

# Relative safety

*Risk and unprotected anal intercourse  
among gay men diagnosed with HIV*

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Peter Keogh  
Peter Weatherburn  
Michael Stephens

**Original Research Report**

# Preface

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No single study can hope to describe completely the lives of any group, nor represent the range and quality of their experiences. In many ways, research of any kind is an injustice to those informants who give so freely of their time because, by definition, it is at best an abstraction, a simplification of their lives. Having acknowledged this, our first and deepest debt of gratitude is to those men who showed courage in coming forward to share their experiences and reflect on areas of their lives which were highly personal.

Second, our thanks to those agencies who helped us in recruiting men from all over England. These are: The Aled Richards Trust in Bristol, Healthy Gay Manchester and BP North West in Manchester, Yorkshire MESMAC and THT Yorkshire (formerly Bridgeside) in Leeds, Open Door and THT South (formerly Sussex AIDS Centre) in Brighton and BP North East in Newcastle.

In addition, the commissioners who had the foresight to support this basic research: Lambeth, Southwark & Lewisham; Kensington and Chelsea & Westminster; Camden & Islington Health Authorities for the main part of the study and THT London who via CHAPS provided the extra funding for interviews outside London.

Finally, as always we were assisted by many individuals who are willing to read earlier, wordier and usually more tortuous drafts of this report. Earlier drafts benefited from the attention of: Will Nutland and Jack Summerside (Terrence Higgins Trust, London), Ford Hickson and Michael Stephens (at Sigma Research) and Professor Peter Davies, now of the Department of Health. Thanks, as always to these readers and commentators.

***Peter Keogh***



© Sigma Research  
Faculty of Humanities & Social Sciences  
University of Portsmouth  
Unit 64, Eurolink Business Centre  
London SW2 1BZ  
Tel 0171-737 6223  
Fax 0171-737 7898  
[www.sigma-r.demon.co.uk](http://www.sigma-r.demon.co.uk)

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# 1 Introduction

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## 1.1 BACKGROUND

At a time when research into the sexual behaviour of gay men and HIV is becoming increasingly concerned with addressing questions of policy or evaluation, this report presents research with a different purpose. Here, we investigate how gay men diagnosed with HIV who engage in unprotected anal intercourse (UAI) conceive of and negotiate this activity. We examine the meanings they attach to UAI, the risks (if any) they perceive, and how engaging in UAI affects their lives. Although we focus on this topic, the research we present is essentially investigative. Our methodology and analytic interpretations are not geared towards addressing questions of priority or intervention design. Rather, we are concerned with investigating the experiences of this group in order to unpack the range of social, psychological and cultural meanings attached to this behaviour. Our results do not easily lend themselves to the production of policy. On the contrary, they tend to challenge the categories we use when we think about epidemiology and gay men's health: primary prevention, secondary prevention, mental or physical health.

This should come as no surprise as the meanings gay men attach to anal intercourse (AI) and UAI are particularly complex. In addition, the epidemiological consequences of gay men diagnosed with HIV engaging in UAI are great. The introduction of highly effective antiviral treatments for HIV is necessitating a re-think of practice in relation to both primary and secondary HIV prevention. Recent research has demonstrated that drug resistant strains of the virus can be transmitted sexually (Hecht *et al.*, 1998). That is, infected men can be reinfected and uninfected men can be infected with already resistant strains. Both sero-concordant UAI (scUAI) between infected men and sdUAI are now more problematic as they threaten the efficacy of new treatments both for those already infected and those currently uninfected. Thus, new dimensions are added to both primary and secondary prevention and the two areas become increasingly interlinked.

What we show here is that UAI is something that resists easy classification. It is an act imbued with myriad meaning, its safety and desirability dependent upon the circumstances under which it occurs and the actors involved. Moreover, the concepts of safety and risk that health promoters employ in relation to UAI are not necessarily shared by the men we interviewed. When we (researchers and health promoters) talk about risk and UAI, we must ask the question, what exactly an individual feels he is risking when he engages in UAI and how valuable are the rewards of this activity for him? It is important therefore, for us to engage actively with difference. This means that differences in HIV status, relationship status etc. will influence how risk is perceived through UAI and sdUAI. Important for our purposes is that gay men with diagnosed HIV infection engaging in UAI risk something entirely different to their uninfected partners.

The data presented in this report has two sources. First, information on sexual risk behaviour is provided by the second annual National Gay Men's Sex Survey, 1998 (Hickson, *et al.*, 1999). This provides a sufficiently large sample to allow meaningful comparison of the demographics and sexual behaviour of men diagnosed with HIV, those who have never tested and those who have tested negative. We can now, for the first time, gain a comprehensive, comparative picture of sexual risk behaviour.

The second part of this report presents an investigation of how men with diagnosed HIV infection perceive the risk they are taking when they engage in UAI. In order to do this, we conducted 64 in depth semi -structured interviews with gay men who have diagnosed HIV infection. All had engaged in UAI in the previous year: some with partners whom they know are also infected; others with partners whom they know to be uninfected; and some with partners whose HIV status they did not know. However, most had done so with a range of partners from all three categories.

As section 3 demonstrates this group represents less than half (43.2%) of all men diagnosed with HIV. More than half (56.8%) of all gay men diagnosed with HIV do not engage in UAI in any given year. Therefore, the men described here, their attitudes and beliefs, are not those of all gay men diagnosed with HIV. Our findings are complex. For this group risk associated with UAI is diffuse, multi -faceted and dependent upon many contextual factors. This report attempts to make sense of these risks.

# 2 Methods and samples

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This study draws on two separate samples: a questionnaire sample and an interview sample. The following section details the recruitment, methods of data collection used and the demographics of both samples.

## 2.1 QUESTIONNAIRE SAMPLE: METHODS AND DEMOGRAPHICS

In the summer of 1998 Sigma Research collaborated with a range of HIV prevention agencies across England to undertake their second, annual National Gay Men's Sex Survey. During nine separate community events 6,332 homosexually active men were recruited face-to-face to a self-completion survey printed on two sides of A4. Completed questionnaires were returned to sealed ballot boxes by respondents.

Any description of the behaviour of a sub-population of gay men and bisexual men is hard to comprehend or assimilate without comparison - so we compare men with diagnosed HIV with men tested negative for HIV and those never tested for HIV<sup>1</sup>. These three testing history groupings are used to describe and compare sexual practice. (For a full report of the recruitment methods, sample descriptions and key findings regarding sexual behaviour and health promotion need, see Hickson *et al.*, 1999). Findings are presented in Section 3.

## 2.2 INTERVIEW SAMPLE: METHODS AND DEMOGRAPHICS

Recruitment took place through the national gay press and through posters and fliers distributed at AIDS service organisations in London and other urban centres (see Preface for a list of participating agencies). During the summer of 1998, a self selecting sample of gay identified men who had been diagnosed with HIV infection and had engaged in UAI in the previous year was recruited. The first forty five respondents who met the entry criteria in London were interviewed as were the first twenty from centres outside London. One interview was spoiled due to failure of recording equipment, therefore a total of sixty four men are included in the study. Participants' confidentiality was assured and all were offered payments covering expenses.

### 2.2.1 Sample Description

The demographic profile is similar to other samples of gay men with diagnosed HIV infection (Anderson & Weatherburn, 1999). More than two thirds (69%) were unemployed or medically retired, with a similar proportion (72%) having experienced HIV related symptoms. The research design stipulated that just over two-thirds of the sample should live in London. The remaining third are resident in (in order of frequency) Brighton, Hastings, Bristol, Manchester, Wigan, Leeds and Newcastle.

<sup>1</sup> We have to bear in mind that, at any given time, about a third of HIV infection in homosexually active men is undiagnosed (Department of Health, PHLS, Institute of Children Health, 1997). Some of these may suspect they are infected but the majority are probably unaware of their infection. Other data (Norton, Elford, Sherr *et al.*, 1997) suggest that the majority of homosexually active men who test positive for HIV have not previously tested negative. Hence, men with undiagnosed HIV infection will be distributed between the never tested and last tested negative categories with the majority probably never having tested.

<b>Age</b>		<b>Years since diagnosis</b>	
Mean Age	35 years	Mean time since diagnosis	5 years
Range	19 -60 years	Range	4 mths. - 12 years
<b>Ethnicity</b>		<b>Anti HIV Treatments</b>	
White	92% (59)	Currently taking	58% (37)
African Carribean	5% (3)	Never taken	28% (18)
Mixed Race	3% (2)	Discontinued	14% (9)
<b>Employment Status</b>		<b>Health</b>	
Employed	30% (19)	Had HIV related symptoms	72% (46)
Unemployed	14% (9)	Had acute HIV related illness	36% (23)
Medically Retired	55% (35)		
Retired	1% (1)		
		<b>Area of Residence</b>	
		London	69% (44)
		Outside London	31% (20)

In-depth semi structured interviews lasting 1-2 hours each were conducted with all respondents. All interviews were tape -recorded and fully transcribed and a full thematic content analysis was carried out on each transcript. Risk and UAI were examined through an analysis of critical incidents in the last year. At interview, respondents were invited to choose the accounts of UAI they remembered best or wanted to talk about. The distribution of accounts is given in the table below.

	<b>Partner known to be diagnosed positive for HIV</b> (No. respondents/ No. accounts)	<b>Partner's HIV status unknown</b> (No. respondents/ No. accounts)	<b>Partner known to be diagnosed negative for HIV</b> (No. respondents/ No. accounts)
<b>Regular</b>	24/27	4/6	19/23
<b>Casual</b>	8/9	13/14	3/3
<b>Anonymous</b>		23/31	

The results of these interviews are presented in sections four to six.

# 3 Sexual practices of men with diagnosed HIV infection

## 3.1 ANAL INTERCOURSE BY TESTING HISTORY

Given the primary focus of this report is an investigation of unprotected anal intercourse (UAI) among men with diagnosed HIV infection, it is useful to establish what proportion of this population engage in this activity. This short chapter examines engagement in UAI among homosexually active men with different HIV testing histories. This data is drawn from the second annual Gay Men’s Sex Survey conducted in the summer of 1998.

In figure 3.1 engagement in various sexual activities in the previous year is depicted for the three HIV testing history groups: those who had never tested; last test negative; last test positive. It reports the proportions of each testing history that: had sex but no anal intercourse (AI); AI but no unprotected anal intercourse (UAI); UAI with 1 man; UAI with 2 different men; UAI with 3 or more different men; and those that had UAI but did not specify their partner numbers (these are placed at the bottom of the chart on the assumption that those that confirm they do UAI but do not specify partner numbers are more likely to have multiple partners than not).

The figure demonstrates that the majority (89.8% overall) of men with diagnosed HIV infection engaged in anal intercourse in the last year and half of these (43.2% overall), did so without a condom at least once. On these basic measures there is no difference between men with diagnosed infection and those tested negative (87.6% of negatives do AI and 44.9% do UAI). Men who have never tested, as a group, differ from those that have tested. They are significantly less likely ( $\chi^2 = 192.39$ ,  $df = 6$ ,  $p < .001$ ) to have had either any anal intercourse (78.2% did so) or any UAI (31.8% did so).

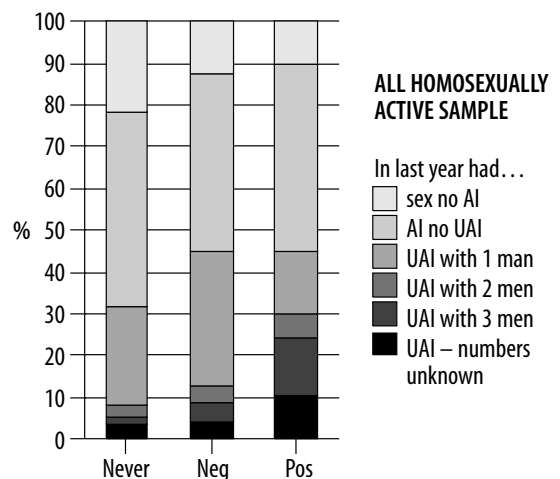


Figure 3.1: Proportion having sex, anal intercourse (AI) and unprotected anal intercourse in the last year by HIV Testing History (never tested, last test negative, tested positive)

Diagnosed positive and negative men who engage in any AI are equally likely to do UAI. However, among those that do UAI, diagnosed positive men do it with significantly more partners than either of the other two testing history groups. Overall a quarter of the never tested (23.5%) and a third of tested negative men (31.8%) did UAI with one man only. By comparison, less than a sixth (15.3%) of men with diagnosed HIV did UAI with one man only and a similar proportion (13.6%) did so with three or more partners.

The men with diagnosed HIV infection that do UAI, are least likely to do so with just one partner, and most likely to do so with two, three or more, or not to specify how many men they did UAI with. If we examine the average numbers of partners UAI occurs with, the same pattern emerges.



Although the diagnosed positive and negative men are equally likely do (U)AI the diagnosed positive men who do so, have significantly more partners. Hence, not only do a substantial proportion of men who are diagnosed positive engage in UAI, but many do so with relatively high numbers of men.

### 3.2 CONGRUENCE OF HIV STATUS IN UAI

Of course, it could be argued that in terms of HIV exposure, UAI between uninfected men is irrelevant. In order to understand sexual exposure to HIV we have to understand levels of engagement in UAI and the HIV status (or at least their testing history) of the participants.

Figure 3.2 summarises engagement in UAI in the previous year across the three HIV testing histories. The three sections denote: UAI only with partner/s known to be of concordant HIV status; UAI with any partner/s of unknown HIV status but not with partners known to be discordant; and UAI with any partners known to be of discordant HIV status’.

Men who have never tested do not fit into this categorisation well. While they are least likely to engage in any UAI it is not possible to classify the UAI they have into concordant or discordant since their own HIV status is unknown (to us). This does not mean that these untested men have no idea of their HIV status; most correctly recognise that they are uninfected and strive to avoid UAI where exposure is likely (Henderson *et al.*, 1999).

Among men that engage in any UAI, those with diagnosed HIV infection are less likely only to engage in UAI that is sero-concordant (25.8% compared to 34.6% among negatives); and less likely to engage in UAI with any partners whose HIV status was unknown, but not where it was known to be sero-discordant (40.9% compared to 58.8%) but most likely to engage in any UAI that is thought to be sero-discordant (33.3% compared to 6.6%). Men with diagnosed HIV infection are also least likely to fail to provide sufficient information to complete this graph, which in itself is worthy of reporting given the very sensitive nature of these questions.

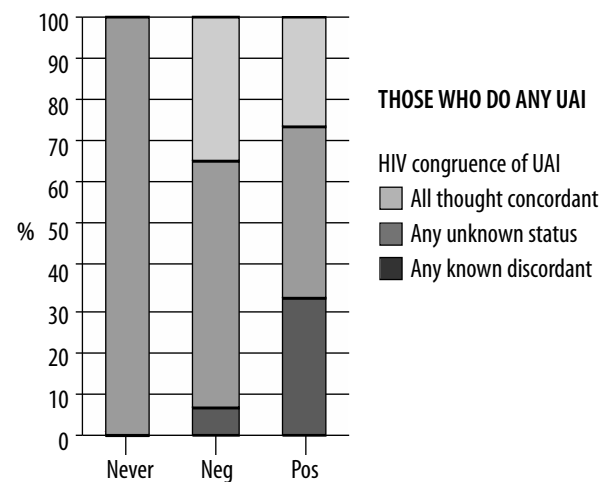


Figure 3.2: Knowledge of HIV congruence with unprotected anal intercourse partners, by HIV Testing History (never tested, last test negative, tested positive)

It should come as no surprise that men with diagnosed HIV infection are less likely to engage in sero-concordant UAI and more likely to engage in sero-discordant UAI. Given that men with diagnosed HIV infection are in a substantial minority, all other things being equal their UAI will usually be sero-discordant while the opposite is true for men (tested) negative for HIV. However, UAI not known to be sero-concordant is relatively common - with a third (32.6%) of all men with diagnosed HIV infection engaging in any UAI with partners whose HIV status is known to be sero-discordant or is unknown.

# 4 Framing risk: hazards associated with UAI

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We have seen in the previous section how having an HIV test result and testing positive are both associated with significant differences in sexual behaviour. Tested men engage in more UAI overall, while men who have tested positive do so with significantly more partners. In the next two sections, we attempt to describe the contexts within which UAI occurs. In this short section, we describe how gay men diagnosed with HIV perceive the risk they take when they engage in UAI. This is intended as an introduction to section 5 which gives a more in-depth account of these risks as they are experienced with a range of different partners. However, before describing their attitudes towards risk, it is worth dwelling on their attitudes to condom use and anal intercourse.

## 4.1 ATTITUDES TOWARD ANAL INTERCOURSE AND CONDOMS

We asked our respondents to talk about their attitudes towards condom use and anal intercourse. Almost unanimously, they voiced a distaste for condoms with two thirds reporting that either they or their partners experienced serious difficulty maintaining an erection while using them.

Traditionally, among gay men diagnosed with HIV, difficulties associated with using condoms have been attributed to psycho-sexual dysfunction with many studies showing that this group show higher levels of psychosexual morbidity and sexual dysfunction than gay men who are not diagnosed positive (Brown *et al.*, 1989; Green, 1993). While not disputing such findings, we must be wary of any impetus to attribute not using condoms solely to sexual dysfunction. The majority of the men in our sample did not use condoms because they did not like them. Very few accounted for not using them reference to mitigating circumstances (such as being drunk or feeling low). As with samples of untested and negative tested men (Henderson *et al.*, 1999) their main reason for not using condoms was that they make anal intercourse less enjoyable.

**“... I don’t like condoms and they ruin the whole thing for me so it gets to the point that I try to put a condom on and everything goes limp so I don’t even try to persevere ... What about when you are being fucked? Is there a problem with condoms then? [...] my partner [...] doesn’t like them either, they ruin it for him. And we both agreed that we would leave them out.”**

Not using condoms was also often associated with love and intimacy in relationships.

**“There was no way that we could go on using condoms for ever. The more we loved each other, the more they became inimical to the way we feel. There are things that are simply more important.”**

Many men reported however, that they would prefer not to use condoms in casual or anonymous contexts also. This is important, as the desire to dispense with condoms did not appear to be associated with any particular type of relationship or context. There was therefore a certain acceptability of not using condoms: in any circumstance, UAI is always an option (even if not acted upon). To understand why UAI is acceptable to many men, it is helpful to examine the risks that these men associate with it.

## 4.2 THREE TYPES OF RISK ASSOCIATED WITH UAI

Our analysis identified three types of risk that gay men with diagnosed HIV experience in relation to UAI. These were: social risks, emotional or psychological risks and physical health risks. These three categories were not distinct. Some men experienced risk of one type more than others, however, most men's experience of risk was multi-layered, incorporating all three.

### 4.2.1 Social Risks

The risk of social censure, of being seen to be irresponsible was most common, especially in relation to partners perceived to be uninfected. Men were concerned about meeting again a partner with whom they had engaged in UAI and this fear influenced their behaviour. Having had social or personal contact before UAI and not disclosing was seen as particularly risky.

**"I know it in my own mind that I'm positive and it's not fair to bring this lad into my house and have full sex with him. Because at the end of the day you are going to bump into him again."**

This fear was lessened somewhat in anonymous environments but it was still present. The same respondent talks about his regrets after engaging in UAI in a sauna.

**"I was annoyed at myself because if I met him in the future... in the waiting area for the hospital or at Body Positive. I thought, I'll meet him again in the future."**

In anonymous settings, there was also the fear that one will be seen engaging in UAI by others who know you are diagnosed positive.

***Supposing [anonymous partner in backroom] turned out to have contracted HIV from you, what would you think about that?***

**I wouldn't have known.**

***But supposing?***

**I would probably have felt guilty but [...] The impression I got was that he was going around doing it with everyone [...] The thing that worries me more is what other people would think."**

The risk of social censure can also influence behaviour in cases where UAI has occurred between two infected men. In the following account, neither partner has disclosed their status to each other. However, he knows his partner is infected through mutual friends.

**"And I thought 'Oh he ain't going to use anything' and then he started to push his way in. And I thought 'oh never mind, I'll let him do it anyway' [...] he fucked me and he actually came up my bum and then later on I fucked him. And the following morning he told me he was positive and I thought well what a strange thing to do because I hadn't mentioned anything about my status [...] Because if you knew you were positive and didn't know their status, you wouldn't do it to them in the first place [...] he obviously isn't bothered about me at all, just getting his end away [...] it did make me realise that he wasn't possible future boyfriend material because he obviously had no consideration for other people."**

### **4.2.2 Emotional and Psychological Risks**

In order to preserve their own psychological well being, some men avoided social contact with sexual partners with whom UAI had taken place. Although believing that responsibility for sexual safety is mutual, they reported not wanting to know if infection had occurred.

**"I would find it very difficult to live with myself knowing a person that I might have infected. I'm sure it's happened, I'm sure that there's somebody out there somewhere with my virus in them, but..... if there is, you know, it was their choice, but it would be too upsetting to be faced with that."**

It was far more common however for emotional or psychological risk to be discussed within the context of long term committed relationships. Here the risk was of the consequences of infecting a loved one. Therefore, for the most part, the risk to be avoided is exposure and transmission. Although men for whom UAI had resulted in the infection of their partner did express guilt, it was more common to report guilt over the possibility of transmission, that is exposure through UAI. This respondent describes his reactions to having UAI with his uninfected partner.

**"I just clicked 'Oh shit what have I done?' type of guilt [...] He [partner] was just like 'well it's happened'. He was saying 'It's my fault for insisting', and I was saying, 'no it's my fault' [...] I wouldn't let it go. I just couldn't really. It was in my head and my head was fucked."**

The risk is not always related to isolated incidents of UAI, some men reported guilt feelings pervading many aspects of their relationship related to incidents of UAI from the past. Many reported that these ongoing feelings of guilt threatened or terminated relationships.

**"I can't help but look back at how wonderful it was and how we could have spoilt it by being so stupid. And also I have this huge feeling of like, responsibility, because if he is positive it will be from me. Now if he'd been out and fucked around a bit before unsafely then there's a chance it could have been from someone else and that would lighten my guilt a little bit, whereas it would solely be from me. So I find that quite hard to... and then every time he's like a little bit ill I get a bit panicky - 'Oh God', you know?"**

### **4.2.3 Health Risks**

Finally, a minority of men reported that they perceived a risk to their health through engaging in UAI. This risk was associated with contracting another strain of the virus, contracting a resistant strain or contracting a sexually transmitted disease. Some reported recently changing their behaviour because of such concerns.

**"The sex [in the past] with positive men at that time was unsafe because you know 'what's the point? - it doesn't matter' - because it's only recently this thing's come around about cross -infection, drug resistance and all that kind of thing. So that's why it's important to use condoms regardless now. But I still don't like them."**

However, the following comment was more typical.

**"I know this thing about being reinfected and all that crap."**

We should stress the social and psychological risks were by far the overriding concern of the majority of the men that we interviewed. Perceptions of a risk to health were reported by a minority in spite of that fact that all men were prompted to talk about this subject.

It is clear that the nature of the risks attending UAI are entirely different for gay men infected with HIV than for their negative counterparts. For an uninfected man, there is an immediate and singular danger: that he might have become infected with HIV. For a gay man diagnosed with HIV, the risk that he exposed another man to the virus and may have infected him, although still serious, is experienced as more diffuse and mediated. Awareness of social, psychological and health related hazards did not stop the men in our sample engaging in UAI. Rather, it led to them developing many and complex strategies for reducing and managing risk. The next section describes these strategies and illustrates how they are mobilised through accounts of UAI with partners assumed to be uninfected or whose status was not known. These strategies reduce the probability of transmission of HIV, that is both primary and secondary transmission. However, should transmission occur, they also reduce the associated social, psychological and health risks described above.

# 5 Managing risk: engaging in UAI

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This section contains the bulk of the qualitative data presented in this report. Here we describe in detail how the hazards we have outlined in the previous section are mobilised in different contexts and with different partners. We start with risks to health and then move to what for most respondents were the two most important hazards: social and then psychological and emotional hazards. Social and psychological hazards were generally expressed in relation to UAI with partners who were either known to be uninfected, or whose HIV status was not known (that is, sdUAI). Health hazards were generally (though not exclusively) expressed in relation to partners who were known or assumed to be HIV infected (that is scUAI). In order to examine both these risks and the strategies that men employ to reduce them, we will present them within the context of men's accounts of UAI.

## 5.1 RISKS TO HEALTH: RE-INFECTION, CROSS INFECTION AND DRUG RESISTANT HIV

**"...what's the best analogy? - if you're in an aeroplane and you know you're going to crash then you might as well screw everybody on the aircraft, mightn't you? [...] What I'm saying in other ways is the threshold for people negative-positive is having it or not having it - but once you've got it, it's a different threshold, isn't it? It's a question of trading off one bug for the other [...] it's a different order. You're not dealing with a life or death situation, you're only dealing with early or later death...."**

Dramatic increases in the range and effectiveness of HIV treatments since 1996 have been followed by studies which suggest or have demonstrated that sexual transmission of drug resistant HIV (DRHIV) is occurring (Hecht *et al.*, 1998). The development and containment of resistance to these drugs has been identified as a major factor for their continued efficacy on a population level.

Almost two thirds of the sample were taking anti HIV drugs at the time of interview. All respondents were prompted to discuss the transmission of drug resistance or other strains of HIV through UAI. For roughly two-thirds of the sample, the risk of re-infection was thought to be minimal or its consequences not important enough to develop strategies to avoid or minimise such risks. The remaining third, however, displayed a variety of attitudes.

**"All I know is that the virus is constantly changing and can adapt and there's different strains so if I'm going out with somebody who is HIV, you've still got to have safe sex."**

**"No, that's [sexual transmission of DRHIV] something I think about in isolation when it's too late [...] I think I only think about it when it's part of a discussion or when I'm reading the paper."**

The significance of re-infection was interpreted as being more or less serious by different men. Many did not think it was likely that their sexual behaviour would lead to a re-infection, that is they perceived the probability of re-infection as low. Of those who did see re-infection as a real possibility, most perceived that the consequences were not grave. That is, re-infection was unlikely to adversely affect their health.

There was therefore considerable difference in how seriously men perceived risk and consequently what risk reduction strategies they felt were necessary. Thus, although the majority of the men saw this issue within a framework of risk, they characterised dealing with infection with DRHIV as a 'trade off' between their own personal pleasure or fulfilment on the one hand and the risk they incurred on the other. We investigated this further by analysing discourses around initial infection with HIV and re-infection. Such an analysis shows that lack of evidence, but more importantly, lack of a 'diagnostic moment' is crucial in shaping men's attitudes to re-infection.

Infection with and diagnosis of HIV has been characterised by respondents as a set of discreet unitary events. An individual becomes infected during an (one) incident of unprotected anal intercourse, then sero-converts and is infected. It is interesting that most of the men felt they could identify the occasion on which they became infected, and how they felt afterwards.

**"...one of his friends in this group was a prostitute - a rent boy. And we decided to go out on the piss [...] and got absolutely paralytic and then went back to my place. He fucked me, woke up sober going 'Oh shit'. [...] he's a rent boy and he's likely to have it [HIV]. I hadn't been fucked for quite a while before then [...] From that moment on I just assumed I had it."**

**"It was this bloke I'd been seeing on and off. One night, he fucked me without a condom [...] it had happened a few times before, and I remember thinking on that occasion, 'he has it and now so do I' afterwards. It was after he was asleep and I just had this dark feeling.... I didn't know his status because after we lost contact, but I'm sure that was the night."**

Stories of HIV diagnosis tended to be similar. It was commonly experienced as a single traumatic event which initiated a period of massive upheaval and rapid adjustment. For most, the way they lived their lives, their life expectancy, self image and how they perceived the world around them were all subject to major and irreversible change.

**"[I] had a one day test. I was admitted to one of the wards that evening because they wouldn't let me out of their sight because I had literally freaked, completely and utterly freaked."**

These accounts describe a singular and sudden transition from being HIV negative to being HIV positive: a 'moment' of infection and/or diagnosis, easily identified and remembered. Such a construction of HIV diagnosis is supported by the way in which HIV is characterised generally. One is either positive or negative, infected or uninfected. A diagnosis therefore, means a sharp transition from one camp to another. It is also clear that such a 'moment' is linked to the development of one's identity as an HIV positive person in complex ways.

In contrast to this, re-infection was seen as something that could not be diagnosed and thus could not be marked by a singular 'moment'. Instead, men tended to characterise the risk as mediated, gradual or progressive and, most importantly, as cumulative. That is, men tended to see re-infection as receiving into the body more of a virus that is essentially the same as the one already there, rather than being infected with a virus that is essentially different to the one already present in their bodies.

**“...given the fact that I’m positive and all the upheavals associated with that, the incremental dislocation [of a re-infection] is so minor given the diagnosis in the first place - it’s like an extra 1% or something. That may not be true in reality, but it’s my perception.”**

So, men compare the psychological and social trauma of infection with that of re-infection and not surprisingly find that the latter fades into insignificance. What they do not compare is the likely harm that re-infection may cause. The conception of re-infection as a matter of degree is related to the way in which men conceive of the virus. Men are used to thinking of the virus as getting stronger and weaker over time, but essentially, it is a singular entity. Moreover, it is not something that can be eradicated, it will be in the body until death and will most likely, eventually overwhelm the body’s resistance to it. HIV is therefore characterised as something to be controlled as effectively as possible for as long as possible. Certain behaviours contribute to this control (stress relief, dietary control, taking certain drugs, keeping healthy, refraining from smoking or alcohol) whilst other behaviours impede it (smoking, drinking, taking recreational drugs etc.). For most men, a balance is struck between engaging in behaviours which control the virus whilst maintaining pleasurable behaviours which might impede this control. This is a common health maintenance strategy. Thus a man may smoke and know that smoking suppresses his immune system. However, in relation to the other benefits of smoking (relaxation and enjoyment) he considers this a risk worth taking.

Many of the men in the sample perceived re-infection in the same way. UAI with other diagnosed positive men was considered to be something that may impede their control of the virus, however when weighed against the benefits, many considered it worthwhile.

**“I know I might be getting something that’s going to help the virus do its work. But when you got to go, you’ve got to go and we all go sometime.”**

A minority of these men reported insufficient knowledge about the subject.

**“It’s something I really don’t know that much about. Maybe if I knew more about it, I’d do something about it.”**

However, the majority felt that they were well informed but that such information made little difference either to their attitudes or their sexual behaviour.

**“It’s [sexual transmission of DRHIV] just never bothered us. We’ve read about it and we’ve sort of heard about it but it’s never really bothered us.**

***Why is that ?***

**I really don’t know.**

***Why aren’t you concerned about these things?***

**Because we both enjoy it without the condoms, and we don’t see any fears in it anyway...”**

Although two thirds of our sample did not see re-infection as a present risk, the remaining third characterised this risk in complex ways. For the minority of this group, re-infection is a straightforward risk to either their own or their partners’ health to which they respond with appropriate risk reduction strategies. The following two examples illustrate this. This recently diagnosed respondent talks about how he learnt about the issue of re-infection:

**“...when we got to bed he did say ‘it’s up to you if you want to use a condom or not’. And because I didn’t really know much about two positives having sex, I said ‘What more risk could we be at?’ He said, ‘Well there’s no proof’, so we both had sex without condoms.**



***What about afterwards?***

**I did think about it afterwards [...] Because I talked it over with my doctor, and she said that the drugs he's on is different to mine and it could be different strains so now I've stopped having unsafe sex with him. So if I do go back now, it's condoms only and he accepts it [...] When I found out that you could still pass things on, the drug resistance, I don't like to put them at risk. It would be like me sleeping with someone who was negative and I don't pass nothing on that they don't want. That's my basic rule"**

The following respondent is resistant to nearly all the treatments he has tried. However, instead of refraining from UAI altogether, he describes a behavioural risk reduction strategy to protect his partners.

**"...The only option for me next is salvage therapy [...] so I'm enjoying myself now. [...] Would you fuck with a casual partner again if he told you that he was positive? Yes.**

***It doesn't really affect you...?***

**But it might affect them [...] as I've said, I'm normally passive so I'd be the one who was getting fucked so I'd be the one who'd be getting infected."**

These men are using strategies of risk reduction. The first is reducing the risk for himself by deciding to always use a condom for anal intercourse with other men who are diagnosed positive. The second does not perceive a risk for himself, but for his sexual partners.

However, the majority of men who talked about the issue of reinfection and DRHIV talked in terms of discriminating between partners. It was often the case that men would engage in scUAI with partners whom they loved or felt close to while not doing so with partners whom they did not know so well. Such discrimination should not surprise us as for the men in this and other studies (Henderson *et al.*, 1999) unprotected anal intercourse is closely related to intimacy and love. What is interesting is the way in which such men used the issue of re-infection to support the decisions they made about UAI with their partners. That is, discourse about re-infection was often elided with this type of discrimination between partners.

In the following case, the respondent has recently broken up with his negative long term monogamous partner and finds himself having sex with a positive casual partner. For him, the issue of re-infection mobilises concerns about maintaining monogamy with his ex-partner and distinguishing between his current (casual) partner and a possible long term relationship in the future.

***"So what was the main reason you felt that you shouldn't be [having UAI]?***

**Because I didn't think that I had completely resolved things with my boyfriend, [...]and I didn't particularly want to put myself at risk really, from a different strain or [...] I mean I'm hoping that I'm going to resolve things with my [partner] but if I didn't and I met somebody who was positive and we were having a proper relationship, a monogamous relationship like I've had for the last year and a half, then I wouldn't be so bothered about condoms then.**

***Is re-infection a real threat for you?***

**It's a real threat for me for like casual partners or anonymous partners, but if I got involved in a serious relationship with somebody and I thought it was going to last then maybe it wouldn't be quite as important."**

In the following case, re-infection and infection with STDs is used as a way of distinguishing a regular or emotionally committed relationship from a casual one.

*"[At the time] did that bother you at all that he was fucking you without a condom?"*

No, no.

*Did you talk about it afterwards?*

We haven't no, still to this day because I'm still seeing this guy quite regularly and we have sex with both of us fucking and condoms unfortunately aren't mentioned at all.

*When you say 'unfortunately', would you prefer to use them?*

Yes I would.

*Why?*

Because of my... I'm just getting myself... my viral load and CD4 count sorted out and I really don't need anything to go wrong at this time which is why if I'm having sex... If I'm having sex with anybody else now, this day and age, I will see condoms are used.

*[...] How does that fit in with what you just told me?*

With the lad I'm talking about... When we have sex, that doesn't really come into my mind. It's only when I go out and I meet somebody else where I start thinking about my CD4 count and viral load. I think because I've known him so long and we've grown very close to each other that when we have sex it's more of love really and it's not casual."

Conversely, for some, the idea that they might be passing on drugs through UAI was seen in a positive light. This respondent is in a committed relationship where both are positive and for whom their relationship is a major source of happiness. The respondent is on protease inhibitors whilst his partner is taking no treatments.

*"...his viral load drops all the time, so he fucked for nine months without condoms, and his viral load gets less and less - fascinating, isn't it?"*

*Have you talked about that?*

Yes - probably he must have been picking up the protease inhibitors or something.

*Is he on any medication at all?*

No.

*It might also be that he's happier?*

Yes, I think so. But it's fascinating, isn't it? We screwed once a day for nine months without condoms, and his viral load progressively gets lower and lower."

Re-infection was not only used as a way of distinguishing between intimate or loving partnerships and non intimate ones. There were many other ways in which the concept of re-infection was mobilised in order to distinguish between sexual partners of all different types. For many men, such distinctions were not rational ones. The following man will not engage in receptive UAI with men who have disclosed that they are infected, but will with men who have not.

*"I mean it's a bit like living in a little bit of denial I suppose. No, it's almost like you're saying 'What you don't know won't hurt you' but of course it does. [...] All I can do is try and be as responsible as I possibly can be and allow other people to be responsible for themselves. And obviously if... I have to be comfortable with the fact that I am prepared to let somebody ejaculate into me not knowing their status when they could be positive but I'm not if they tell me. I know that doesn't make a lot of sense but it's something that I can live with."*

## **5.2 SOCIAL RISKS AND EMOTIONAL & PSYCHOLOGICAL RISKS**

The accounts of UAI presented here constitute the majority we received. They covered regular partners within long term loving relationships, regular partners within what might be called

sexual friendships, casual or one off partners and anonymous partners with whom no social interaction took place.

### **5.2.1 Risk Reduction Strategies in Long Term Committed Sero-discordant Relationships**

In all of the accounts of UAI within long term committed relationships, both partners knew about their sero-discordance. Men in such relationships who practised anal intercourse regularly with their partners, perceived the likelihood of UAI occurring to be high.

For some, this was problematic. For others however, it was acceptable. Those who found UAI within their relationships problematic generally referred to accidents or slip ups. These were sometimes the source of considerable anxiety, the severity of which could be enough to damage or terminate a relationship.

**“... as soon as [UAI] had happened we just felt horrendous afterwards, and this was the beginning of the little problems. And then it was never going to happen again. And then there’d be a spate of like safe sex for a few months or a month or whatever, and then we’d have a little... we’d go out or something, and it would happen again a few times. And then there’d be a spell of like safe sex. And this is when we started to have sexual problems then a bit, and he started coming very quickly, and there was a lot of anxiety around sex at this time [...] and we decided never, ever, ever again. And then [we] had unsafe sex again - and that was the... that was like the start of real problems then, because I kind of went off sex, and he’s very sensitive as well. He’s a very sensitive person. And because I’d gone off sex a bit, because I felt guilty and stuff, he’d kind of thought I wasn’t into him as much and he’d get very insecure [...] I just thought ‘I’ve had enough of this’”**

Others reported that they found the idea of using a condom for all instances of anal intercourse for the rest of one’s life entirely unacceptable and an intolerable barrier to sexual and emotional intimacy (see section 4). The men were obliged to develop risk reduction strategies.

We have already shown that the main risk perceived was the emotional or psychological consequence of infecting a loved partner. Such difficulties were overcome by changing one’s perception of the risk posed to oneself and the risk of infection faced by their partner.

This is dependent firstly on distinguishing between exposure and transmission. Many men learned that accidents or slip-ups had exposed their partner to HIV (perhaps including ejaculating inside their partner) and yet their partner had remained uninfected.

**“HIV isn’t the easiest thing in the world to catch. You might be unlucky, but it’s not like the moment he gets a dribble of my infected cum up him, he’s going to get it [HIV].”**

Learning the distinction between exposure and transmission experientially was seen to be important. However, it was more important that the uninfected partner understood this distinction, having risked infection through exposure in the past and remained uninfected. This was an important factor which signified that both partners had a certain proximity to HIV.

***“Are you surprised [that partner tested negative]?”***

**Well, I’m relieved. If I’m not totally surprised, possibly it’s because I knew that he fucked without a condom before he met me, with other people - and some of those people have been positive.**

***Did that form any part of your decision to fuck without condoms?***

**Yeah, I think it must have influenced that.**

***In what sense?***

**I think one way it informed it was that it wasn't as if it was totally... you know, he was coming to it cold."**

This experience of exposure without transmission influences perceptions of risk in many ways. One minority reaction was to believe one's partner to be immune to HIV.

**"... we're both very lucky and he's one of these people who have a natural immunity. But I don't know... I think, as it happened, I didn't infect him."**

More often, it contributed to greater acceptance of accidental instances of UAI. For many, this experience leads to a re-appraisal of acceptable risk and an acceptance that any anal intercourse with their partner (even if protected) involves some degree of risk.

**"We know that it [infection] may happen, but we have to live with that. We're doing our best to make sure that it doesn't, but, it might. [...] any condom we use might have a hole and we'd be lulled into a false sense of security. I think we're just trying to live with the insecurity and get on with it."**

It is clear therefore that this unique proximity to the hazard and the consequent acceptance of risk helps to explain how instances of sero-discordant UAI are acceptable to both partners. What is important here is the level of risk that partners are willing to take to enjoy a fulfilled sex life. Therefore, the disadvantages of condom use will be weighed against the risk of infection and the risks balanced with benefits.

**"It's a development over the past couple of years [...] it's sort of gradually come.... He's actually worked it out that it works and he thinks that it's quite safe, so [...] I think just actually trying to have sex with condoms. It wasn't really working. He'd lose his erection. I'd perhaps get annoyed about it. That annoyance would make me tense up so he wouldn't be able to get his semi erect cock inside me. [...] but he can often get an erection to start off with so he will actually start fucking me and way before he is about to come but once he's actually got a good erection and he's been doing it for a while, he takes it out and quickly puts on a condom.[...] I suppose it is safer sex to the extent that any damage might occur later on in the fucking process and not in the first sort of minute or so. [...] I think we seemed to think that the risk was low, so... it's really a choice from doing that or not having [anal intercourse]."**

It is clear that such strategies are based entirely on the personal circumstances of the partners. In the above, when insertive, the infected partner always uses a condom, based on a belief that transmission is less likely from the receptive to the insertive partner than vice versa. They also believe that if transmission is to occur in this way, it is likely to be later in the intercourse when the penis of the insertive partner can suffer abrasion. Finally, they have taken risks before (both by accident, slip-ups and through the use of this strategy) and the uninfected partner has remained uninfected. Thus, they believe this to be an indication of the broad utility of their strategy. Finally, they both accept the possibility that the uninfected partner may become infected, but this risk is minimised by this strategy and when set against the advantages of a fulfilled sex life, is judged to be a risk worth taking.

By definition, risk reduction strategies do not eliminate the potential for transmission but reduce it to a level acceptable to the partners. Clearly, what is acceptable involves a complex

assessment of the circumstances. Therefore men take into account whether the infected partner is insertive or receptive; and if insertive, whether he ejaculates, as well as how vigorous the anal intercourse is (that is how likely it is to damage the lining of the rectum and/ or traumatise the penis). For most men, if the infected partner is receptive, a lesser risk is perceived.

Other factors inform strategies of limited risk taking in long term loving relationships. One is the past sexual experience of the uninfected partner, specifically, how much risk he has taken with either his other present or past partners. This has two facets. The first is the possibility that the undiagnosed partner is already infected as a result of past UAI (either by accident or before both partners knew that one was infected). In the following case, this belief has not been validated by HIV test results, the respondent unwilling to learn whether or not his partner is infected.

**"We know he's infected, but if he got tested do you see, we'd know for sure it was me that did it and he'd know for sure he was positive. So we don't really want to know that for sure."**

For some, a negative test result would mean not only that the couple would have to re -think their practice of UAI and change their sexual behaviour, but also if the uninfected partner were to sero -convert in the future, then he is very likely to have been infected by the respondent.

**"The way I thought of it was that I know having had the test that if he becomes positive, it will be me that's made him positive."**

There appears to be an ambivalence (at least) or a denial (at most) at work in these cases. It does seem that it is easier for these respondents to assume that both partners are already infected rather than deal with the difficulties associated with a sero -discordant relationship. These are certainly not examples of epidemiologically perfect strategies to avoid HIV exposure or transmission.

The second case where the uninfected partner's past risk taking is significant is in mobilising his active participation in the decision to engage in UAI. In this instance, it is not that the partner might be infected that makes the difference, rather that he has opened himself up to the possibility of infection in the past. That is, he is aware of the risks and has taken them before. On one level, this makes it possible that if one's partner tests positive, he was infected by someone else or prior to one's own diagnosis.

**"...he has done it before and he knew what he was up to. It's not that we believe he's positive, it just means that when something goes wrong [an accident or slip -up], it doesn't mean 'Oh my God I'm infected' 'cos he might already have it. It takes the guilt thing off me."**

Moreover, the fact that one's (undiagnosed) partner has previously exposed himself to infection has other meanings. Having engaged in UAI with someone else indicates that he is not naïve to UAI nor to its possible consequences.

**"I think one way it informed me was that it wasn't as if it was a totally... you know, he [uninfected partner] was coming to it [sero -discordant UAI] cold. He had thought about it before and assessed the risks. He had set his pleasure against the risk of becoming infected. And he had, in a sense, made that decision before he even met me..."**

This is not to say that past risk behaviour is seen as a green light to engage in UAI. Rather it is used along with risk reduction strategies (such as the infected partner always being receptive for UAI) to provide reassurance that the risk is worth taking.

Not all couples found successful strategies to maintain a fulfilled sexual and emotional life while remaining sero - discordant. Some reported cases where UAI was clearly problematic for them and for their partner. Sometimes UAI occurred at times of stress in the relationship. Other men reported engaging in UAI as a way of sealing their relationship with their undiagnosed partners. Such cases were a minority, but counteract the impression that all cases of UAI within long term committed sero -discordant relationships are planned and unproblematic.

### **5.2.2 Risk Reduction Strategies with Casual and Anonymous Partners of Unknown Sero status**

Transmitting HIV to a partner in casual or anonymous contexts was still perceived as a potential source of guilt and other negative feelings, but it was also important to avoid the negative social consequences of being seen to have exposed a partner to HIV. A key factor in this perception of risk was the notion that within casual or anonymous encounters, one had sole responsibility for maintaining sexual safety. This contrasted with loving or committed relationships where most men felt that they were acting as part of a couple where the consequences of risk taking were often shared.

We examined the strategies developed to reduce these risks. The primary strategy involved a personal or ethical code of conduct regarding sexual safety which, if not breached, protected one both from self blame and from the blame of others. Analysis revealed two extremes of such a strategy. We called these the protective and the permissive positions. Belonging to the former were those men who took on themselves all responsibility for sexual safety during anal intercourse with casual or anonymous partners.

***"I don't think you should just think 'well obviously because they've [partners] not asked me, [if I am infected] obviously they're not concerned'. I mean I couldn't live my life like that. I couldn't have sex, well not penetrative sex and stuff like that without condoms. I couldn't put anyone at risk."***

In contrast, men who took the permissive position tended to believe that the responsibility to avoid infection is entirely that of the uninfected partner.

***"If he [casual uninfected partner] had said to you, 'shall we use condoms?' What would you have said?  
'If you want', probably, it's his business."***

The men at either of these extremes were in the minority<sup>2</sup>. The majority felt that they shared responsibility for avoiding transmission during UAI with their partners and varied in the amount of personal responsibility they perceived or were prepared to take.

<sup>2</sup> As we have emphasised before, our sample (containing no men who have not engaged in UAI in the last year) is likely to under-represent men who take the protective position and over-represent men who take the permissive position. Men in the former category are likely to be better represented in the 56% of gay men with diagnosed HIV infection who have not engaged in UAI in the last year who are purposely excluded from this study.

**"And I think he told me he hated using condoms as well and he'd like to fuck without condoms. And I said, 'well you know what the risks are, don't you?' He said, 'Yes but I'm not bothered'. And then I agreed that I much preferred being fucked without condoms."**

***"You would have gone along with that [UAI]?"***

**Yes. Not because I'm some sadistic butcher that wants to go around spreading disease about and making everybody riddled but... He's obviously thought about it. I would have said, 'Have you thought about the risk?'. To which he would have probably said, 'Yes I know'. But if he had said no I would take him along to the hospital with me and say 'Look, talk to this bloke, tell him the risks'. Then if he still decided, 'No I don't want a condom, then it's his problem, not mine."**

Although men varied in the amount of responsibility they were willing to take, they developed risk reduction strategies for these contexts. The first was to maximise the likelihood that a casual or anonymous partner whose status is unknown is already infected (that is reduce the probability of exposure). The second is to reduce the possibility of transmission by modifying sexual behaviours (for example, reducing the duration of anal intercourse, always being receptive etc.). Finally, the third is to ensure that should exposure occur, social embarrassment or blaming are avoided. Thus partners already likely to be infected were selected, behaviour was modified to reduce the possibility of transmission and finally, information was controlled in social and sexual encounters to reduce social and psychological harm should transmission occur. It is worth dwelling on these three strategies.

First, one of the most common risk reduction strategies was to select partners whom one either knew or believed to be diagnosed with HIV or whom one could assume was infected with HIV, even if not diagnosed. Indicators that an unknown partner is indeed infected are many and generally dependent upon the social context within which the encounter takes place. Geographical areas or certain social scenes were identified where there are likely to be a high proportion of diagnosed positive men. This man refers to a gay resort in Miami where he recently lived.

**"I think a lot of people over there [Miami] would assume that people are positive unless they tell you otherwise."**

However, men in London and Brighton described social settings where the concentration of diagnosed positive men are assumed to be high(er). These centred around certain bars and certain times of day.

**"There are places where you go where you know that if you pick someone up, it's likely he'll be a positive bloke. [Names a gay bar] is always packed after [names an HIV drop-in] empties out."**

**"Everyone knows that there's a positive crowd that goes to [names a gay club] on a Sunday night - everyone else has to work on Monday."**

However, often other clues are necessary. Who one knows, or who one is seen with and being seen in HIV service centres are also important. Often, friends will supply the missing information.

***"...had you any idea what is status was?"***

**Yes - 'cause he said something to one of my friends."**

Topics of conversation are often taken to indicate a positive HIV status.

**"I had an inkling that [he] might have been [HIV positive] from various things that had been said - not actually related to HIV, but just on actually illness and things [...] He kept on saying that he had colds a lot and was tired a lot and things like that. But it wasn't really related to an HIV sort of conversation, but it's just sort of things he said in general."**

As well as the presence of HIV treatments and other drugs in a partner's home.

**"When we got into his bedroom, there were pill bottles everywhere."**

Finally, a simple willingness to engage in UAI is often what reassures respondents that their partner is indeed already infected.

***"What do you think his HIV status was?"***

**Probably positive**

***Why do you say that?***

**Just by his keenness, his eagerness, his familiarity with it**

***His familiarity with what?***

**Shagging without pausing for a thought."**

The accounts that we have given were marked by a certain assurance in the assessments that were made. It was common for men to report 'just knowing' about their partner's HIV status without being able to easily pinpoint how they came by this knowledge. Often, respondents had to stop and think when asked about this and go through a process of analysis of their own actions and accounts before being able to answer our questions. That is, many men had to bring to mind a series of assumptions that were perhaps not consciously made. This analysis is borne out by the lack of actual conversation with partners about HIV or about their HIV status. In this case, a respondent talks about a partner whom he has ceased to see and whom he describes as HIV positive.

***"How did he react when you told him [you were HIV positive]?"***

**It never came up. It never came up because I think... we never talked about it. So it wasn't an issue that was ever brought up. [...] It was just... I think like one of those things that you know - you don't say anything but you both know what you're doing. You both know certain things like... he was talking about his flat and it was sort of like benefits and stuff and the rest of it, so it was obvious.**

***But you say that you knew he was positive before?***

**Not from him [...] Through the grapevine.**

***The circles you moved in?***

**Yeah - and like sort of... yeah, the circles we moved in, and basically people would say 'oh there's [Name] over there' and then somebody would sort of like viciously 'oh well - another benefits queen' kind of thing [...] So that's how I knew he was.**

***So you never really discussed it with him either way?***

**No."**

What we have described as clues or indicators might better be described as a system of signs. That is, certain social and cultural meanings (social networks, types of bars, topics of conversation etc.) mediate a shared view of the world. This shared view gives confidence when making assumptions and transforms the need for a conscious assumption or deduction to a simple cognition. By learning the language and reading the complex system of signs, one simply knows. Such cognitions are dependent on highly developed gay and HIV positive subcultures which in turn are dependent on urban cultural and social contexts.



If you go to the same places - if you go to [names a club] and you go to [names a pub]... it's not just malicious gossip or like bitchiness or whatever... but you do get to know who is and who isn't [diagnosed with HIV]. Well you get to know... who definitely is. And the rest of them: it's either they know they're not or they don't know. But it's all one mass. [...] The other thing that comes into it is association. If somebody's known to be positive and like somebody's else's talking with them - people will sort of say 'well, oh - he's part of the gang as well' kind of thing, [...] There are just like known places, and what people say and ... you put it all together and it just reinforces it - 'oh yeah, he must be positive'. And people you see like passing by the HIV clinic and stuff... I suppose it's being a small place [London] and everything - you just see the same faces around and put two and two together."

This brings us to the second risk reduction strategy: control of information. Some men felt a substantial disincentive to disclose their HIV status to sexual partners because of past rejection or fear of rejection in the future.

**"At first, when I put it to them, a couple of men, you couldn't see their tracks. Now, I don't see the point."**

For others, having to volunteer information that they considered personal was associated with stigma and a special responsibility for HIV generally: a responsibility they felt should be taken by their partner.

**"It's not something I choose to talk about...I don't like being forced to talk about personal stuff with comparative strangers. It's like having to do it means that you're already the guilty one in the relationship, you've got something to confess and you've done something wrong."**

As well as being associated with stigma, the act of disclosure to many men was seen as a form of self alienation and stigmatisation.

**"Yeah, I've always found disclosure very, very difficult to handle, even now - [...] the only way you can control information generally, is by keeping it to yourself, because you can have absolutely no idea who's going to... where it's going to go, once you've told another person, even once you've told your best friend. When you think how many secrets your best friend has told you about other people - especially in the gay world. The only way to withhold the information is not to tell anyone at all. So I found it incredibly difficult, even telling my closest friends about my HIV status. In many ways I thought that demeaned me, that I was sort of a lesser person because I was positive, or people would look at me in a different light..."**

Disclosure is, however, complicated by the common system of signs that we have described above. If one inhabits a social milieu where there is a shared understanding and a shared system of meanings, then disclosure becomes unnecessary, since a gay man who inhabits a gay urban social network will be able to read the signs that indicate someone's HIV status. Thus, the most common strategy was not to conceal their HIV status from partners, but not to volunteer the information unless asked outright. It was widely assumed that partners would either know or certainly suspect that they (the respondent) were infected. Therefore, partners' actions were often read as confirmation that they were aware of this. For example, a partner's willingness to engage in UAI will often be assumed to signify that he is also infected. We can see how pervasive this is in the following case where a respondent tries to disclose his status to a partner whose status he is unsure of.

**“And I said ‘look, I think you should use a condom for your own benefit’ [...] and he went... he only said I was frigid and that I was not the only person in the world with HIV, you know?”**

The most extreme example of partner selection and information control is the case of anonymous encounters. Many instances of UAI occurred in such settings and in the majority of these cases, a similar system of cues is at work as in the case of casual or social encounters. That is, it is commonly assumed that all men frequenting sex venues are aware of the risks of engaging in UAI and will act according to their conscience and to the need to protect themselves. Cottages and cruising areas are similar, although, in the latter many men tried to initiate condom use with their partner.

**“I did go down to [Name - cruising area] to get fucked. Well you don’t go down there with the intention of getting fucked but it just happens. I used to you know, throw a condom at them. If they put it on, they put it on, if they don’t, it’s up to them.”**

Sex in PSEs brings us to our third risk reduction strategy, that of behaviour modification. For example, because sex in backrooms and saunas is for the most part public, common assumptions about participants’ HIV status are informed by a set of signs regarding behaviour. These have been explored elsewhere (Keogh *et al.*, 1998). Men in our sample did report a remarkably similar understanding of the how certain behaviour indicates a certain HIV status. Therefore, willingness to engage in receptive UAI denotes that the participant is likely to be already infected (whether or not it is diagnosed).

**“Most men who take it [are receptive] in places like that are positive already.”**

Willingness to engage in insertive UAI does not denote a particular status.

**“What do you think his status was?**

**I don’t know. I suppose I’d like to think he was positive as well, but, then I can’t be sure ‘cause he was fucking me, and a lot of negative men do that because it’s less risky to them, so I don’t know to be honest.”**

Likewise, beliefs about the likelihood of transmission influenced behaviour. The most common of these is that transmission is less likely during UAI from the receptive to the insertive partner. Therefore, many men only took the receptive role during UAI with men with whom they knew or suspected to be sero discordant.

**“I believe for them that it’s safer if I’m the passive partner. There’s less chance they’ll get it from me, but there’s still a small chance.”**

The second most common belief regarded withdrawal before ejaculation. Some men withdrew before ejaculation in order to protect their partner.

**“I’ll never actually come inside someone, I’ll always withdraw before I come. I think that’s a bit safer.”**

Some went further and also considered how much pre- ejaculate they normally produced.

**“I’m normally as dry as a bone until I come.”**

### 5.3 DISCUSSION

In this section, we have identified three types of risk: social, emotional and psychological, and health related. We have also described the strategies men developed in order to minimise both these risks and the possibility of HIV being transmitted, either from an infected to an uninfected man (primary infection) or between infected men (re-infection). These strategies are complex and not easily schematised. In this discussion, we will draw out some of the main points developed above.

Social, and emotional and psychological risks were seen as far more immediate and important than risks to health, and we have identified three risk reduction strategies developed in response: the selection of certain types of partners; the control of personal information; and modifying sexual behaviour. It is worth dwelling on each of these in turn.

Partner selection is used in a range of contexts. For example, in long term relationships, respondents engaged in UAI with partners who had risked exposure to HIV in the past (even if they had remained uninfected). In this way, the responsibility for sexual safety was shared and the respondent could be reassured that his partner was well aware of the risks he was taking. Likewise, in casual situations, many respondents reported a preference for partners who were already likely to be infected. Selecting such a partner in this context depended more on a cultural systems of signs than on explicit negotiations. Some men reported a preference for sex in anonymous settings because they perceived anonymous sex participants to be more experienced about HIV risk taking. Anonymous environments also guaranteed minimum social contact with partners. Therefore, partner selection is a dual risk reduction strategy. It serves first to minimise the chances of new exposure (by maximising the likelihood that one's partner is either already infected or has been exposed to HIV). It also controls the amount of social interaction with partners, thereby reducing negative social and psychological consequences associated with UAI.

Information control is the second risk reduction strategy. However, this was much more than simply a case of whether or not to disclose one's HIV status. Universal, direct and voluntary disclosure of HIV status was usually perceived as simply untenable because it tended to elicit negative reactions from partners and was in any case, seen as an infringement of one's right to privacy. Therefore, information control for many men was not about disclosure per se, but was rather about intimating (or not) that one was positive while 'reading the signs' about one's partner. As we have seen, for many men, this was not necessarily a conscious activity.

It should be stressed that both partner selection and information control are not strategies of duplicity. The men we interviewed were not attempting to 'pose' as uninfected men in order to 'seduce' others to engage in UAI. The opposite was the case. The accounts we report on here are the result of an integration of an HIV positive identity and the inhabitation of a highly developed HIV positive gay (urban) subculture. Often, HIV is something that is simply assumed in certain (though not all) circumstances. In these situations, it may be more appropriate for the negative partner to disclose his status than the other way around.

Our third risk reduction strategy (modifying behaviour) is used when a partner is assumed or (less frequently) known to be uninfected and is based on beliefs about the transmission of HIV. The most commonly cited strategies are engaging only in receptive UAI (as transmission is thought to be considerably less likely when the infected partner is receptive) or withdrawing before ejaculation. This strategy is also used in the full range of contexts from long term committed relationships to casual and anonymous partners.

Although these three strategies are used in a range of contexts, they are unlikely to be used in isolation. Reducing the risks in any single incident of HIV is likely to involve the use of all three. For example, information control is used in the selection of partners who are likely to already be infected, or if not, where social contact will be minimised. Behavioural modifications will seek to ensure that if one's partner turns out to be uninfected, the possibility of transmission is minimised.

Our final comments concern risks to health. For most of the men in our sample, re-infection was not considered a serious risk. Our analysis suggests re-infection is experienced differently to primary infection inasmuch as there is no singular diagnostic moment. Diagnosis with HIV is both constructed and experienced as a highly significant event with life altering personal, psychological and social consequences. There is no similar significant event associated with re-infection.

Also, although men are aware that there are hazards associated with re-infection, they tend to characterise these hazards as cumulative: in the same way as they characterise other health hazards (such as smoking). If they want to avoid the harmful effects of re-infection, they must engage less in the activities that lead to it (UAI with other men who are already infected). However, like smoking, if the pleasure outweighs the risk, they will, under certain circumstances, engage in it. Therefore, re-infection is a risk that men are willing to take in certain circumstances (such as with a loved partner), but not randomly.

# 6 Conclusions

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We end this report with a summary and some comments on our findings. First, as data in section three shows, it is likely that less than half (43.2%) of gay men diagnosed with HIV engaged in any UAI in the previous year. The rest either always have protected anal intercourse or had no anal intercourse and these men would probably have a different story to tell.

Although there was a significant minority of instances where informants attributed UAI to regrettable accidents, slip -ups, condom breakages etc, the majority of instances of UAI occurred within a framework of risk assessment and risk reduction. Most men engaged in UAI because they enjoyed anal intercourse and disliked condoms or found using them debilitating. Therefore, risk assessment tended to consist of a balancing of hazards on the one hand and the value of the UAI on the other. However, both the perception and reality of these hazards were entirely different from those perceived by gay men who either know or assume themselves to be uninfected (Henderson *et al.*, 1999). For gay men in the latter category, the hazard of infection is personal, immediate, singular and generally catastrophic. For gay men diagnosed with HIV, the risk is more diffuse and mediated. The most important hazards by far were social censure or psychological damage. Personal health hazards were generally perceived as much less important.

As we have said, most of the men we interviewed had developed risk reduction strategies that facilitated doing UAI. Certain factors enabled the development of these strategies.

First, the men we interviewed had engaged in UAI in the past and as a result, been infected with HIV. Although their sexual desires may remain the same, their relation to risk changes. That is, not only are they risking something different when they engage in UAI, but they have experienced (and more importantly, survived) the negative consequences of risk taking. Therefore, what they report is not only a change in what they perceive is at stake, but a change in their overall attitude towards sexual risk.

Second, nearly all of the men we interviewed live in urban or semi urban contexts where the concentration both of gay men and infected gay men is relatively high. Many of the risk reduction strategies they reported depended on living in an environment with a high proportion of gay men with diagnosed HIV infection. That is, a culture where gay men are aware that their peers and their sexual partners include gay men diagnosed with HIV.

Although informative in themselves, the significance of these two factors acts as a reminder about the nature of risk. When we talk of risk, we cannot conceive of it as unitary and unchanging. Although the outcome of UAI might always be the same (exposure to and possible transmission of HIV/ DRHIV), the way in which that outcome is perceived by the participants will always vary. This depends on two factors.

The first is the perception of how likely the outcome is. For example, if, for whatever reason, partners choose to believe that they both have the same HIV status, or resistance to the same anti -HIV drugs, then both will under -estimate the likelihood of exposure. If both believe that withdrawing before ejaculation will result in no release of semen, than both will under-estimate the likelihood of both exposure and transmission should exposure occur.

The second is how each partner perceives the seriousness of the hazard. Because they estimate the hazard of the transmission of DRHIV in a particular way, gay men diagnosed with HIV tend to downplay the hazard of infection in relation to the value of (sc)UAI. Likewise, in the case of sdUAI where both partners know their own status, both will assess the hazard and weigh this up against the value of UAI differently.

As we have seen, the types of strategies are varied and dependent on a range of factors. Although such strategies are complex, it might be helpful to see the decision whether or not to engage in UAI as a question of balancing risks with pleasure. That is, the magnitude of the risk of engaging in UAI balanced against the value of UAI to the individuals involved, at that time, in that place and with that partner. Therefore, we need to think about risk as an equation, the variables of which will change according to the circumstances that both partners are in. For example, sdUAI within a relationship will be utterly different from anonymous UAI. Hence the risk reduction strategies employed (the way that the equation is balanced) will also differ dramatically. The equation will look something like that represented in figure 6.1 below.

**Figure 6.1: Factors influencing decisions to engage in UAI.**



The magnitude of risk associated with UAI will depend on: the perceived threat to one's social stability or psychological and physical health; how likely it is that one's partner will be exposed to HIV and if so; the likelihood that he will become infected as a result. On the other hand, the value of UAI is influenced by how pleasurable anal intercourse is to both partners, whether or not either of them experiences difficulties using condoms or simply dislikes them as well as the relationship between both partners. For example, for some men, anal intercourse with a long term beloved partner is particularly valuable while for others anonymous anal intercourse is experienced as particularly exciting.

Engaging in UAI is not something any of the men in our sample took lightly. However, the fact that most of these occasions did not lead to undue personal trauma is testament to the ingenuity and efficacy of the risk reduction strategies employed rather than callousness on the part of respondents. We have identified three broad risk reduction strategies in this report (partner selection, information control and behaviour modification). That these strategies are imperfect is a point generally understood by all those who employ them. That is, they reduce the possibility that infection might occur, but they do not eliminate it. What these strategies demonstrate is the extent of individuals efforts to prevent transmission while maintaining a fulfilled sex life, the consequences of which are not personally detrimental. They can only be mobilised once a certain risk of infection has been accepted. This is why we call them risk reduction as opposed to risk elimination strategies.

None of these strategies is without problems. However, the difficulties we perceive with them are dependent on our viewpoint. From the perspective of public health, they are indeed problematic. If we are concerned with primary HIV prevention, we might seek to increase disclosure (either way), improve risk assessment, or advocate condom use. On an individual basis, important decisions are often made on incomplete or unclear information. However, on the basis of individual mental health and social and sexual functioning, these risk reduction strategies seem to be very helpful. How helpful they are in achieving the goals of primary HIV prevention is open to question.

These findings make problematic some of the health promotion approaches we employ. If we are to educate men, to alert them to the risks of both scUAI and sdUAI, we must be able to represent the risks to them. This becomes problematic if risk itself is mutable. Part of this process must include equipping gay men (both diagnosed with HIV and undiagnosed) to assess and manipulate risk better while understanding that their partner is likely to be doing the same. However, he is probably doing so very differently. Such an approach must start from the point of working with the differences among gay men and recognising the variable and often contingent contexts within which they assess risk.

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