said that I was more, I had more chance of passing on hepatitis B than I did of passing on HIV given the low detectable, the undetectable level of my viral load … … I walk about with those words reverberating in my head, not knowing whether I can believe them or not … ([14]: 36).

This quotation suggests tensions in relation to biomedical effects and HIV prevention. Confusion regarding the advice from a medical practitioner and awareness of its controversial implications are present here. It appears that knowledge of HIV risk in light of HIV treatment is not necessarily an answer to the question of how to act. HIV education is necessarily bound up with the ethical considerations of sexual intimacy intersecting with those of HIV prevention [15]. The extract above suggests ethical challenges and in particular concern over what position to take on the effective regulation of HIV risk in the face of the possibilities and uncertainties that come with biomedical interventions. In Freire's terms, the quotation suggests the 'thematic universe' of a protean critical consciousness for biomedical forms of HIV control. Similar challenges of ethical subjectivity apply for the readers of onelove. Reflecting on MCP in terms of HIV risk is analogous to assessing the risk for HIV transmission in light of HIV treatment effects. Critical reflection on interview data as above and pedagogy such as in onelove can inform the practice of educators, alerting them to the tensions at play in HIV control.

Critical pedagogy for biomedical HIV prevention

An obvious application of the biosocial approach is to address controversies in HIV control. HIV education often addresses these concerns, but they are ordinarily taken as problems to be resolved, rather than as starting points for HIV education exercising debate. Some examples are as follows.

(i) Antiretroviral treatments disinhibit risky sexual behaviour and therefore lead to the transmission of HIV.
(ii) HIV antibody testing does not require pre- and post-test counselling.
(iii) Male circumcision will prevent new HIV infections.

In what circumstances can communities, for example, affected by efforts to use anti-retroviral treatment to secure HIV prevention goals, reflect on the implications for them and their loved ones? HIV education has a crucial role promoting the means by which such critical reflection can be established and sustained. The onelove example does this in connection with MCP. By posing questions and encouraging readers to record their stories, reduction in MCP is potentially opened for discussion and dissent is feasible.

This critical consciousness for the biomedical means of HIV control seems particularly salient given that at times, interventions appear to suspend choice. The test-and-treat strategy noted earlier depends on near absolute compliance and leaves little room for people to defer testing and treatment if they so choose. The strategy is couched in terms of voluntarism, but its underlying logic, and certainly that of the mathematical models used to substantiate it, rely on a fully or mostly compliant population. This is doubly worrisome since other strategies such as the approach to MCP of onelove appear to give credence to diverse lifestyle choices.

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HIV education has a role to play in drawing attention to these contradictions and therefore assisting communities to act on them.

Conclusions

The biosocial approach supplies a useful way of conceptualizing HIV educational practice in this era of biomedical HIV control. Among its virtues, the biosocial perspective makes it possible to recognize what is equivalent in different HIV control approaches such as test and treat and the reduction of MCP. Both seek control over HIV via the regulation of social relations, more or less meshed with biomedical rationalities and technologies. The biosocial point of view also points to how these two methods of HIV prevention differ. Via onelove, the MCP strategy implies a preferred choice but makes room for diversity. The test-and-treat approach makes a nod to voluntarism but depends on the acquiescence of large numbers of people. We can see a tension here between choice and coercion, arguably the axiomatic problem of public health governance, articulated with the new possibilities implied in biomedical methods of HIV prevention. Some might say that such tensions should be resolved at the level of policy. My point is that the subjects of HIV control cannot be properly governed from afar, as if they ever have been. The practice of HIV educators is shaped by these conditions for HIV control. Likewise, those expected to take up these biomedical methods of HIV control are required to subject themselves to such conditions more or less as a matter of their own volition or acquiescence. Along with assisting communities to take advantage of biomedical forms of HIV control, HIV education also has a role in assisting communities to assert other points of view and courses of action, to resist and negotiate such expectations. In this mode and if the history of the epidemic is any guide, HIV education can also assist affected communities to engage with whatever may be the next paradigm of HIV control and its related opportunities and drawbacks.

We can see then that HIV education is an active part of the network of biomedical methods of HIV control. It is co-productive of present and future configurations of HIV control. Put another way, HIV control is already, always educational. After all, how else can affected communities take up these new biomedical rationalities and technologies if not through taking them on, at least in part, as a matter of self-regulation? When we make lists, therefore, of the proliferating biomedical methods of HIV control, I suggest that we include education: a biosocial technology in its own right. On this foundation, practitioners can work to ensure that biosocial pedagogy of the critical kind has a role in future HIV control.

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Conflict of interest statement

None declared.

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