

# Relative safety II

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

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**Original Research Report**

# Acknowledgements

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# Contents

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<b>1</b>	<b>Introduction</b>	<b>2</b>
<b>2</b>	<b>Methods and sample</b>	<b>5</b>
2.1	Methods	5
2.2	Sample description	6
<b>3</b>	<b>Perceived harms associated with UAI</b>	<b>7</b>
3.1	Physical harm	7
3.2	Harms to social and moral identity	10
3.3	Discussion	13
<b>4</b>	<b>Managing the risk of infection</b>	<b>14</b>
4.1	Condoms as a sole risk management tactic	15
4.2	Means of managing risk other than condom use	16
4.3	Lacking the capacity to manage risk	18
4.4	Discussion	19
<b>5</b>	<b>Managing identity</b>	<b>20</b>
5.1	Managing sexual pleasure	20
5.2	Managing moral and social integrity	22
5.3	Managing reactions from others	24
5.4	Managing the risk of criminal prosecution for HIV transmission	27
5.5	Discussion	28
<b>6</b>	<b>Conclusions</b>	<b>30</b>
	<b>References</b>	<b>33</b>

# 1 Introduction

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In 1999 Sigma Research published *Relative safety: an investigation of risk and unprotected anal intercourse among gay men diagnosed with HIV* (Keogh *et al.* 1999). This study explored the social, psychological and cultural meanings associated with unprotected anal intercourse (UAI) among men with diagnosed HIV. It highlighted both the complexity of sexual interaction for men with diagnosed HIV, and the many potential costs and benefits perceived by them. Now, with more than 24,000 homosexually active men diagnosed with HIV in the UK (Health Protection Agency 2008), a figure that is set to increase in years to come, it is vital that agencies involved in HIV prevention interrogate their own beliefs about UAI and ensure that their interventions meet the needs of men with diagnosed HIV.

Sexual enjoyment and satisfaction are important to men irrespective of their HIV status. However, more than two thirds (71%) of gay and bisexual men with diagnosed HIV have had problems related to sex in the previous year, and more than half (52%) are currently unhappy about their sex lives (Weatherburn *et al.* 2009). The most frequent problems are having no sex, or very little, often linked to poor self-image or low self-confidence and a loss of libido or interest in sex. Other related problems with sex commonly reported by men with diagnosed HIV include anxieties about passing on HIV infection to partners, rejection by potential sexual partners and difficulties disclosing to partners. In addition, some had concerns about potential prosecution for onward transmission of HIV during sex.

Men with diagnosed HIV are thus faced with many obstacles to the fulfilment of their own sexual desires, a right that all people maintain regardless of their HIV status. Faced with this complex balancing act, many men with HIV avoid anal intercourse altogether, or do so only with condoms, or with other men with diagnosed HIV. Others engage in UAI with varying perceptions of the risk that such behaviour may pose. This report seeks to update and expand our understanding of how gay men with diagnosed HIV seek sexual pleasure during UAI while minimising the chances of infecting others, causing further physical harm to themselves, or acting in ways that threaten their own sense of moral integrity.

Previous research has shown that when presented with the statement: "As an HIV positive man I should feel an extra responsibility not to pass on HIV to another person", 87% of men with diagnosed HIV agreed (Stephenson *et al.* 2003: 9). However, when presented with the statement: "HIV positive gay men have more responsibility to practice safer sex than HIV negative men", far fewer (35%) agreed. The mis-match between these responses suggests that while diagnosed men tend to seriously consider their own responsibility in avoiding transmission, they do not hold that undiagnosed men should be absolved of theirs. In addition to this risk of HIV transmission, Keogh *et al.* (1999) identified the emotional and psychological harm that could emerge if men discovered they were the source of infection for another individual, coupled with a further concern for the risk of social censure (being seen by others to be behaving irresponsibly). Taken together, this evidence demonstrates that the majority of men with diagnosed HIV wish to avoid participating in HIV transmission.

The *Gay Men's Sex Survey* (GMSS) indicates that men who have received a positive HIV test result are more likely to engage in UAI than those who have not tested positive, and men diagnosed positive do so with significantly more partners than negative and untested men (Weatherburn *et al.* 2008). Given that homosexually active men engaging in UAI with high numbers of partners are more likely to acquire HIV than other men, it is possible that men's sexual activities after diagnosis simply mirror what they did prior to diagnosis. However, Weatherburn *et al.* (2008) also found that while engagement in UAI was more likely among men diagnosed with HIV compared to negative or

untested men, one third of men with diagnosed HIV had not engaged in UAI at all in the previous year. Such men do not form part of the current study, and they would no doubt tell a very different story of risk perception and response.

Of those men with diagnosed HIV that do engage in UAI, not all risk exposing men without HIV to their infection. In GMSS 2002 (Hickson *et al.* 2003a), among 1133 respondents with diagnosed HIV, only 34.5% said they had probably or definitely participated in sero-discordant UAI (sdUAI) in the past year.

Among those men with diagnosed HIV that do engage in UAI, the reasons for doing so are highly contingent upon a number of situational factors. Numerous studies have demonstrated the symbolic nature of condomless sex and have made clear the value that many gay men, regardless of HIV status, place on being able to have anal intercourse with their partners without the use of condoms (Schilder *et al.* 2008, Flowers *et al.* 1997). Some see the cessation of condom use as a milestone in a romantic or long-standing relationships (Flowers *et al.* 2006). Sex without condoms enables a greater sense of intimacy that extends beyond skin-to-skin contact to incorporate an enhanced self-comfort and comfort with one's partner. Others have suggested that factors such as these, and their role in establishing relationship stability and satisfaction can be more important than any infection-related risk (Cusick & Rhodes 2000). These findings exist in addition to the widely reported feeling that the physical sensation is more satisfactory without condoms.

Keogh *et al.* (1999) highlighted that engagement in UAI among men diagnosed with HIV was rarely the result of 'regrettable accidents' or of being 'carried away', but rather emerged as a result of considered risk assessment and subsequent behaviour modification. The harm-reduction tactics and strategies employed included elements of negotiated safety (Kippax *et al.* 1993, Hickson *et al.* 1992), avoiding the insertive role during intercourse, and withdrawal before ejaculation when insertive in UAI.

One of the most common tactics among the Keogh *et al.* (1999) study respondents, was purposeful selection of sexual partners sharing the same HIV sero-status. By 'sero-sorting' their sexual partners in this manner, men felt they could eliminate the possibility of being the source of primary HIV infection for another person. Data from Hickson *et al.* (2007) show that among men with diagnosed HIV, engagement in UAI in the previous year was far more common with partners they knew to have diagnosed HIV, than with partners known to be tested negative. Research undertaken with men with diagnosed HIV in London clinics who engaged in UAI found that 58% had sought it only with other diagnosed positive men within the last 12 months, which was significantly associated with their subsequent behaviour (Elford *et al.* 2007). This desire to engage in UAI with men of the same sero-status is examined by Frost *et al.* (2008) who found that men seeking sero-concordant partners report a greater sense of intimacy when having sex with other diagnosed positive men.

However, the success of sero-sorting in preventing HIV transmission relies on both parties being accurately aware of each others' HIV status. Parsons *et al.* (2005) reported that the pervasive problem with sero-sorting is that men having UAI overestimate the likelihood that those they are having sex with are also diagnosed with HIV (see also Adam *et al.* 2008, Elford *et al.* 2007, Zablotska *et al.* 2007). Sero-concordancy can be especially hard to establish in casual, anonymous sex environments where the opportunities for communication are limited (Keogh *et al.* 1998, Richters 2007).

Concerns about sero-sorting are sometimes raised by those working in the field, given that participation in UAI with partners of the same HIV status does not help to reduce the risk of other STI transmission. Health professionals, health promoters and researchers also highlight the possibility of acquiring an additional strain of HIV: a so called 'superinfection'. Despite individual case reports of superinfection in the literature, there is little agreement about its prevalence, or what factors affect its acquisition (Piantadosi *et al.* 2007). Some researchers have demonstrated superinfection rates between 4% and 9% in particular cohorts (Kraft *et al.* 2008, Chohan *et al.* 2005, Smith *et al.*

2004). Others found no evidence of superinfection amongst 101 people whose HIV was resistant to treatment (Bezemer *et al.* 2008), with a further study finding no evidence of superinfection among a sample of 49 individuals with diagnosed HIV having unprotected intercourse with their sero-concordant partners (Willberg *et al.* 2008). This latter study also demonstrated a clear relationship between long-term exposure to a single partner's HIV via receptive intercourse, and an enhanced immune response to that virus. It is not clear to what extent men diagnosed with HIV are aware of research developments in this area, how they perceive the risk of superinfection and how, if at all, they respond to it (although, as an exception, see Adam *et al.* 2005). Therefore, the current study also examines the extent to which men's awareness of superinfection impacts upon their risk perceptions and sexual behaviours.

There have been a number of other clinical developments since the Keogh *et al.* (1999) study that have the potential to impact upon the sex lives of men diagnosed with HIV. The advent of PEP provides a method of preventing sero-conversion not widely available at the time of the last study. Körner *et al.* (2005) found that PEP was viewed as an additional line of defence when trying to avoid HIV infection among negative or untested men, however there has been little work examining how men diagnosed with HIV understand PEP and if (or how) they utilise this knowledge when having sex with men of negative or unknown HIV status.

In early 2008, a consensus statement on behalf of the Swiss Federal Commission for HIV/AIDS (Vernazza *et al.* 2008) suggested that individuals diagnosed with HIV who are on anti-retroviral therapy with an undetectable viral load cannot transmit HIV through sexual contact. This suggestion was, however, based on a review of clinical studies relating to heterosexual HIV exposure, and even then restricted by a number of explicit caveats. No similar suggestion was made that related to sex between homosexually active men, but that has not prevented a great deal of debate within the HIV sector about the significance of the statement and the implications it may have for future HIV prevention activities. It remains unclear however if, and how, gay men diagnosed with HIV have incorporated knowledge of these developments into their perceptions of, and responses to, risk when engaging in UAI.

In addition to clinical developments, there have been some important criminal policy developments over the last 10 years that have the potential to impact upon the sex lives of men diagnosed with HIV in the UK. In 2001 the first prosecution for reckless transmission of HIV occurred. Similar cases have featured prominently in the gay press in subsequent years. Dodds *et al.* (2009) reported how men with and without diagnosed HIV viewed such prosecutions, but as yet there is little information on how such prosecutions have influenced sexual behaviour. The present study seeks to address gaps in our understanding by asking men with diagnosed HIV about their awareness of criminal prosecutions, and how such awareness has impacted on the sex they have.

The following chapter explains how the study was undertaken, outlines the broad topic areas addressed during the interviews, and describes the sample of men who took part. Chapter 3 outlines the range of harms that men with HIV perceive when engaging in UAI. Chapters 4 and 5 explore the ways in which men responded to these perceived harms, firstly those relating to the risk of onward HIV infection, or superinfection, and latterly those concerning the potential for harms to their personal and social identities. Chapter 6 considers the implications of these findings for health promotion interventions targeting men with HIV, and with homosexually active men more broadly.

## 2 Methods and sample

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This study explores the experience of unprotected anal intercourse amongst homosexually active men living with diagnosed HIV. It draws on interview data from forty-two homosexually active men in England and Wales, spanning a range of years since diagnosis, and living in areas of differing HIV prevalence.

### 2.1 METHODS

Recruitment took place in collaboration with a number of community-based HIV organisations across England and Wales (see Acknowledgements). These agencies distributed materials promoting the study to service users with diagnosed HIV either by email or in person. To be eligible men had to be diagnosed with HIV, and had to have participated in unprotected anal intercourse with a man in the last year. Approximately one hundred men volunteered to take part and, in an attempt to gain a diverse sample in terms of age and time since diagnosis, forty-five were subsequently invited to interview. An approximately even split between men living in areas of higher HIV prevalence (London and Manchester) and lower HIV prevalence was also ensured, given that men's experiences of sero-sorting, disclosure, support and HIV-related stigma can be influenced by attitudes to HIV expressed in local gay scenes and services. Of the forty-five invited to interview, three were later excluded as they did not meet the study criteria. Participants' confidentiality was assured and all were reimbursed expenses of £20. Ethics approval for this project was granted by the Faculty of Humanities and Social Sciences Research Ethics Committee at the University of Portsmouth.

Interviews lasted 1-2 hours, were hosted at Sigma Research, at collaborating agency offices, or at participants' homes, and took place in the following cities and towns: Bristol, Exeter, Leeds, Liverpool, London, Manchester, Stoke-on-Trent, and Swansea. Each interview was digitally recorded and transcribed verbatim. The interview covered the following topics:

- the impact of HIV diagnosis on respondents' sex life;
- HIV status disclosure to sexual partners and others;
- awareness of sexual partners' sero-status;
- details about the most recent experience of UAI;
- awareness and experience of HIV risk reduction tactics; and
- awareness and experience of HIV prevention technologies (e.g. PEP, PrEP).

A full thematic content analysis was undertaken on each transcript, and then compared across transcripts by two researchers working independently. Following initial reading, and re-reading, an analysis template was developed and used as the basis for a synopsis of each transcript. The synopses were then used to identify significant, recurring themes.

In the following chapters, blocks of **bold** text are verbatim quotes from respondents. The quotes selected give an overall sense of key issues raised by various respondents, and cannot be taken to be representative of all responses in a single theme. Quotes were selected for their clarity and descriptive purpose. We have given brief demographic descriptions after each quote. This is both to illustrate the range of men contributing their perspectives and also to show that men sharing an age, locality, and time since diagnosis do not necessarily have the same views and experiences.

## 2.2 SAMPLE DESCRIPTION

The characteristics of the forty-two men whose data were included for analysis, are summarised below:

<b>Age</b> Range 18 – 58 Median 37 yrs	<b>Time since diagnosis</b> Range <1 – 23 yrs Median 6.75 yrs
<b>Area of residence</b> London 15 Manchester 8 Lower prevalence areas 19	<b>Education</b> 'O' Levels / GCSE or less 14 'A' Levels / college diploma 16 Degree or higher 12
<b>Ethnic group</b> White British 33 White other 3 Mixed 2 Black African 2 Asian British 1 Chinese 1	<b>Relationship status</b> No current regular partner 24 Sero-discordant partner 7 Sero-concordant partner 11
<b>Term used for sexuality</b> Gay 37 Homosexual 4 Queer 1	<b>Number of male partners in the last year</b> Range 1-562 Median 27

# 3 Perceived harms associated with UAI

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This chapter describes the potential harms that respondents associated with having unprotected anal intercourse. Men's perceptions of the potential outcomes of UAI are clearly linked to knowledge of their own HIV infection. This knowledge presents men with an altered risk landscape – one in which they often feel a tremendous burden to consider and manage risk in ways that sharply contrast with their own experience prior to diagnosis. After diagnosis, men's risk perceptions continue to undergo significant changes, influenced by their own emotional state, experience, and information gained as they make decisions about being sexually active individuals with HIV. Therefore during the research interview, each respondent was able to reflect only on his own feelings at that particular point in time, in relation to his own experience of HIV up to that point. Men diagnosed for longer periods of time tend to focus their attention on different components of risk compared to those who are more recently diagnosed. Just as men consider risk differently at different times after their diagnosis, so too do men find that the importance of sex in their lives can change once they know they have HIV. What the men in this study collectively express is the value they hold in sexual intercourse, and the key role it performs in achieving a sense of fulfilment and well-being in their lives. They are thus tasked with deciphering how this desire for enjoyable and fulfilling sex fits alongside their knowledge of the risk they know they pose to others, and the risks they face themselves.

In addition to the potential physical harms that can arise from UAI, many men held pervasive concerns about how sexual behaviour and HIV status interacted in ways that threatened to undermine their self-regard, as well as damaging their standing among others. Sustaining an identity as a responsible gay man while simultaneously protecting oneself from HIV-related stigma was of critical importance to a substantial proportion of participants. An examination of men's views on the non-physical risks associated with their participation in UAI forms the final part of this chapter.

## 3.1 PHYSICAL HARM

All respondents were aware that their own HIV could be transmitted to others through unprotected anal intercourse, but at the same time they held widely varying interpretations about the extent to which facilitating factors could increase or decrease the risk of transmission. Their views on their own vulnerability to new infections and HIV superinfection were even more diffuse. The following two sub-sections of this chapter describe the physical, infection-related elements of harm perceived by the men taking part in this study.

### 3.1.1 Physical harm to others

The men taking part in this study were, on the whole, acutely aware of the potential harm they posed to others during unprotected anal intercourse. They recognised HIV as a transmissible disease and were aware of the impact it could have on a person's life.

**I was HIV positive and the last thing that I wanted to do was put somebody through, you know infect somebody and let them go through what I had just been through. Of oxygen masks, intensive care and being incubated and all that stuff. I did not want to inflict that on anybody.**

[Early 40s, low prevalence area, diagnosed 8 years]

For those who had been recently diagnosed (a shorthand term we use to represent those diagnosed for two years or less), concerns about the onward infection of HIV to others permeated their narratives of risk perception and reduction. It was this concern that led many to avoid sex altogether for weeks, months or even years following first HIV diagnosis.

**But there was always at the back of my mind that sort of feeling of being unclean and not wanting to infect anyone else you know? I suppose that idea of why I can't have sex with anybody ever again.**

[Early 40s, high prevalence area, diagnosed 2 years]

Men who had been diagnosed for longer periods of time were no less aware of the physical harm they posed to others, but their concerns about transmission of the virus tended not to result in avoidance of sex. They had accepted the potential for harm as part of their sex lives and described taking routine measures to reduce transmission risk without having to exhaustively consider the consequences each time they had sex. Most were unwilling to gamble with another person's health and well-being, even if that individual was willing to do so themselves. Among all respondents, notions of 'gift-giving' were uniformly rejected.

**And we were having sex and I was fucking him [without condoms] and he was saying 'I want you to make me positive'. And instantly I lost all interest and I couldn't get out of there quick enough.**

[Early 40s, high prevalence area, diagnosed 2 years]

When considering the potential harms associated with UAI, most men referred solely to the harm they might cause to partners who were not already infected with HIV. There was only one individual who commented on the risk he felt he posed to sero-concordant sexual partners in terms of superinfection.

**It would always be in the back of my mind you know ... there's a sort of one in ten billion risk that I'd give him a version of the virus that he hasn't got. Which, you know, I mean he's younger and I certainly wouldn't want to damage his health you know. I'm considerably older and I'm not too concerned.**

[Mid 50s, high prevalence area, diagnosed 14 years]

The overwhelming majority of respondents went out of their way to clarify that they aimed to avoid transmitting HIV to all of their sexual partners. All men recognised that anal intercourse without condoms carried a greater risk of transmission than intercourse with condoms, or no intercourse at all, but felt that they generally took enough care, or in some cases, aimed to take better care (through the tactics explored in detail in chapter 4) to reduce this risk to a degree acceptable to them.

### **3.1.2 Physical harm to self**

A small proportion of respondents raised concern about the risk of contracting another sexually transmitted infection when engaging in UAI.

**I think that you tend to forget sometimes when you are HIV positive you think 'Oh well I have got it now and we can get it on with other guys'. But you do tend to forget that there are other things out there.**

[Mid 40s, low prevalence area, diagnosed 12 years]

However, such views were certainly in the minority, with most men reporting that after receiving a positive HIV diagnosis, anything else paled into insignificance. Where men had acquired subsequent infections, they had been identified and treated quickly due to routine HIV clinic appointments, and they expected that this would continue to happen in future. Fewer than one fifth raised some concern about the risk posed to them by hepatitis C co-infection.

**I'm more concerned about getting stuff like hep C. Hep C really. Because STIs are treatable. So it's hep C I'm worried about.**

[Late 30s, high prevalence area, diagnosed 10 years]

Although concerns about HIV superinfection were not commonly raised when considering potential harm to others, the possibility of becoming infected with another strain of HIV arose with relative frequency. A significant minority of men were concerned by the potential long-term consequences of acquiring a superinfection, particularly in terms of reduced treatment options.

**I don't want to miss out on the therapies which I could have because he's on them. That would then slim my chances of having that type of therapy. So because I would have then built up a resistance to that type of drug which he's on. So it would be pointless then trying that drug.**

[Mid 30s, low prevalence area, diagnosed < 1 year]

Concerns about the likelihood of superinfection were most common (and most intense) among recently diagnosed men to whom the risk of acquiring a new strain had been emphasised by health professionals, and men who experienced periods of ill-health. Such individuals often expressed a desire to behave in a more positive health-related manner.

*Is superinfection something that you might be taking more seriously in the future then?*

**Yeah, very much so. Very much so. I sort of got to the stage now where, I had a few problems with my medication and resistance and things like that. I think I have missed combinations and its got to the stage now where I think to myself, you know, I have got to start taking things a bit more seriously and start thinking about myself. Because I keep thinking, it's twenty years down the line and I am still here and if I want to be here in another twenty years I will have to start taking a bit more responsibility for myself.**

[Late 30s, low prevalence area, diagnosed 20 years]

This is not to say, however, that the majority of respondents perceived superinfection to be likely. Nearly two thirds saw it as an insignificant risk, particularly when compared to the risk of transmitting HIV to others. Some respondents engaged in unprotected sex with other men with HIV over long periods of time and had neither acquired a superinfection themselves nor met anyone else who had. When talking about a friend who often had receptive UAI, one man said:

**He used to go out and take multiple loads off multiple partners time and time again, repeatedly. So if anyone would be superinfected, so to speak, I would think it would be him. But it doesn't appear to be so.**

[Mid 30s, low prevalence area, diagnosed 6 years]

For some, its absence from lived experience led to a belief that superinfection was a myth, a theoretical possibility not borne out in everyday life.

**Yeah, there is also kind of a rumour that it's an urban myth. That this cross infection doesn't really happen [...] so I think somebody once referred to it as scare-mongering from the doctors.**

[Early 40s, low prevalence area, diagnosed 8 years]

At present, it appears that men are reliant upon on heresay to guide their behaviour regarding superinfection. Such data implies unmet information need and underlines the need for honesty and reliability in information provision.

### 3.2 HARMS TO SOCIAL AND MORAL IDENTITY

In addition to the physical harms described, a number of potential social or moral harms were also identified. Whereas the physical harms related directly to experiences of unprotected anal intercourse, perceived social and moral harms related to experiences of sex as a man with diagnosed HIV more broadly. Threats to moral integrity or one's positive sense of self were often coupled with threats to one's social identity and how they were perceived by sexual partners or their wider community. The harms men felt they faced could best be considered as falling into two types: those that influenced how the men saw themselves, and those that influence how they were seen, or treated, by others.

A number of men reported a desire for positive change in their health-related behaviour following their diagnosis with HIV. High-risk sexual activity and a high frequency of drug or alcohol use were common, and many believed these issues to be central to their own sero- conversion. The period following diagnosis was often seen as a time to reflect and to develop new practical and moral guidelines for themselves. Such reflection also occurred after periods of ill-health among those who had been diagnosed for some time. Many of the newly diagnosed respondents felt that they should always disclose their status to sexual partners, never have UAI, and should avoid high-risk sexual environments as a means of slowing down and taking better control over their lives.

**It's not good news to become positive but in a way it seems like a change to regain self-control ... not just sexually, but also in a more general kind of way.**

[Late 40s, high prevalence area, diagnosed < 1 year]

Men described forging new, more responsible identities, and stressed their desire for more stable intimate relationships (a goal already achieved by almost half of the men taking part in the study).

**I used to be able to get lots of cute guys. Then you get up in the morning and you are alone and I decided that I didn't want that any more [...]. So I deleted my gaydar profile 'cos I didn't want to meet random guys off the internet any more. I wanted something more than that. I think at some point in life it's good to sit back and think about what you're doing and think if you're achieving the things you really want.**

[Late 30s, high prevalence area, diagnosed < 1 year]

The risk of harm emerged when men's moral integrity was challenged or threatened. This could occur either as a result of their own actions, or by observing the actions of others in similar circumstances (that is, other sexually active men with diagnosed HIV). Having developed moral and ethical guidelines for themselves about how to have sex with others, men faced a great deal of inner turmoil when, for whatever reason, the guidelines they had established were broken.

**Yeah, and I would hope that in future that I can consciously get back to that. I don't want this [UAI] to happen again, because I am aware how these are my boundaries now, and I want to stick with them.**

[Late 30s, low prevalence area, diagnosed 18 years]

Some described their concern over falling back into behaviour patterns that they had tried to avoid since being diagnosed.

**A lot of men want to have sex with me. A lot of them, they're all positive and they all want to have bareback sex. And I...I'm in this situation now where I'm really starting to struggle with myself because I can see I'm going back there. I feel like I'm returning to my seedy life, but I don't want to go back to bareback sex again. No way.**

[Early 30s, high prevalence area, diagnosed 3 years]

Such individuals displayed a clear lack of the confidence needed to communicate and maintain the decisions they had made about sexual risk, yet demonstrated that they had no meaningful contact with anyone or any service that helped to meet such needs. Men did not speak of any friends,

HIV prevention workers or other support networks that could help them to develop and practice tactics and strategies for sticking to their plans, once conceived – a theme that will emerge again in subsequent chapters. This same support gap was evident among those who identified that their problematic relationship to alcohol and/or drugs exacerbated their continued risk-taking behaviour.

A small number of respondents, again mainly those recently diagnosed, were keen to distance themselves from men who engaged in sexual practices they did not approve of. This action was as much to do with not wanting others to associate them with certain types of risky sexual practices, as it was about men's own sense of propriety. Thus, they wanted to clearly delineate what it was to identify as a responsible social actor (themselves), and an irresponsible one (others).

**I don't log into gaydar HIV chat to specifically say to somebody 'Looking for bareback fucking now'. Which is what the majority of them do and to be honest it just makes me sick.**

[Mid 30s, low prevalence area, diagnosed < 1 year]

The possibility of others finding out about their engagement in risky sexual behaviour was also a concern. Some feared that acquaintances, friends, and other men on the scene would view them as irresponsible or reckless if they ever discovered they had engaged in UAI while being aware of their HIV status.

**I don't want to feel that I am having to put myself at risk of being re-infected. And the other thing is putting up with the risk of condemnation from my community.**

[Late 30s, low prevalence area, diagnosed 18 years]

Concerns about condemnation and judgement extended beyond engagement in UAI to encompass the very fact that they were living with diagnosed HIV. While stigma of this sort was less commonly reported by men in areas of higher HIV prevalence, it was notable among men in lower prevalence towns and cities, and among Black and minority ethnic respondents.

**And people seeing you as that, rather than seeing you as the person. You know seeing the diagnosis and not the person [...] You know I've already got two big labels anyway. I'm Black and I'm gay. So now I'm Black, gay and HIV positive. It's like another thing to, you know, have a go at.**

[Late 40s, high prevalence area, diagnosed 17 years]

Feeling stigmatised, judged, or ostracised by their local community because of their HIV infection status also made it difficult for some men to make friends or find sexual partners. Again, this was a particular concern for men outside of London and Manchester, and led some to question whether they had made the right decision in disclosing their status in the first place.

**I don't know why. I just... I just went through a phase of telling everyone. And then it was the biggest mistake because everyone was talking about it then on the gay scene. They were like 'Oh he's HIV, he's HIV'. And as I say when I became... everything became normal again, I just wanted to put that behind me. And I was like, I was just telling people 'No, no I'm not. It's a fucking rumour. It's ...someone's spread the rumour'.**

[Early 30s, low prevalence area, diagnosed 2 years]

By far the greatest concern shared by nearly all of the men in the study – regardless of local HIV prevalence – was the possibility of rejection by sexual partners following disclosure of their HIV status. The harm this caused to an individual's self-esteem and self-confidence was often serious and long-lasting. Nearly every respondent had experienced rejection by potential sexual partners in some form because of his HIV status.

**We met on this date and spent all day together, and he was really, really nice. He told me that he really liked me and wanted to see me again. And he was a [healthcare professional] and I thought 'I'm just going to tell him'. So I did and we talked about it all. And then later he went to go home and he said 'I'll speak to you soon'. I texted him that evening, and again on Monday but he didn't reply. And then on Tuesday he texted me and said 'Thank you for a lovely time and for you honesty but I'm sorry, this is not the kind of relationship I want. No hard feelings. Take care'. That's it.**

[Late 30s, high prevalence area, diagnosed < 1 year]

**I'd say to someone [that I'm HIV positive] and there would be a really strange reaction and I'd have to leave that person's house, you know kind of thing. And you feel a bit like a pariah. Or people would, you know, get this horrible reaction to it.**

[Late 40s, high prevalence area, diagnosed 17 years]

This fear of rejection was by no means limited to those who had been recently diagnosed. Men who had been diagnosed with HIV many years ago, and who felt comfortable with their status, were concerned about how sexual partners might react if they were disclose their status.

**I find it very difficult. Unless I know the person through a social relationship. But if you like to meet somebody and then think about a sexual relationship, I find it a very hard thing to disclose [...] Again it's a fear of rejection at the end of the day.**

[Mid 50s, low prevalence area, diagnosed 17 years]

Emotional distress was not the only feared outcome of disclosure. Following several high profile incidents in their local areas, several men reported a fear for their physical safety should they disclose their HIV status to a sexual partner.

**Like I say, if you are going out on the pull are you going to disclose to that person? If it's going to be a one night stand are you going to disclose to that person? I remember reading in the paper about a guy who got jailed, I think he had actually murdered them...I think he picked the lad up and disclosed his status after they got together and I think the guy beat him to death, didn't he?**

[Early 40s, high prevalence area, diagnosed 2 years]

In addition to the possibility of physical or emotional harm stemming from disclosure of their HIV status, men also had to face a fear of criminal prosecution for reckless transmission of the virus. While detailed knowledge of cases and legal policy shifts was uncommon, most were well aware that prosecutions had taken place in recent years. Personal concern about such legal action was not universal, but over a third of men did feel it was a potential harm that could arise when having sex in knowledge of an HIV diagnosis. Some men felt it was yet another thing to worry about.

**And I suppose whereas before I would have regretted doing it for the sake of the other person, thinking that I might have infected them and stuff, now there's an added anxiety to do with the fact that I could be prosecuted for it.**

[Late 30s, high prevalence area, diagnosed 10 years]

While others were concerned about the risk of retribution from disgruntled ex-partners:

**At the end of the day if you know this person and have sex with them and they have a grudge against you, they can say something 'You shagged me bareback and I am going to get you done'. It does have consequences to it.**

[Mid 30s, high prevalence area, diagnosed 15 years]

Therefore, in addition to their concerns about social and sexual rejection on the basis of their HIV status, men also expressed anxieties about how criminal prosecutions for the transmission of HIV might also impact on their personal and sexual lives.

### 3.3 DISCUSSION

Concerns about STI acquisition during UAI were minimal (with the exception of some worry about the possibility of hepatitis C infection), and there was no evidence in men's narratives of awareness of the impact of STI co-infection on the effectiveness of anti-retroviral therapy, or of its role in onward transmission of HIV. In general terms, men with a more recent diagnosis were more likely to attend to the different physical risks associated with UAI than men who had been diagnosed for some time, and this pattern was particularly striking in relation to men's views on the likelihood of superinfection. Where discourses about superinfection were mobilised, men either felt that healthcare providers had been untruthful about the extent of this threat to their own health (a prevalent view among men diagnosed with HIV for some time), or were convinced that it was a fairly common occurrence (a prevalent view among men diagnosed with HIV within the past few years), with a small number reporting a shift toward insertive UAI as a means of avoiding superinfection themselves. This data suggests that diagnosed men's conceptions of HIV (and superinfection with HIV) are heavily informed by perceived social norms or personal experience, and are liable to change over time. HIV interventions and programs must attempt to keep pace with these changing conceptions of sexual risk held by men diagnosed with HIV.

Beyond concerns of physical harm, these findings echo those from the earlier study regarding men's extensive concerns about the social and personal impact of participation in UAI which frequently supercede their perceptions of transmission risk (Keogh *et al.* 1999). Among the current sample, this was particularly the case for men who had been diagnosed with HIV for longer periods of time. Rather than being overwhelmed by the fact that they have the capacity to pass on HIV to others during UAI, with time it appears men give more prominence to the reality that, by choosing to have UAI, they are required to attend to the various emotional, psychological and social fallout that such a choice may entail.

Some men made it clear that in order to maintain their self-regard, they had developed significant social and sexual distance from other men with HIV whom they frequently characterised as morally inferior. They felt strongly that being associated with HIV positive sexual spaces (either online or offline) would mean bringing compounded stigma, on top of the immense concerns they already held about sexual rejection from potential sexual partners. Men within smaller social networks (particularly those in smaller towns and cities) were acutely aware that there was a degree of community surveillance undertaken in order to keep men with HIV 'in check', and some had significant personal and professional concerns about falling foul of strict social norms against men with diagnosed HIV participating in UAI. Therefore, as will be discussed in the following chapters, there is a tendency for a significant proportion of respondents to regard UAI as something that should never be planned, or managed – as this would call their moral probity into question. Seeking UAI is regarded by such men as carrying a significant risk of alignment with all that is stigmatised about HIV positive gay identities. In many ways, men regarded criminal prosecutions as a formalised social extension of this same system of surveillance that had become a part of life with HIV. Thus, in addition to the already heavy moral burden that many shouldered as diagnosed men having UAI, for some, criminal prosecution made their navigation of the threatening sexual terrain even more anxiety-ridden. In the absence of widespread changes in community norms about HIV, risk and responsibility, health promoters continue to be faced with considerable challenges to the acceptability and uptake of interventions that aim to increase harm reduction practices (including, and perhaps especially, sero-sorting) among diagnosed men.

The next two chapters describe how the men taking part in the study responded to the risks that they perceived to be associated with their participation in UAI. Chapter 4 focuses on men's management of the physical transmission risk posed to others, and of the physical transmission risk they faced themselves. Chapter 5 describes their efforts to maintain a personal and public identity within which they felt secure. There is significant overlap between this chapter and those that follow, however, in representing men's complex rationales and behaviours through a thematic structure, some repetition is inevitable.

# 4 Managing the risk of infection

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There are a number of ways in which men diagnosed with HIV can reduce the possibility of infecting another individual, and acquiring another infection themselves, when having anal intercourse. The risk-reduction tactics available to them can be used singularly or in combination, at which point they may best be considered strategies. Their implementation can differ from one context to the next, and any one of them may be utilised imperfectly. These tactics exist in addition to the option of avoiding anal intercourse, or indeed any sexual contact, altogether.

- **Avoiding unprotected anal intercourse:** Some people use condoms during anal intercourse to reduce semen transfer.
- **Attending to sero-status:** Men may directly or indirectly disclose their sero-status to sexual partners as the starting point for sexual risk-reduction behaviour in order to then negotiate sexual contact with an informed partner. Men may also employ sero-status knowledge by seeking out other men with HIV (a practice commonly referred to as sero-sorting).
- **Attending to modality of anal intercourse:** Men may avoid being the insertive partner during anal intercourse so that the likelihood of infecting another partner is reduced. Alternatively, some may avoid being the receptive partner in order to reduce the possibility of acquiring another infection.
- **Attending to viral load and infectiousness:** There are those who will only have UAI when their viral load (or a partner's viral load) is low, in order to reduce the likelihood of transmission and /or superinfection following exposure.
- **Avoiding internal ejaculation:** Men may withdraw before ejaculation when being the insertive partner during UAI, or ensure a partner withdraws when being the receptive partner, in order to reduce semen transfer.
- **Attending to duration of anal intercourse:** Men can reduce the length of time spent engaging in anal intercourse, thereby reducing the possibility of damage to the anus and/or penis during sex, which can facilitate HIV exposure.

It should not be presumed from the accounts in this chapter that men with diagnosed HIV always have anal intercourse when they have sex, or that they never use condoms when they have anal intercourse. Nonetheless, intensive focus during the interviews was directed towards how, where and why men *had* been involved in UAI in the previous year, offering significant insight into the their experience of this very specific risk behaviour. Therefore we acknowledge that the experiences described here do not capture other important elements of risk management outside of participation in UAI.

Men's ability to plan and implement a range of tactics to minimise infection-related risk during UAI is dependant on a number of associated factors. These include being aware of the likelihood of transmission associated with particular behaviours, and having the practical skills to implement intentions as well as having backup tactics to draw from in case things do not go according to plan. This chapter considers the differing extent to which men in the sample planned and implemented strategies and used a variety of tactics to reduce the physical risks they associated with having anal intercourse. While an attempt is made in this chapter to separate out some of the key issues and approaches raised by men in dealing with infection-risk, in real-life contexts, these elements are frequently combined in highly complex ways.

## 4.1 CONDOMS AS A SOLE RISK MANAGEMENT TACTIC

A small group of respondents aimed to use condoms with every anal intercourse partner. They found, however, that this aspiration was difficult to maintain in practice, particularly when confronted by disruptive factors. For these men, when their one and only means of reducing risk (*always* using a condom) was challenged, they had nothing with which to replace it, resulting in UAI about which they expressed significant regret and concern.

For some, the routine use of condoms or a personal commitment to routine disclosure was disrupted after taking drugs such as cannabis, ketamine, or alcohol. However, when asked to elaborate on the role of substance use in relation to their experiences of UAI, men expressed ambivalence.

**I guess I'm putting the blame on the drugs, but it's true that if I was totally sober then I would probably have thought of using condoms.**

[Late 30s, high prevalence area, diagnosed 10 years]

On the one hand, these respondents did not want to be seen as men that used drink or drugs as a means of absolving themselves of responsibility for their actions, yet on the other hand, they knew that without the use of such substances, they probably would have managed the risk better. One respondent considered that for him, the occasional incidents when he got high, went to a sauna, and did not use condoms were an inevitable part of how he interacted with the scene.

**But it is only afterwards you think 'Oh what the fuck have I done?'. But then that passes. And then you put yourself back in the situation again that you were in before. It's like a vicious circle, isn't it? Just what comes around goes around.**

[Late 30s, low prevalence area, diagnosed 2 years]

There were others whose aim to always use condoms with sexual partners was disrupted, not by substance use, but by their sexual partners' desire to have UAI. Rather than forgetting about risk in a moment of passion, what these men described was submission to their sexual partners' dominance resulting in UAI. Here, one respondent described a recent encounter where he and his casual partner got through all of the condoms they had at the time.

**I said to him 'Oh, I haven't got any condoms', and he was...actually we used another one for another time. I don't know how many times we fucked, but the last one he was just...he just ended up fucking me. He just took control and fucked me. And I just thought 'OK'. I mean it wasn't forceful or anything. But he just wanted to fuck and that's what happened. And I was like 'OK, well I told you I haven't got any condoms and you still chose to'.**

***Were you thinking about the lack of condom at the time it was happening?***

**Yeah, I just thought 'OK, well I hope...I hope it's minimal risk', you know? Whatever you know, you just think...I thought 'OK, I'll just have to enjoy it, and whatever'.**

[Late 20s, high prevalence area, diagnosed 7 years]

This respondent was at pains in the interview to make it clear that he is not the 'type of man' who seeks UAI sex with casual partners. He felt that in general, he took care to take responsibility for others' well-being (and his own) by using condoms. Yet on those rare occasions when someone else takes 'control', he is somewhat relieved of that burden.

In contrast, another man described himself as someone whose wish to use condoms was repeatedly undermined by his own lack of confidence and sexual negotiation skill.

**Yeah, because even if I tell you 'OK, well I prefer to have sex with condoms, yeah'. But at the end if you say 'Oh no, I don't want it, I would like bare sex' I would let you.**

[Late 40s, high prevalence area, diagnosed 23 years]

Despite support interventions from clinic staff, this man felt ill-equipped to manage risk in any meaningful way. Crucially, like the others described above, there was no consideration that other harm reduction measures (such as withdrawal) might reduce risk in the absence of condoms.

## 4.2 MEANS OF MANAGING RISK OTHER THAN CONDOM USE

The majority of men we interviewed, while not necessarily seeking it exclusively, were conscious that UAI could occur within the context of their sexual relationships. As such, many had planned ways in which to manage the risk associated with UAI should it occur. Such plans could be singular (tactical) or multi-faceted (strategic) in nature.

### 4.2.1 Attending to sero-status

A small group of respondents (one fifth of the sample) described always disclosing their HIV diagnosis before having penetrative sex. Essentially, disclosure was idealised as a practice which enabled men to regularly engage in UAI that was generally regarded as preferable to protected anal intercourse. On the whole, these men had lived with an HIV diagnosis for a considerable time, and had tried different ways of navigating HIV risk (including for some, consistent condom use). Thus, they described disclosure as their universal risk management tactic, usually with a small, somewhat select range of regular and casual partners. Although it will be discussed in greater detail in Chapter 5, a significant factor for a number of men in this group was the extent to which letting partners know about their HIV status interfered with their management of the social and emotional risks they faced as diagnosed men engaging in UAI.

Explicit disclosure before sex (which usually occurred face to face or in private online exchanges between individuals) helped the men in this group to meet a range of aims. For some, sharing such information signaled a request for reciprocation. That is, there were those who told others that they had HIV in order to confirm that the sexual partner had also been diagnosed.

**I would rather go with somebody and say 'Right I am HIV positive, you are HIV positive lets do bareback sex! Ok? Brilliant'. You know its done and dusted in like two minutes and there is none of all that which goes with it all and that 'Oh I don't want to do this and I can't do that'. Have it out in the open and move on from that and just have good sex and then if you decide to meet again it's a bonus. It's as simple as that.**

[Late 30s, low prevalence area, diagnosed 14 years]

However, there were few among this group of universal disclosers who were *certain* that all of their UAI partners in the previous year were also diagnosed with HIV. Instead, some presumed that those who had acknowledged their disclosure and were willing to proceed must be sero-concordant.

**You said that a lot of the guys you have sex with are positive. How do you know they are positive? Because they wouldn't fuck without a condom otherwise would they? If I say 'Can you use a condom?', and I have told them, you know, that I am positive... I have had guys saying 'Do you bareback?', and I think, 'well bareback, you know, he must be positive. If he wants to bareback me then fine. Its no skin off my nose'.**

[Early 30s, high prevalence area, diagnosed 7 years]

Establishing or even guessing at concordancy was not a necessity for all of the men who used disclosure as a harm reduction measure prior to UAI. In a few instances, men described going ahead with UAI after disclosing to partners without diagnosed HIV. There was frequently a pervasive regret and concern expressed about such situations, although in one case, a man described not knowing how to stop having UAI with a new partner (who he later found out was sero-discordant) once it had begun.

**We started kissing and everything, and the next thing he was sort of pulling my underwear off. And I was just thinking that, 'Shit I have not disclosed my status'. And then the next thing it had progressed into oral and I was thinking 'Oh crap', because I wanted to tell him beforehand. It all just kind of happened a bit quickly. I could have stopped him to just sort of say 'Woah, hold on, I have got something to tell you'. But it just felt a really awkward time to have done that and also I was kind of scared about him rejecting me at that point whilst I was pretty much naked at that point. I just felt very vulnerable.**

[Mid 20s, high prevalence area, diagnosed 2 years]

Although universal disclosure can often be idealised as a shield against risk, men tended to take further measures in order to attain a degree of physical and psychological safety with which they felt comfortable. Ensuring, presuming, and even hoping that partners were sero-concordant enabled many to avoid the feelings expressed by the respondent above, although, without certain knowledge of concordancy, the risk of transmission remains.

#### **4.2.2 Combining tactics to formulate risk-reduction strategies**

Fewer than half of all respondents described combining a range of sexual risk-reduction tactics depending on different sexual contexts. Where they did so, men described what might best be imagined as a strategic 'flow chart' of risk management that helped them to decide which risk reduction tactics (if any) to employ in a given situation or with a given sexual partner. Men mixing together different tactics in this way sought to have unprotected sex (or were conscious of that fact that it may occur given the context in which they liked to have sex) and therefore had planned a number of ways in which to reduce the likelihood of risk to self and others.

Different rules were used for men who were casual partners and men who were regular or romantic partners, or who at least had the potential to become so in the future (although this is often a difficult distinction to make). To these regular and romantic partners, disclosure of HIV status was almost uniformly made, generally in an explicit and clear manner prior to sexual contact. A discourse of responsibility emerged towards those men with whom they had a more intimate or personal connection. It was felt fair and right to be honest about the risk with such men. Once disclosure had taken place then, dependent on sero-concordancy, a decision could be made as to whether condoms and/or other risk reduction tactics should be used. On the whole, UAI with sero-concordant boyfriends or regular partners was regarded as an activity that carried little physical risk to either partner.

**If I am positive and they are positive then they have got no worries... you know, I know there's such thing as them [STIs]. I know I've had them in the past as well, and am a lot more careful now and have got my head sorted out, just about... You know it's 'I stick with one partner and just don't go off and sleep with every Tom, Dick and Harry'.**

[Early 30s, high prevalence area, diagnosed 7 years]

With casual partners however, the guiding rules of sexual engagement were more complex, usually dependent on the known or perceived HIV status of the sexual partner. Similar to those described in section 4.2.1, the status of sexual partners was sometimes established by reciprocal disclosure, or, as was more common, sero-concordance was assumed based on the context in which sex was taking place. Men advertising their willingness to have UAI, or men having UAI in saunas, were considered to already have HIV. In such circumstances, disclosure of one's own HIV status was not deemed necessary:

**I think the rules in bathhouses [saunas] are different to other encounters. If you meet in a bar or general, if you see what I mean, I think there is a certain amount of risk attached to any activity. There is risk going into bathhouses. If you are going into a bathhouse and having unprotected sex you know the risks involved.**

[Late 40s, high prevalence area, diagnosed 18 years]

UAI with casual partners who were presumed to also have HIV was constructed by many as risk-free, therefore no further risk management was required. For others, however, it was at this point of ascertaining (or assuming) the HIV status of their sexual partner that they enacted plans to manage the physical risk to themselves. While by no means the case for all of the men, some were concerned enough about the risk of superinfection, or infection with other STIs (particularly hepatitis C) to either use a condom, or to avoid receptive UAI.

**I would honestly say that if the table was turned and I was being the receptive partner I would like a condom on, thank you very much. I don't want no superbugs thank you! Whereas some people are open to whatever might be going around.**

[Late 50s, high prevalence area, diagnosed 3 years]

If, however, respondents felt unable to ascertain the HIV status of their sexual partner, or where partners said they did not have diagnosed HIV, then a range of other approaches were adopted. Some respondents insisted on using condoms with men whose HIV status was unclear, while many others described withdrawal before ejaculation when having insertive UAI with such partners.

**But then again it depends whether... I think if I'd kind of minimised the risk... it depends on whether you knew them or what the situation...[...] If you're not honest or it's a sort of casual thing. It's a weird one. That's one of the reasons I probably wouldn't come inside somebody. I couldn't... you know... that kind of minimises it you know.**

[Late 50s, low prevalence area, diagnosed 10 years]

Those men who combined harm-reduction tactics depending on different sexual contexts were, on the whole, trying to operationalise their desire to have UAI while also avoiding transmission and acquisition of infection. However, what these findings clearly demonstrate is that if the starting point of their risk reduction strategy was an assumption of their partner's sero-status (rather than an explicit disclosure), their later tactics were likely to unwittingly result in HIV exposure.

### **4.3 LACKING THE CAPACITY TO MANAGE RISK**

In contrast to those men whose plans to reduce risk were superceded by intervening factors, a small number of others did not appear, in any significant or sustained way, to plan to reduce physical risk to themselves or others during intercourse. While they shared an absence of considered strategy to address potential risk in sexual situations, the reasons for such a position were complex.

For men who lacked the capacity to plan for risk, it was often the case that they lacked control over most of their sexual encounters. There was sometimes a fear that they would not be able to have any sex at all unless they agreed to the wishes of their sexual partners. This was often the source of regret, not least because the sex they were having was unsatisfactory as well.

**But yeah, I suppose I was left with the question 'Well, am I not able to control myself?'. You know to the extent of not doing that? Because it's not why I came here. This is not the kind of good sex I want, quite apart from him.**

[Late 40s, high prevalence area, diagnosed < 1 year]

One respondent also appeared to lack the cognitive capacity necessary to fully comprehend and respond to sexual risk. As such, any attempt to reduce risk of onward HIV transmission was left solely in the hands of his sexual partner. If the partner made no attempt to manage risk in the sexual encounter, then UAI took place. This man was in no way ignorant of the consequences of HIV infection more broadly, but simply lacked understanding of HIV risk-related behaviour and the capacity to manage risk. On the few occasions he did consider his status during sex, and what the possible consequences of his actions might be, his response was to stop sex entirely rather than attempt to enact any form of risk reduction strategy (including using condoms).

While the men described in this section felt strongly that they would not ever want to be responsible for transmitting HIV to sexual partners, they lacked the capacity to sustain a pre-planned approach to harm reduction. Furthermore, they demonstrated no concern about acquisition of a superinfection or another STI during such encounters.

## 4.4 DISCUSSION

The findings presented above reveal men's diverse responses to the physical risks of having anal intercourse without condoms. Some report that they would prefer to avoid UAI, but that other factors such as substance use and partner's demands can prevent the use of condoms. They lack the knowledge and resources to use alternative HIV prevention tactics. Similarly, others are unable to actively manage transmission risk each and every time they have sex. Lacking any fall-back plan once the goal of using condoms is lost, is not terribly different than lacking any plan at all. Although they do not comprise the majority of this sample, respondents in these two categories demonstrate considerable need across a range of areas, including: their understanding of the biology of transmission (including the overlapping roles of modality, viral load, lubrication and duration of intercourse), their knowledge of a range of tactics that can reduce positive to negative semen transfer, and the confidence and skills to negotiate sex both verbally and non-verbally.

The interaction between psychological well-being and risk management is also evident among men who lack strategic approaches to physical risk management. Men who revealed a low self-image often said they felt lucky to be having any sex at all, and subsequently lacked much control over how sex occurred. They described UAI as being not so much a choice, as a necessary hazard of being sexually active. Such men tended to have been diagnosed within the last two to three years.

In contrast, there were many participants who described having at least one tactic (usually disclosure) or a strategic approach (a string of tactics), that they used to navigate the physical hazards accompanying UAI. In the main, awareness of how HIV is transmitted, the realistic likelihood of superinfection, and their awareness of a range of potential harm-reduction tactics was relatively sound (with some significant exceptions). Many also appeared to be relatively satisfied with the sex they were having, and, felt they exercised control over the likelihood of acquisition and transmission of infection. However, when considered against the wide range of tactics that can be used to manage the risks inherent in UAI, most men relied on a relatively narrow range. While it was common for men to attend to sero-status, in its many complex forms, other tactics (aside from condom use) were rarely used. A small number attended to the modality of anal intercourse or sought to avoid internal ejaculation, but generally only as a means of reducing the likelihood of acquiring a superinfection or other STI. Not one respondent described attending to the duration of anal intercourse, or to their own or their partner's viral load, as a means of reducing the risk of HIV transmission.

Even amongst the men who attended to sero-status as a way of reducing transmission risk during UAI we see evidence of significant need. This problem is by no means a new one. Establishing that a partner has diagnosed HIV with absolute certainty usually requires explicit disclosure of one's own HIV status. As we shall explore in detail in chapter 5, men perceive a broad array of social risks associated with that type of openness. Therefore, some respondents described using a range of proxy behaviours which they believed to be a simulation of disclosure, and which they also thought could generate a fair idea of their partners' status. Thus, some believed that behaviours such as: asking for UAI; attending a sauna; asking a partner if he is *sure* that he doesn't want to use condoms; or ticking 'safer sex to be discussed' on an online profile, to be tantamount to disclosure of HIV status. Secure in the belief that their partners are aware they are having sex with someone who has HIV, and are likely to have HIV themselves, such men regarded the physical risks of UAI to be significantly diminished.

There were those who were much more direct about disclosing their own HIV status to all partners, as well as always eliciting information about partners' knowledge of their own status. However, they constitute a minority of those taking part in this research. It would appear instead, that sero-sorting is far from being a perfected, widespread approach to harm reduction amongst diagnosed men.

# 5 Managing identity

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As described in chapter 3, many of the respondents perceived a number of harms that had the potential to impact upon their social identity or how they perceived themselves as a moral person. Men responded to these harms in a variety of ways according to their own unique circumstances. Tactics of risk reduction were by no means used uniformly. Different men used varying tactics to respond to the same perceived harm, and some men used the same tactic but in response to vastly different, and often opposing, perceived harms. In the course of pursuing sex that was enjoyable and meaningful, men described having to simultaneously manage damaging self-perceptions, as well as the harm that can be introduced by others in the form of rejection and the possibility of criminal prosecution for HIV transmission. These harms, and their management or avoidance, exist in addition to the ever present risk of physical (infection-related) harms to self and others described already.

## 5.1 MANAGING SEXUAL PLEASURE

Sexual enjoyment and satisfaction was important to all of the men who took part in this study. While a drop in libido was often experienced following diagnosis, respondents who were longer-term diagnosed typically reported that it returned to previous levels after a few months or years. However, they were of course still confronted with having sex as a man living with diagnosed HIV, incorporating all their concerns about infecting others, causing further physical harm to themselves, or perhaps acting in such a way that might threaten their sense of moral integrity. The men we interviewed responded to these concerns in several different ways.

An approach adopted by around a quarter of the respondents was to only have sex with other men who were diagnosed with HIV. By sero-sorting in this manner they could be assured of not being the source of primary infection for another individual and also limit the possibility of them being rejected by a sexual partner on the basis of their HIV status. After several months of abstaining from sex for fear of infecting sexual partners, or fear of how they might respond to knowledge of his HIV status, one man who sought partners with diagnosed HIV on the internet says:

**So yeah, and then I noticed that I started...is it sero-sorting or whatever it's called? Where I was kind of actively looking for positive people to take the pressure...The mental pressure away.**

[Early 40s, high prevalence area, diagnosed 2 years]

Having sex with other men with diagnosed HIV meant that such respondents didn't have to fulfil a role of a sex educator, a position many found themselves in after disclosing their status to a HIV negative sexual partner. At the point of sexual contact, some were reluctant to engage in an in-depth discussion about the nature of HIV and the probabilities of transmission even when condoms were being used. Sero-sorting therefore provided a significant opportunity to have uninhibited sex where HIV status did not remain the most salient concern throughout the sexual encounter.

**I still worry even when we do have sex and its protected sex, you still have that worry at the back of the mind 'Is the condom still on, is it not going to split, is it going to split?'. You do worry about that but with an HIV positive person you are not thinking about that, you are not having to worry about it with them which is, yeah, I don't know, it's a strange one to be honest.**

[Late 30s, low prevalence area, diagnosed 20 years]

With the possibility of HIV transmission removed, respondents who sero-sorted felt free to have sex in any way, and with as many men, as they pleased.

**I think just my experience of it anyway, sex with people who are positive has generally been much more dirty. And often involved drugs to a much higher degree. I've enjoyed it a lot.**  
[Late 20s, high prevalence area, diagnosed 3 years]

Men who sought out sexual partners of the same sero-status rarely used condoms with them. As described in section 3.1, most respondents were not very concerned by the risk of superinfection, or infection with other STIs. In addition to a commonly reported experience of intercourse without condoms being more sensually satisfying, some respondents involved in 'harder' sexual practices, such as fisting, felt that condoms simply weren't compatible with their sex lives.

**If you're having a good fisting, say it's a bit of faffing around which you could do without [...] there's no point in using condoms. From a practical point of view they wouldn't last five minutes.**  
[Mid 50s, low prevalence area, diagnosed 12 years]

This approach to achieving sexual pleasure, without having it interrupted by nagging concern about transmission, was described by men who had been diagnosed for longer periods of time, and who had tried different combinations of tactics before this one. There was an overriding sense among this group of respondents that when all else had failed, and they had come to accept elements of their identity as a sexually active man with HIV, that sero-sorting provided them with both a moral and sexual haven.

Saunas provided another opportunity for many of the respondents to meet their sexual needs. Not only was sex nearly always available, but the environment was deemed conducive to men with HIV having sex freely with less fear of rejection from sexual partners. Most respondents who frequented saunas believed that a significant proportion of the other men inside also had HIV.

**I kind of make an assumption that when they're doing the kind of things that they're doing in the setting with people that they are, some of whom... they're obviously positive. Then it's, kind of like, taking it as read for me that they basically are.**  
[Late 20s, high prevalence area, diagnosed 3 years]

As with online HIV positive chat rooms, or face-to-face HIV support groups, explicit disclosure of status was deemed unnecessary as saunas were frequently regarded as HIV positive spaces. Men having unprotected sex in saunas, or reporting their willingness to do so, generally felt that they did not have to actively disclose their HIV status as they presumed it to be evident by their presence in that space, as well as by their actions. Communication of any kind in saunas or sex clubs was regarded as rare, let alone communication about significant and potentially stigmatising health-related issues.

**It might just be a pure sexual encounter when there is no verbal communication at all. You might just go to a sex club, or whatever, and the last thing people want to talk about is their HIV status. HIV status is hardly ever discussed.**  
[Mid 30s, high prevalence area, diagnosed 9 years]

The implicit manner in which HIV awareness was handled in saunas meant they also provided an opportunity for some respondents to 'switch off' from the reality of their status. Having to disclose the fact they had HIV was seen as a significant barrier to the formation of both intimacy and eroticism, with several men describing it as a delicate balancing act: their desire to be honest and morally integral on one hand, and their desire for sexual satisfaction on the other. Saunas, it seems, afford them with the opportunity to achieve both.

## 5.2 MANAGING MORAL AND SOCIAL INTEGRITY

For a large proportion of respondents, UAI with high numbers of partners (30 or more in the past year) formed the basis of their sexual activity. They were comfortable with the actions they were taking, particularly when they considered they had minimised the risks to others by attending to their own and/or their partners' sero-status when having sex. However, for a smaller proportion of men UAI was rare, with perhaps only one occurrence within the last year. Explanations for these rare instances were often exhaustive, with men keen to stress that this was in no way part of their normal pattern of behaviour. When UAI did occur, it was often the cause of a great deal of discomfort.

**Yeah I find... I feel upset because I broke the rules in having bareback sex with somebody that is HIV, but it's not the point because you should not have bareback sex anyway.**

[Mid 30s, high prevalence area, diagnosed 15 years]

Such respondents tended to take a dim view of other diagnosed men who engaged in UAI on a regular basis. While the term 'barebacking' was used by most men to describe unprotected anal intercourse, respondents with less experience of UAI used the term to refer to what they perceived as a high-risk, esoteric practice. Their own experiences of UAI were exceptions arising within unique circumstances (passion, substance use, sero-concordance *etc.*), and not at all similar to the behaviour they perceived many other men diagnosed with HIV engaged in.

**Like if you go on gaydar and you go on a HIV site, that's all they are interested in, bareback sex, raw sex and this is on the HIV site and I have had arguments on there umpteen times. Yeah, you are on a HIV site and you want bareback sex, but there's no point in the matter... there's people like you who do it constantly. Yeah, I done it once and paid the consequences but there are people, like you know, going spreading it round because they are shagging willy-nilly.**

[Mid 30's, high prevalence area, diagnosed 15 years]

Men unaccustomed to UAI since their diagnosis were keen to distance themselves from sero-sorters at all costs, regarding such behaviour as irresponsible and immoral. Interestingly, the same men maintain their view of sero-sorters even when they had actually engaged in UAI with other HIV positive men themselves. Despite describing how enjoyable and emancipating they found it to be, some were quick to assert that their sero-concordant sex occurred by accident, affirming their belief that it should never become a regular or purposeful practice.

In sharp contrast, those who had UAI rather more regularly, highlighted the risk reduction tactics they employed, such as status disclosure or withdrawal, and many who purposefully engaged in UAI with other men of the same sero-status were equally keen to construct their behaviour as responsible.

**I would prefer to have unprotected sex and I wouldn't want to put someone in the situation where obviously I was going to give them HIV, so if I am looking for a partner for a long-time relationship, usually I would be looking for somebody who is HIV positive. I am just totally honest and open about it.**

[Mid 40s, low prevalence area, diagnosed 12 years]

More commonly, however, men wholeheartedly rejected the idea of sero-sorting and sought to distance themselves as far as possible from those who did. To be associated with men who deliberately sought out UAI amongst others only seeking the same posed a threat to their moral integrity, as well as their social identity.

**But if you ever went in to gaydar and you went, and you did a sort of positive, putting HIV positive as a search, you tend to come up with sort of a certain type of gay man who is giving the impression of being very promiscuous and being into just about, you know, everything.**

[Mid 50s, high prevalence area, diagnosed 14 years]

The majority of men who reported high numbers of sexual partners, and had participated in UAI repeatedly over the previous year (many of whom would not consider themselves to be sero-sorters), utilised diverse means to maintain their moral and ethical integrity. While acknowledging that they had engaged in UAI, many justified and defended their actions to the interviewer with little or no prompting. Such individuals devised a series of guiding principles that had to be adhered to when engaging in behaviour they believed to be risky. For many, disclosure of their HIV status to a potential sexual partner was an absolute necessity prior to any sexual contact. Disclosure was frequently described as responsible behaviour and 'the right thing to do'.

**I always tell someone if I am sleeping with them because I always do. I always have done since I was diagnosed [...] And I think it is the right thing to do anyway.**

[Late 30s, low prevalence area, diagnosed 13 years]

For some, particularly those more recently diagnosed, disclosure was about providing sexual partners with the information needed to make an informed decision as to whether they wanted sex to occur. A number of men stressed their need for disclosure to be clear and explicit so that they might be able to keep a clear conscience. Some of the respondents constructed honesty as the pivotal feature of their sexual behaviour.

**I have always been upfront about it with people, always, always, because I had always thought at least I could hold my head up and say 'Well at least I was honest'. And every sexual partner I have always had, I have always said the minute... even when I have been on a night out. You know, like you do, you go out and you get pissed and you want a shag at the end of the night. Even before I have got out of the club and gone home I have always said 'I am HIV so you either come back or you don't'.**

[Late 30s, low prevalence area, diagnosed 14 years]

A shared aspect of many of these narratives was men's comfort with their belief that they had ensured they had done 'the right thing' by making their own HIV status known. How partners behaved subsequently was regarded as their own affair.

**I've had people say to me 'Surely you should insist on them wearing a condom?' and I have said, 'Hang on a minute, it is just as much their responsibility as mine'. I've told them the score and I've said 'Look you should wear a condom'. If they choose not to then that's not my fault.**

[Late 30s, low prevalence area, diagnosed 20 years]

For others, however, explicit disclosure of HIV status was not essential. Some men were felt that generic highlighting of the potential risk inherent in UAI was sufficient to both allow the sexual partner to make an informed risk decision, and to maintain their own sense of moral integrity.

**Now what I do with people is if I meet them, there is a nineteen year- old not too far away from here who keeps texting me for sex, and what I've basically done with him is I've said 'Look I have bareback sex. I have bareback sex with HIV positive men. You are at risk if you have sex with me' without saying I am HIV positive.**

[Mid 30s, low prevalence area, diagnosed 6 years]

The rationale for this approach to disclosure is complex, yet, there can be little question that concerns about rejection or stigmatisation play a vital part. However, this way of signposting the potential risks can also be considered a way of being moral 'enough'. Men adopting this approach maintain their sense of moral integrity while at the same time taking steps to ensure the other person considers the risks associated with unprotected anal intercourse. Once the potential risk has been made clear it is the responsibility of the sexual partner to make sex as safe as they so desire. These respondents felt that offering the others the option to ask for the use of condoms could amount to an implicit disclosure of status, while also enabling them to share responsibility when UAI is chosen.

*What was the difference between them... the ones that were protected, were they at home or were they in the sauna or..?*

No in the sauna. At home it would always be protected as I said. At the sauna I would... if condoms are to hand and they are there, if they say 'No I don't want a condom' then that's it. Do you normally go to put one on or normally suggest it or...

I would suggest it. They may suggest it. It is up to them to suggest it, but to be honest the onus is on me because I know what I am. So if they then say 'No don't bother, don't bother' then that's your look out.

[Late 50s, high prevalence area, diagnosed 3 years]

There were a very small number of men who defended their moral integrity by assigning *complete* responsibility for avoidance of HIV infection to their sexual partner. The primary focus of sex for such men tended to be on what was satisfying or enjoyable, rather than what might reduce the risk of HIV transmission. They felt it was the responsibility of their sexual partners to ensure that sex was safe, if they wanted it to be.

**I realised that I am not responsible for anybody else's sexual health and that I should live my life to the fullest as to how I want to live it and I am not responsible for Joe Bloggs on the street. He's responsible for his own sexual health. And that's when I completely changed my sex life and started then having completely unprotected sex. I haven't used a condom in five years.**

[Early 40s, low prevalence area, diagnosed 8 years]

Some men thought that if their sexual partners were willing to have unprotected sex then they must be comfortable with the risk they faced in that situation. Some respondents felt that many gay men simply were not concerned about the risks associated with anal sex and, therefore, saw little need to plan to reduce the risk themselves.

**...and even going out cruising in lay-bys again, there is unsafe sex on tap and you can go and have sex with two or three blokes... being fucked, getting fucked, fucking them, shooting a load up your arse, you shooting your load up their arse. And then they will go and sit in a car and there is a baby seat and a wedding ring so, its not even, its not just the gays. It's the bisexuals as well, you know, they are going back to their wife and child and they don't care.**

[Early 40s, low prevalence area, diagnosed 8 years]

The few who took this approach maintained their own integrity by regarding all responsibility for sexual safety as a matter for their sexual partners to manage, never themselves. For them, this served to protect their sense of self in much the same way that other men did by disclosing their status, by sero-sorting or, indeed, by distancing themselves from the notion of sero-sorting.

### **5.3 MANAGING REACTIONS FROM OTHERS**

In addition to coming to terms with their diagnosis, and forging a new sex life, many men described taking on an active role in managing how others regarded them. The possibility of rejection following disclosure of HIV status was a common, serious and pervasive concern. As described in section 3.3, many of the men had experienced rejection or hostile responses from sexual partners on numerous occasions since their diagnosis. This encouraged them to manage the process carefully, and to take steps to limit the possibility of being hurt, emotionally or physically, following disclosure of their status. As explored above, many were keen to disclose their status in order to maintain what they felt was a moral and responsible course of action, but the timing of this varied somewhat. Some would leave it until the moment sex was about to occur while others would make their status clear much earlier on, perhaps in the bar or club where they met. Most common, however, was disclosure prior to face to face encounters via the internet. Nearly all had at one time or another used the internet to seek sexual partners. Respondents often reported they found it easier, and safer, to disclose their HIV status to individuals online.

**And I found it dead easy to disclose to people on the internet. Because again it was anonymous. Totally anonymous really. Because you didn't see them. It wasn't on a one to one basis [...] So it was a lot easier to disclose your status on the internet.**

[Mid 50s, low prevalence area, diagnosed 17 years]

In addition to disclosure being easier in an online environment, it was also easier to deal with the consequences of disclosure should they be negative. Rejection from an online contact with whom no emotional or sexual connection had been forged was easier to deal with than rejection from an individual met in a bar or club where attraction had already developed.

**Because its not somebody who is actually there sat in front of you and sort of going through everything, and then you get carried away and then they can turn around and say 'We can meet' or 'We can't meet'. [...] Sometimes you can tell, not by anything that they say, but their face drops a bit and it sort of doesn't go any further than that.**

[Late 20s, low prevalence area, diagnosed 3 years]

Even given the perceived safety of online disclosure, some men were reluctant to have their HIV status displayed on their profile for all to see, instead choosing to only disclose on a person by person basis, generally via private instant messaging. There were numerous reasons offered for this particular approach. Some men felt that disclosing their status on their profile might put off potential sexual partners who might otherwise have contacted them. Others simply felt that there was no reason for other people to know unless it was clear they were going to have sex together. A small number of men went as far as to generate two gaydar profiles: one stating their HIV status, and one not. In doing so these men felt that not only could they appeal to two different groups of men, but also that they could reduce the possibility of being rejected by potential sexual partners. Men contacting them via their HIV positive profile were likely to either have HIV themselves, or be comfortable having sex with men who had a positive diagnosis. Men from whom rejection could occur were unlikely to contact them in the first place.

**Saying that, I have two profiles on gaydar. I know you are not meant to have two profiles but one is a HIV profile of me with no pictures on obviously and then there is my proper one with descriptions and everything. So I do sometimes log into gaydar on the other profile and wait for other people to contact me, which people do, quite a few people ... because I don't want to advertise that I am HIV positive. Yeah if they contact me then I may chat to them for a bit and if I think they are OK I will give them my real profile.**

[Mid 20s, high prevalence area, diagnosed 4 years]

The attempt to minimise the likelihood of rejection embraced other behaviours as well. A number of respondents deliberately sought out environments where disclosure was not necessary, or deemed not appropriate. When seeking out sexual partners in HIV positive chat rooms, or at HIV support group meetings, disclosure was deemed unnecessary due to their presence in a positive people's space. As outlined already (section 5.1), some men considered gay saunas to be sexual spaces for men with HIV, where status disclosure was not necessary. Other men were selective about the contexts or environments in which they disclosed, dependent on the perceived likelihood of rejection.

**Yeah, I only tend to sort of go for people that I actually like. It's sort of a set of morals and now I have sort of narrowed it sort of to people who I like and who I would feel comfortable disclosing my status to. If I think at any point that they might be uneasy about it then I will, I won't go any further should I say.**

[Mid 20s, high prevalence area, diagnosed 2 years]

Some respondents tried to avoid the possibility of rejection by making their disclosure of HIV less explicit such as by simply highlighting the potential risk of HIV exposure during unprotected sex. While this same approach to disclosure, what we might term 'implicit disclosure', was outlined earlier in relation to apportioning responsibility for safe sex, it seems clear that its primary purpose is as

a way of reducing the chance of them being rejected by sexual partners. Implicit disclosure allows men to be moral 'enough', while at the same time circumventing the stigma they are acutely aware is associated with HIV.

**I remember saying 'You know we should use a condom' especially after, you know. 'We should use a condom'. But I never said to him that I was HIV.**

[Late 30s, high prevalence area, diagnosed 10 years]

However, in the case of this respondent, his persistent recommendations to use a condom resulted in his sexual partner directly asking him to clarify his HIV status. When he did so the man became angry and quickly left, severing all contact.

A large number of respondents who used gaydar indicated that safe sex 'needs discussion' on their user profile, believing this to be a clear indicator of their HIV infection. However, misunderstandings did occur.

**I have started to negotiate having sex online and, you know there is that eroticisation that goes on within that, within that conversation that you have. There is like a build up thing and, the person will start talking about bareback sex and [...] I assumed that therefore the other person, and if they are talking about it will also be positive, and I just remember, I can't remember quite what the hints were and I thought 'This guy doesn't get it'. And then I said 'Well, you know I am poz', and he said, 'What does poz mean?'. And then I thought 'God, right this is very different, very different' and that was a learning point even to me, really, that even though it is down on my profile and... I have to get back to how it used to be where I don't make that assumption, which I would have in London.**

[Mid 40s, low prevalence area, diagnosed 22 years]

Repeated experiences of rejection caused some men to stop disclosing their HIV status to casual partners. The frustration and upset that can result following disclosure and subsequent rejection was often deemed too high a price to pay. However, non-disclosure also proved problematic to respondents who were seeking more long-term romantic partners, or who were amenable to entering a long-term relationship should they meet the right individual. In such circumstances it was difficult to identify the most appropriate time to disclose their HIV status.

**You can't just meet someone in a bar and then when you're going to have sex with them, say 'By the way I'm HIV positive'. But you know if you're going to see him more, then you have to be honest and say. But there isn't a rule about how long after you've met someone that you have to tell them.**

[Late 30s, high prevalence area, diagnosed < 1 year]

Done too soon, disclosure risked the chance of any relationship forming in the first place. Done too late, it could lead to claims of dishonesty and distrust, resulting in the breakdown of relationships.

**You know, I thought he was okay with it and everything and ... he just seemed a little off and I thought 'Fair enough I have just given him a big bit of information to digest and I will see how it goes'. The next day he seemed okay and I sort of, I sent him a... I apologised for not telling him before hand, and I sent him a text again afterwards sort of saying 'Thanks for a really nice night and sorry for not telling you before the event itself and I hope to see you again on Friday'. He sent one back saying that he was quite disappointed that I had not told him beforehand and I have spoken to him since and he, since Saturday he has become a bit more upset and angry about it. At one point he had sort of mentioned that it's a criminal offence to intentionally have sexual contact with someone but, you know, I said to him 'I wasn't intentionally trying to do anything to put you at risk' [...] And now he's sort of gone, 'I'm not sure I even want to be friends with you. I can't trust you'.**

[Mid 20s, high prevalence area, diagnosed 2 years]

Men diagnosed with HIV therefore carefully select the timing of status disclosure in order to meet their sexual and/or relationship needs. However, as the way in which they try to communicate their sero-status increases in complexity, so does the possibility that it will be mis-interpreted, leaving both sexual partners at risk of further harm.

## 5.4 MANAGING THE RISK OF CRIMINAL PROSECUTION FOR HIV TRANSMISSION

For some men, the possibility of facing criminal prosecution for transmission of HIV was a serious and pervasive concern. While many were not familiar with the details of recent prosecutions, and few were able to articulate the specific legal terminology relating to such cases, a significant number were concerned enough by the possibility to modify their sexual behaviour. For a few respondents, this meant directing their sexual attention more exclusively towards men who shared the same HIV status, thus removing the possibility of onward transmission.

**It would make me less inclined to get involved with a negative person. Because you never know how somebody will react when they do turn positive and how vengeful they might become. So, those cases have had an effect, yes.**

[Mid 50s, low prevalence area, diagnosed 12 years]

The possibility of criminal prosecution sometimes provided an added incentive to disclose HIV status, and to make sure that the other person was comfortable continuing with sex given that knowledge. While in the past some respondents were content to disclose their status and leave the decision as to whether to have UAI to their sexual partner, the current climate of prosecutions made them keen to gain an explicit reciprocal disclosure so that the sero-concordancy of the sex could be made crystal clear. When status disclosure took place on-line, a few went as far as saving their online chat logs as proof that they had made their status known to the other person prior to sex occurring.

**The reason I like to meet people online is you hear all these court cases with people not telling people they are HIV positive, but on MSN you have got written confirmation [...] That's just me being paranoid really but at the end of the day I am covering my own back.**

[Mid 20s, high prevalence area, diagnosed 4 years]

However, the act of disclosure and explicit sero-sorting was by no means the only response to the possibility of criminal prosecutions for HIV transmission. Other men appeared to gravitate to the opposite response of not disclosing their status at all, particularly with casual and anonymous partners. With no awareness of HIV status, and little likelihood of them being contacted again, they believed that no criminal investigation could ever be launched. Men adopting this approach tended to feel it was the responsibility of the other person to be mindful of their sexual health and avoid situations that may facilitate HIV transmission. Ensuring that sexual partners did not have knowledge of their HIV status also had implications for other HIV risk reduction tactics. One man described an incident of sero-discordant UAI several years ago which had led him to recommend PEP to his sexual partner. However, when having UAI with a different partner more recently, he had assumed the man also had HIV. When it subsequently transpired this assumption was mis-placed, and the sexual partner reported he was actually negative, the fear of criminal prosecution dissuaded him from recommending PEP in the same way he had done so in the past.

**Did you consider that [recommending PEP] at all with this guy, the one two months ago?  
I didn't. No.**

**OK. Why do you think that was? That you didn't with this guy... but you did in that context before?  
I think it's to do with the prosecution thing.**

**OK. So that you know if you'd... if you'd rang him to say that then he then would have been aware of your status. And then kind of open the door to that possibility of things.**

**Yeah. I was really scared that he might then say...**

[Late 30s, high prevalence area, diagnosed 10 years]

Many other men reported no concern about criminal prosecutions, because they believed they only had sero-concordant sex, and therefore had seen no need to modify their behaviour. However, as previous sections have highlighted, what was seen as a disclosure of one's own HIV status, was not always perceived that way by the other sexual partner.

## 5.5 DISCUSSION

Disclosure forms a central point around which many other concerns rotate: the need to maintain a moral integrity, the need for sexual enjoyment, a need to avoid rejection by sexual partners, and a desire to avoid prosecution for HIV transmission. A balance between disclosure and non-disclosure is often employed in order to satisfy these different needs at different times and in different contexts. The men who expressed a desire to disclose their HIV status to all sexual partners did so because they felt it was simply the right thing to do. It was a responsible course of action that helped them maintain a positive view of themselves, as well as being a means of managing the risk of prosecution for transmission of HIV.

However, disclosure left men vulnerable to significant harm. While, on a general level, it is true that not all rejection is based in HIV-related stigma, for the men we interviewed, the link was clear. In most instances, contact had been made with the other person and attraction had developed, either in a purely sexual, or in a romantic sense. Rejection did not occur until the point at which respondents disclosed their HIV status to the other person. Hence it becomes clear that the stigma of having HIV all too often led to rejection by sexual partners and resulting emotional trauma, or lack of sexual opportunity. Experiences of rejection were widespread and pervasive, and the fear of these experiences being repeated was enough to provoke changes in behaviour that persisted for many years. Many chose to minimise the chance of social harm by avoiding disclosure of their HIV status altogether. This approach also meant that the sex men had could occur uninhibited by risk concerns, hopefully ensuring a more erotic and sexually satisfying experience. Those choosing not to disclose their status to casual partners also believed that doing so diminished the possibility of criminal prosecution for HIV transmission if exposure did occur, because the chances of being identified as the infecting partner were lessened. In addition, withholding one's HIV status from a sexual partner presented a significant barrier to the establishment of trust and intimacy, an essential component of the long-term romantic relationships so many respondents desired.

Nestled between these two extremes, however, were those men who disclosed their status in rather more ambiguous ways, or who assumed that their sexual partners were aware of their HIV status by virtue of their presence in what they considered to be 'HIV positive spaces'. This approach presented men as being responsible or moral 'enough'. Some had established a way of satisfying their sense of moral integrity by highlighting risk inherent to UAI, or by frequenting saunas. Often, the probability of rejection was reduced by avoiding explicit mention of HIV, or by only having sex with men assumed to also have HIV. Such assumptions of sero-concordancy will frequently be incorrect and represent a potential avenue for onward transmission of HIV. Men endeavored to reduce the possibility of transmitting HIV, but were effectively unable to so as they are simultaneously faced with trying to manage a range of other competing risks present in their environment.

The internet, often regarded as a facilitator of high-risk sexual behaviour, is shown here to serve an important social purpose. It offers men an opportunity to screen potential sexual partners without fear of reprisal or rejection. It provides a safer space where men can control disclosure of their HIV status dependent on their sexual or relationship desires. However, the internet, through the existence of chat rooms and interest groups, also makes visible the range of sexual behaviors undertaken by men with HIV. Some men robustly rejected the notion of such spaces because they contained individuals who were actually seeking to engage in UAI. In the eyes of some respondents, men in HIV positive chat rooms represented a segment of gay lifestyle from which they were keen to distance themselves. Thus sero-sorting, the one option that enabled both sexual satisfaction and

avoidance of the risk of rejection, was rejected by many as a behaviour only engaged in by those enjoying esoteric sexual practices, and those who were usually disinterested in forming long-term romantic partnerships.

Above all, this chapter demonstrates the heterogeneity of our sample. The men taking part shared a sexual orientation and an HIV status. In other respects they were very different, with contrasting needs, desires and experiences. What to one man was an appropriate course of action, was to another entirely unacceptable. Perceptions of specific behaviours differed enormously depending on the type or longevity of the sexual relationship desired. Such complexity demands that interventions and programs targeting diagnosed men use a multiplicity of interventions when trying to address these needs and reduce risk-taking behaviour.

## 6 Conclusions

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In the decade that has passed since the publication of *Relative safety*, significant changes have occurred which have the potential to impact on how men with diagnosed HIV regard and undertake UAI. This chapter offers an opportunity to reflect more closely on the extent to which some of these changes influence men's decision-making with regard to UAI, the range of meanings now associated with the practice, and what challenges these present to the overarching *Making it Count* (Hickson *et al.* 2003b) goal of reducing HIV transmission during sex between men.

Similar to those taking part in *Relative safety* ten years ago, men in the current sample generally engaged in UAI because they enjoyed anal intercourse, and they (or their sexual partners) disliked condoms, or found their use problematic. In both studies, where men reported involvement in long-term partnerships, these were most likely to be sero-concordant. With undiagnosed boyfriends, men undertook measures during intercourse (including condom use, withdrawal, and avoiding the insertive role) to balance their sexual desires with the risk of transmission. However, unlike its predecessor, none of the participants in this study practiced UAI within monogamous sero-concordant relationships, nor did they describe UAI within relationships premised on agreements about condom use with other partners. A good number of respondents aspired to such arrangements, yet felt them to be unattainable. Instead, when asked to recount their most recent experience of UAI in detail, most men participating in this study described encounters with casual partners of unknown (or uncertain) status.

Men's involvement in casual sex emerged as a key component in their management of the personal, social, and sexual impact of having diagnosed HIV. Concerns about, and experiences of, rejection and HIV-related stigma dominated the ways that most respondents considered their involvement in risk, and the limited communication afforded by casual sex environments provided many men with a way of navigating those concerns. We therefore cannot underestimate the challenge that HIV-related stigma and discrimination presents to men's ability to avoid involvement in HIV exposure and transmission. Men's consideration of transmission risk in sauna environments offers particular insight into how this works. In the main, sauna-using respondents presumed that partners shared their HIV status, given that making such an assumption allowed them to not make an explicit disclosure. Men's impulses for self-protection, and their resulting approaches to risk management, were essentially a part of their survival mechanisms within community settings where it remains the norm to be openly hostile toward people with HIV – particularly, but not exclusively in areas of lower HIV prevalence. What anonymity allows is not only a lack of certainty, but a lack of a need for certainty, summed up by the idea that he probably has it, so he should be thinking that I probably have it too. Therefore, some of the common ways in which diagnosed men negotiate a sexual landscape that is suffused with HIV-related stigma, results in considerable risk of involvement in transmission. If stigma was ameliorated more successfully, men's need to protect their own social identity would likely be less of an overarching concern when engaging in UAI.

Although many expressed a good deal of satisfaction with the sex they had in casual sex settings, for some, the anonymity and lack of communication that can pervade such environments posed a challenge to their desire to find a boyfriend. Those expressing a desire to 'settle down', aspired to build long-term commitment on openness and honesty. Yet at the same time, having UAI with high numbers of casual partners in anonymous settings made it difficult for these respondents to imagine how they might find themselves in the arms of a man to whom they felt they could tell anything. Nothing in their recent experience helped them to conceive of where they could possibly find him.

This brings us to men's highly diverse accounts of the practice of sero-sorting. Most health promoters or health researchers might conceive it as a practice whereby men who know their HIV status seek to have sex exclusively with one or a range of sexual partners whom they know to share the same status. None of the *Relative safety II* participants described their current sex lives in these terms. The finding that men may approximate sero-sorting by guessing at their own partners' status supports other research reaching the same conclusion (Adam *et al.* 2008, Elford *et al.* 2007, Zablotska *et al.* 2007). However, what was unexpected was the disgust with which some respondents greeted the notion of purposely selecting partners with diagnosed HIV. There is little question that HIV-related stigma plays a central role in these men's distaste for the idea that they might find something sexually appealing about another diagnosed man. Not only do men fear the stigma of being associated with the most 'unsavoury' elements of HIV positive gay identity (unrestrained sexuality, barebacking, esoteric sexual practices, STI and superinfection risk), they also feel it is un-romantic to have to choose from a limited range of men. It is clear that for some respondents, disgust for the idea of sero-sorting equates with the low regard in which they hold others with HIV. Distancing themselves from this particular harm-reduction tactic, as well as an array of others, was used as means of distancing themselves from the harsh reality that risk is an integral component of sexual activity for all people, perhaps especially men with an HIV positive diagnosis. For many, living with conscious recognition that they risk exposing uninfected men to HIV, would mean reinscribing themselves with the HIV-related stigma which they find to be debilitating and destabilising. This also goes some way to explain why so few men in the study were willing to publicly post their HIV diagnosis on online sexual networking sites, such as gaydar.

The findings therefore demonstrate that despite many of the changes that have taken place over the past decade, direct contradictions between men's intentions and their behaviours persist. Almost all men said they would never want to be responsible for transmitting HIV to a sexual partner, and they demonstrated a uniform understanding that having UAI could lead to such an outcome. On the whole, respondents were neither callous nor calculated about their involvement in UAI, or the possibility of HIV transmission. Instead, many had constructed systems of belief about risk that enabled them to have the sex they desired, while simultaneously protecting their own sense of propriety by feeling that they had done as much as was needed, to either make others aware of their HIV status, or to establish sero-concordancy. Others believed that such active management of risk was unnecessary, as they were only likely to be coming into contact with men who were already infected due to their presence at in venues where UAI occurred, such as saunas. Most regarded the acquisition or transmission of other STIs – with the exception of hepatitis C – as relatively inconsequential, and many dismissed the idea of superinfection as a cautionary tale invented by clinicians to warn them off unprotected sex. Where men had been diagnosed for longer periods of time, they were less likely to consider the possibility of co-infection or superinfection to be a significant issue. Finally, there was a small group who demonstrated little control over their involvement in UAI, due to a range of factors such as substance use, submissiveness, and a lack of skills.

Also of significant note, were respondents' low uptake of various HIV prevention technologies and tactics that have dominated the health promotion literature in recent years. No one taking part in this study reported attending to their viral load in relation to the risk of transmission, and only three had ever recommended that a sexual partner considered taking PEP. Few men reported modifying their modality (being insertive or receptive) in order to reduce infection risk, and while withdrawal was sometimes described as one element within a harm-reduction strategy, its use was far from widespread. Where these tactics were employed they were used to avoid the possibility of acquiring a superinfection, rather than a way of reducing the likelihood of onward transmission of HIV. Once again, when asked about such tactics, a large proportion of respondents recoiled from the notion that they might plan for risk, as they feared that developing strategic approaches to manage risk would mean that they were either calculating or duplicitous, an association they wanted to avoid.

The men taking part in this study held a wide array of views about the risks associated with UAI, and demonstrated varying capacities for successfully managing those risks. One element which unified almost all of them, was the existence of extensive HIV prevention need. Some needs are wide-reaching and diffuse, such as needs related to accessing appropriate drug and alcohol services, as well as having the necessary communication skills and self-confidence to manage risk. Men with diagnosed HIV should be able to enjoy sex without fear of rejection or discrimination emanating from HIV-related stigma, as well as having access to formal and informal support mechanisms to help them deal with such stigma where it occurs. This report clearly demonstrates that this need is currently unmet.

The findings presented in this report therefore offer ample evidence of a need for tailored and targeted HIV prevention interventions for men with diagnosed HIV. There are a range of key issues raised in this report for planners of such interventions. HIV prevention interventions for men with diagnosed HIV should account for the fact that HIV-related stigma is central to many men's reticence to engage with harm reduction strategies. Interventions should also seek to significantly increase health promoters' and health providers' capacity to engage men with diagnosed HIV in frank discussions about their sexual lives without judgement or prejudice. Finally, the development of a successful range of interventions that directly address diagnosed men's engagement in UAI requires that they are credible, informative, non-stigmatising and innovative.

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