A telling dilemma

HIV disclosure between male (homo)sexual partners

Catherine Dodds
Peter Keogh
Peter Weatherburn

Briefing Paper

Preface

This Briefing Paper is part of an on-going series that forms one strand of the research and development programme supporting CHAPS, the national HIV prevention programme for Gay men, Bisexual men and other homosexually active men. It is intended to explore the contentious issue of HIV (positive) disclosure in sexual contexts. The topic was chosen by CHAPS partners as an area of interest to their organisations and others engaged in HIV prevention and sexual health promotion.

The intended audience for this paper includes HIV prevention and sexual health promotion practitioners, policy makers, health service commissioners and researchers, especially those concerned with sex between men.

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Catherine Dodds
Research Fellow

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1 Introduction

One of the basic principles of a human rights approach to HIV and AIDS is that people living with diagnosed HIV should have control over if, how and when to tell others about their infection. On this basis HIV organisations in the UK have historically encouraged people who have been diagnosed with HIV to consider their situation carefully and to talk to others about their status only when they feel it is appropriate to do so and when they feel fully prepared. Some of the core issues at the heart of disclosing HIV infection include: the relationship and the degree of trust between the two people concerned; what the person with HIV might gain or lose by their decision to disclose; and whether it will have any beneficial impact for the other person involved (see Hays *et al*. 1993, Katz 1997, Petrak *et al.* 2001, Kalichman *et al.* 2003). Most of those working in HIV would agree that in the majority of such situations, the well-informed and supported individual living with diagnosed HIV is the best person to decide whether or not professional and personal contacts need to know about that diagnosis (Hays *et al.* 1993, Green & Sobo 2000, Petrak *et al.* 2001, O'Brien *et al.* 2003). Moreover, in almost all cases, if a decision is made to disclose, then the person with HIV should be the one to do the telling.

Sector-wide consensus on the issue of HIV disclosure is not so straightforward when people are engaged in a sexual interaction or relationship. The primary reason why sex is regarded as distinct from the social, familial or professional situation, is because it introduces the possibility of HIV exposure and transmission. The key question usually posed here, is: *does the HIV positive person have a responsibility – or even a duty – to tell his sexual partners about his status?* This is a question that has vexed the HIV sector for many years.

Most Gay and Bisexual men with diagnosed HIV infection who are in a relationship with an negative or untested partner will share this information with that partner in order to gain emotional support (Holt *et al.* 1998) and because they are concerned about exposing that partner to HIV (Klitzman & Bayer 2003). The emotional and sexual health needs of men in HIV sero-discordant relationships are complex (Kippax *et al.* 1993, Moreau-Gruet *et al.* 2001, Hickson *et al.* 2003a) and while HIV risk management strategies within such relationships remain central to many research investigations and health promotion interventions, they are not the primary issue under discussion here. Instead, we focus on expectations and realities of HIV disclosure among men having sex (particularly unprotected anal intercourse – UAI) with new partners.

In this paper, we discuss disclosure of HIV status under three headings. First, disclosure is discussed within the context of HIV prevention need. Here, we consider the role that disclosure plays in reducing HIV-related needs, and subsequently, HIV exposure. We then move on to consider evidence related to disclosure of a positive HIV status to sexual partners. Finally, we consider evidence concerning disclosure of a negative or unknown HIV status to a sexual partner. We conclude with recommendations for health promotion practice around HIV disclosure in sexual contexts. We focus on both UK and international research on homosexually active men. Where appropriate, we consider projects which include but are not exclusively concerned with homosexually active men.

This paper will not address concerns about the likelihood of co-infection or re-infection that can take place when two people with HIV have unprotected sex. While there are a host of health implications relating to these matters, they are outside the remit of this review.

2 Disclosure and HIV prevention need

When the question of disclosure as it relates to HIV prevention need is posed, two very different broad approaches generally emerge.

The first approach advocates blanket disclosure by men with diagnosed HIV infection to all sexual partners. The assumption here is that this will meet the aims of HIV prevention, because it will result in both partners avoiding behaviours that involve a high risk of HIV exposure and transmission. This assumption generally incorporates the notion that a person with diagnosed HIV infection has a moral responsibility to tell sexual partners (especially if the partners are untested or tested negative) so they can take action to protect themselves from infection (Bayer 1996, Klitzman & Bayer 2003, Reece & Smith 2003).

The second approach attends to concerns about marginalisation, stigmatisation and isolation of people with HIV and rejects the notion that diagnosed positive men should always disclose to their sexual partners. Here, it is argued that all sexually active people are responsible for protecting themselves from sexually transmitted infections, including HIV, and that such responsibility does not rest exclusively with the individual who has been diagnosed with HIV (Summerside & Davis 2002, Sheon & Crosby 2004).

These two approaches are poles on a continuum. People hold a diverse and sometimes contradictory range of views about whether there is any (legal or moral) 'duty' to disclose or prompt a discussion about HIV; who may have more or less responsibility to do so; how certain behaviours or personal characteristics can be used to infer a sexual partner's status; and (perhaps most importantly) how risk is managed within the context of these expectations and assumptions, especially in the absence of verbal disclosure (Rooney & Taylor 1997, Keogh *et al.* 1999, Davis 2001, Sheon & Crosby 2004). Some authors argue that most existing policy and research stems from a standpoint of 'HIV negative normativity' (Summerside & Davis 2002: 16), whereby the motivations, perspectives and experiences of people with diagnosed HIV are ignored, as the push to 'protect' the uninfected from HIV takes precedence.

2.1 MAKING IT COUNT

Reviewing the aims of the *Making it Count* (MiC, Hickson *et al.* 2003b) allows us to consider the extent to which (non)disclosure of HIV status is relevant to HIV prevention aims and HIV prevention need. MiC aims to reduce new HIV infections by reducing the number of times that men diagnosed with HIV engage in insertive or receptive unprotected anal intercourse (UAI) with partners of unknown or negative sero-status, and the number of times that uninfected men have receptive or insertive UAI with men of unknown or positive sero-status. For a range of reasons, disclosure of HIV diagnosis is not a strategic aim in *Making it Count*.

Disclosure of HIV status cannot be identified as an HIV prevention need because it is a behaviour. While promoting disclosure of HIV status might be considered as a possible intervention, this should not be confused with a need. The need that does exist is for men to recognise that some of their sexual partners will not share their HIV status (whether or not it has been diagnosed). One way that some might consider meeting that need is to encourage disclosure on the part of men diagnosed with HIV, but as such, the absence of disclosure in itself, is not a need.

However, we argue that interventions which encourage positive men to disclose their HIV status risk reinforcing the highly problematic presumption, currently held by the majority of untested and tested negative men, that men with diagnosed HIV are responsible for preventing HIV infection, and that it is reasonable and realistic to expect a positive man who knows his status to always disclose before having sex (Reid *et al.* 2002). Therefore, increasing men's capacity to reflect and act upon the possible disjuncture between their own HIV risk management processes, and those of their sexual partners is a more appropriate way of meeting need around discordant or unknown UAI (see also Sheon & Crosby 2004 for a discussion of these same issues in the American context).

Making it Count (Hickson *et al.* 2003b: 24)

Homosexually active men – strategic aim 2:
Reduce HIV sero-discordant unprotected anal intercourse, condom failure and HIV positive to HIV negative semen transfer.

Sub aim: **Homosexually active men of all cultural and religious affiliations have control over the sex they have.**

Including:

- men are able to invite and decline sexual contact, either verbally or non-verbally
- men are able to manage and where required to assert or protect their personal boundaries during sexual encounters

Sub aim: **Homosexually active men of all cultural and religious affiliations are equipped and comptent to negotiate sex.**

Including:

- men have the self-confidence to negotiate sex
- men have the interpersonal skills to negotiate sex
- men know that an HIV positive man is still potentially infectious even if he has an undetectable viral load

Sub aim: **Homosexually active men are aware of the possible HIV-related consequences of their sexual actions for themselves and their sexual partners.**

Including:

- men know that a man's appearance, age, ethnic group, life experience and behaviour are neither accurate or reliable ways of telling whether they are infected with HIV or not, and that men can have HIV without experiencing any symptoms
- men are aware that some men have undiagnosed HIV infection
- men are aware that some men believe their HIV status to be other than it actually is
- men are aware that some men who do not know their HIV status will engage in UAI without revealing that they do not know their status
- men are aware that some men who know they are not infected with HIV will engage in UAI without revealing their negative status
- men are aware that some men who know they have HIV will engage in UAI without revealing their positive status
- men understand that having HIV infection does not depend on whether than infection is diagnosed or not

MiC asserts that telling people what to do is not appropriate in the context of complex health promotion interventions concerning sexual behaviour. Simply directing men with diagnosed HIV to always disclose in the context of sexual encounters is not helpful. While it may be easy to presume that certain MiC strategic aims could be met *if only* all diagnosed men would disclose their HIV infection to all new sexual partners, such an approach overrides aims pertaining to the health and well-being of HIV positive men themselves.

The evidence presented in this paper demonstrates that it is far from clear how disclosure impacts on subsequent sexual behaviour. We do not conclude that disclosure of HIV status will necessarily increase the probability of protected sex (Cusick & Rhodes 1999, Crepaz & Marks 2003), as there are so many contextual and social factors which also impact on decision making. Research focussing on disclosure and risk behaviours is covered in more detail in chapter 3.

3 Men with diagnosed HIV: making decisions about disclosure to sexual partners

In this section, we consider research concerning how and why Gay and Bisexual men living with diagnosed HIV choose to disclose or not disclose their HIV status to new sexual partners. We start by reviewing evidence concerning the sexual behaviour of men with diagnosed HIV. Then we distinguish between different types of research around disclosure and follow-up with a brief examination of both how knowledge of HIV status affects sexual risk practices and men's attitudes towards disclosure.

3.1 SEXUAL BEHAVIOUR AND EXPOSURE RISK

A study of 413 homosexually active HIV positive men attending a London HIV clinic (Stephenson *et al.* 2003) found that 22% of respondents engaged in UAI with one or more new sexual partners within the past month, and 39% had done so within the past year. The likely HIV-concordance and modality of these sexual acts was not reported. In a UK national survey of homosexually active men (Hickson *et al*. 2003a) findings revealed that of 1133 positive respondents, 34.5% said they had probably or definitely participated in sero-discordant UAI (sdUAI) in the past year (although again, there is no information on modality for these encounters, and not all of these encounters are necessarily with new partners). Of sixty HIV positive Gay and Bisexual men surveyed in Sydney, Australia, 33.3% had engaged in UAI with at least one casual sexual partner in the previous six months, and 21.6% reported that the HIV status of their casual partner was unknown (1998 SMASH data reported in Prestage *et al.* 2001). Thus we know that, in any given year, between one fifth and one third of Gay and Bisexual men living with diagnosed HIV are engaging in sexual behaviours that have the potential to expose an uninfected partner to the virus.

3.2 'BARRIERS' VERSUS 'CONTEXTS OF DISCLOSURE'

We can distinguish two types of research into HIV disclosure: research which seeks to identify the barriers to disclosure and research which investigates the contexts of disclosure.

Much of the research on disclosure between sexual partners has focussed on 'barriers' to disclosure. This is especially true of American research (for example see, De Rosa & Marks 1998, Wolitski *et al.* 1998, Marks & Crepaz 2001). This approach is based on an assumption and a value that disclosure of HIV positive status is a useful intervention in its own right.

> **Many HIV prevention programmes have not fully addressed the ethical responsibility of HIV sero-positive persons to inform sex partners of their sero-status and to prevent the further spread of HIV. This unwillingness to confront the fact that some HIV sero-positive persons continue to struggle with disclosure and safer sex has been a disservice both to HIV sero-positive and HIV sero-negative persons. Men and women living with HIV may benefit from the greater availability of supportive programmes that openly recognise and address personal barriers to disclosure, safer sex and communication with their sexual partners. The challenge will be to develop supportive interventions for this population that limit the spread of the epidemic but do not contribute to the stigmatization experienced by people living with HIV.**
>
> **(Wolitski** *et al.* **1998: 609)**

These authors assume that by removing the 'barriers' to disclosure, behaviour change (ie. 'safer sex' or UAI avoidance) will automatically ensue. There is also an implication that protected anal intercourse, or any other sexual activity that carries a lower risk of HIV transmission, is dependant upon HIV disclosure. While research that operates from this standpoint can reveal social and cultural constraints which can restrict men's capacity to disclose despite a desire to do so, it simultaneously silences evidence of resistance against the imperative to disclose in circumstances where men deem it inappropriate or potentially harmful (Rooney & Taylor 1997: 51). 'Barrier- focussed' research tends to concentrate on issues such as drug and alcohol use, psychological well-being of the positive individual, denial, communication skills *etc*.

In direct contrast to 'barrier-focussed' research there exists a literature which examines positive men's experiences of, and thoughts about HIV disclosure to sexual partners (Rooney & Taylor 1997, Keogh *et al.* 1999, Davis 2001, Sheon & Crosby 2004). This research demonstrates that a range of factors influence disclosure. In the remainder of this section, we concentrate on this type of investigation. We preface this with some comments on research into the affects of HIV status on sexual behaviour and the disjuncture between men's beliefs and attitudes and their behaviours.

3.3 BELIEFS AND ATTITUDES ABOUT HIV RISK AND EXPOSURE

It has been demonstrated that men's attitudes toward HIV exposure are not perfectly matched to their sexual behaviours. 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 positive men agreed (Stephenson *et al.* 2003: 9). However, far fewer (35%) agreed with the idea that on balance, men with diagnosed HIV have more responsibility for preventing exposure than negative men. Perhaps the different degree to which positive men agree with these two assertions provides some guidance when interpreting the data on the prevalence of sdUAI, reported above. While the vast majority of positive men would not want a partner to become infected as a result of the sex they have together (Stephenson *et al.* 2003), many also feel that a negative or untested partner has an equal responsibility with regard to avoiding HIV exposure. Thus when it comes to sexual practice in particular contexts, positive men do not feel that they have sole responsibility for HIV prevention. This becomes especially clear when we consider the findings from qualitative research which investigates the circumstances under which positive men decide to have unprotected anal intercourse, and whether or not this is accompanied by disclosure.

Another way to interpret this gap between attitudes and behaviours is that there is often a disjuncture between a principle held and sexual behaviour within a specific situation. That is, people may believe one thing (hold a principle), but not always act according to that principle in a situation once they have taken account of a range of contextual factors. This is often the case when behaviours involve both sexual desire and some risk of harm. Thus, people often act according to incentive and the relative safety of a situation rather than firmly held principles. This is how risk is lived with and managed.

> **Awareness of social, psychological and health related hazards did not stop the [positive] men in our sample engaging in UAI. Rather, it led to them developing many and complex strategies for reducing and managing risk.**
> **(Keogh *et al.* 1999: 11)**

Thus, perceptions of the context, the partner's possible HIV status, the social consequences of actions and the possibility that exposure may occur will influence a decision to disclose as well as subsequent sexual behaviours. It is therefore helpful to consider the factors which are relevant to the decision to disclose. We look at these factors under a range of headings. We start with the personal / interpersonal and move on to the social / contextual. Finally, we deal with the broader question of stigma and discrimination.

3.4 PERSONAL / INTERPERSONAL FACTORS INFLUENCING DISCLOSURE

Research suggests that the two key inter-personal factors affecting the decision to disclose in sexual contexts are a) the likelihood that HIV may be transmitted to an uninfected partner through a particular sex act, and b) the degree of personal intimacy that has already been or might develop with that partner.

Qualitative research shows that in instances where sexual activity is believed to carry little or no risk of HIV transmission (such as mutual masturbation, oral sex *etc*.) then it is unlikely that disclosure will occur (Rooney & Taylor 1997, Keogh *et al.* 1999, Davis 2001). In the context of low risk sexual activity, there is little reason for a positive man to risk rejection or to share a highly personal piece of information about himself that is unlikely to have any relevance to the outcome of his action. Low-risk sex is one way positive men avoid disclosure.

Disclosure is also less likely to occur in instances where sexual partners are casual, anonymous or new. The likelihood of disclosure increases as partners get to know one another more intimately and over time (Rooney & Taylor 1997, Wolitski *et al.* 1998, Keogh *et al.* 1999, Davis 2001, Klitzman & Bayer 2003, Ciccarone *et al.* 2003). Disclosing HIV infection to another generally requires a degree of trust that the response will not be negative, stigmatising or violent. Sharing this type of highly personal information also requires that a certain expectation of confidentiality or discretion can be relied upon. As a result, a large proportion of positive men who have sex with new partners report that they do not immediately disclose their status because to do so would be to lose control over a piece of information which could potentially cause social and personal harmful (Keogh *et al.* 1999, Flowers *et al.* 2000, Cusick & Rhodes 1999). It may largely be due to a lack of trust in a new or unknown sexual partner that a positive man will decide that immediate disclosure is inappropriate.

Alongside the notion of trust, positive men often articulate a belief that each person who takes part in sex with a partner of unknown HIV status bears individual responsibility for his own actions (Keogh *et al.* 1999, Cusick & Rhodes 1999, Stephenson *et al.* 2003). Men tend to make clear distinctions between their own imperatives of individual responsibility in casual and anonymous settings, and the shared decision-making which is commonly reported within loving or committed sero-discordant relationships (Kippax *et al.* 1993, Keogh *et al.* 1999, Green & Sobo 2000, Klitzman & Bayer 2003).

In addition to concerns over privacy and trust, many positive men report that to initiate a discussion about HIV status in the middle of a backroom, in a toilet, at a club, or on a first date is completely out of step with the norms that govern behaviour in these settings. Those seeking anonymous sexual partners in some contexts feel that to begin a verbal conversation of any substance, let alone one as complex and intrusive as HIV disclosure, would completely destroy that particular sexual encounter (Keogh *et al.* 1998, Keogh *et al.* 1999, Davis 2001, Sheon & Crosby 2004). Others report the strong emotional and psychological need to feel 'normal' – to have social encounters and 'dates' where HIV is not discussed – so that other aspects of their personalities and experience are shared without always living under the shadow of an 'HIV positive identity' (Keogh & Beardsell 1997, Green & Sobo 2000).

Some positive men express substantial anxieties that a casual (UAI) partner may later find out that they knew they were HIV positive and did not disclose (Keogh *et al.* 1999:9). The risk of social harm that could be brought on by such a discovery is tangible for many men, and informs their behaviours in a variety of ways. In some instances, men report avoiding the scenario of blame by minimising the chances of HIV exposure. Alternately, other men have said that if they wanted to have unprotected sex, they would do so in anonymous settings so that the potential for ever 'bumping into' such partners again was unlikely. It is likely that such concerns are dependent upon the individual's own attachment to geographical and ideological communities, as well as the

different features of Gay scenes, venues and public sex environments which will vary between urban and rural settings.

3.5 SOCIAL AND CONTEXTUAL FACTORS INFLUENCING DISCLOSURE

The main factor influencing disclosure is the likelihood that a potential sexual partner is already infected with HIV. Various studies report that men with HIV will use a variety of markers to determine this likelihood and simply put, if individuals can gain '*good enough evidence*' (Davis 2001) that their partner is positive, then they are more comfortable having UAI without disclosure of their own diagnosed HIV infection. This is a strategy that can enable diagnosed men who are seeking UAI with casual, anonymous or new partners to have the sex that they want without having to overcome the difficulties associated with verbalised disclosure such as lack of trust, loss of control over personal information, loss of 'normality' or passion, or personal rejection (Flowers *et al.* 2000). In addition, it allows men to minimise the feelings of guilt or worry which may affect them if they were to engage in UAI without disclosing to a partner they assumed to be uninfected.

The markers in such cases are often environmental. In several studies, men described particular venues such as parks, cottages or commercial events as being the domain of positive men (Keogh *et al.* 1999, Davis 2001, Sheon & Crosby 2004). Some positive men assume if a man is there, and particularly if he wants to engage in UAI in that setting, then it is safe to assume that he is positive. This process of typification is not unusual, nor is it particular to Gay and Bisexual men diagnosed with HIV (Green & Sobo 2000, Klitzman & Bayer 2003). In many instances we manage and regulate our own behaviour by cross-checking it with that of others. If we feel that others are doing the same thing as us then we feel more comfortable with what we ourselves are doing. In such instances, men might for example, talk of particular nights in a particular bar to be full of positive men because that is the night the HIV support group meets next door. In other instances, the offer of UAI is taken to be an indication that a partner must surely be positive, otherwise he would only have protected sex (Rooney & Taylor 1997, Keogh *et al.* 1999). Alternatively, some men say that the mention of involvement in HIV organisations is taken as *good enough evidence* that a partner is positive (Rooney & Taylor 1997, Cusick & Rhodes 1999). The importance of contextual, environmental and individual factors in this process of decision-making cannot be underestimated. The same man who purposefully checks out a casual partner's HIV status before he feels comfortable having UAI with him at home, can still believe that a partner who offers UAI in a sauna or backroom is probably also positive (Rooney & Taylor 1997: 45, see also Keogh *et al.* 1999, Green & Sobo 2000, Davis 2001, Sheon & Crosby 2004).

There is some quantitative evidence which offers some insight into the likely assumptions that may be made by positive men about the likely HIV status of their sexual partners. For example, if no disclosure occurs, only 16% of positive men will assume this means that the sexual partner is HIV negative, whereas negative and untested men are more than twice as likely to assume a non-disclosing partner is HIV negative (Reid *et al.* 2002: 44). In this same study, just under 80% of untested men and 68% of men who had tested negative said they would expect a positive man to disclose his status before having sex. In contrast, only 36% of positive men would have the same expectation. The majority of HIV positive men do not expect their partners to disclose, and in the absence of disclosure, qualitative investigations confirm that many assume sexual partners are positive (Keogh *et al.* 1999, Davis 2001).

3.6 THE EFFECTS OF STIGMA AND DISCRIMINATION ON DISCLOSURE

Media and lay conceptions of HIV transmission have historically been imbued with the image of the 'mass infector' or the 'beautiful deceiver' who knows of his infection and intends to infect others as either an act of retribution or callousness (Patton 1986, Shilts 1987, Gilman 1987, Watney 1994). It is our task as health promoters to recognise the harmful impact that such constructions have on HIV positive Gay and Bisexual men, and to maintain a vigilant stance against the proliferation of such stereotypes. This is especially important because there is evidence demonstrating that the vast majority of people with HIV do not set out to cause harm.

> **People can and do keep their sero-positivity a secret from some sexual partners. However, the idea that many people do so in order to infect others would appear to reflect public paranoia and the media sensationalism that feeds it rather than factual reality.**
> **(Green & Sobo 2000: 166)**

The vast majority of Gay and Bisexual men with diagnosed HIV aim to avoid infecting their sexual partners. Stephenson *et al.* (2003) report that 87% of HIV positive Gay and Bisexual men attending a London HIV clinic feel an extra responsibility not to pass on HIV to another person. A range of qualitative studies provide evidence to support this finding (Rooney & Taylor 1997, Keogh *et al.* 1999, Davis 2001). Most men with HIV make the decision about whether or not to disclose to a new sexual partner *while at the same time* maintaining a strong desire to avoid exposing that partner to new infection.

Stigma is commonly posited as the main 'barrier' to HIV positive men's capacity to disclose their status to new sexual partners (Holt *et al.* 1998, Wolitski *et al.* 1998, Shriver *et al.* 2000, Green & Sobo 2000, Petrak *et al.* 2001, Reece & Smith 2003, Klitzman & Bayer 2003, Kalichman *et al.* 2003). Some of the research reviewed in this paper supports this straightforward hypothesis. However, stopping with this conclusion disallows a fuller comprehension of the way in which expectations of disclosure construct and reinforce this cultural divide between Gay and Bisexual men with HIV and those without. Flowers *et al.* (2000) describe this divide as a form of apartheid, with negative and untested men having the privilege to take little or no responsibility for their own sexual health, while positive men are constructed as being culpable for the physical threat that they pose to others in the absence of disclosure.

> **In response to this threat, it appears that the duty to warn assumes priority... Responsibility for the safety of sexual activity is unequally distributed and the HIV positive partner, with knowledge of his status, is presumed to be culpable for any HIV exposure.**
> **(Flowers** *et al***. 2000: 291)**

Flowers *et al.* (2000) also claim that the sexual stigmatisation of HIV positive men has divided the Gay community which in turn has impeded HIV prevention. Effectively, the job of protecting others from infection is left to those men with diagnosed HIV. Negative and untested men allow themselves to believe that most of their sexual partners are also negative, since they assume that positive partners would (or should) disclose their HIV status – thereby allowing them to terminate the sexual encounter, or reduce the risks taken within it (Hickson *et al.* 2003a). This is a situation that draws a boundary between infected and uninfected men, and thus promotes and exacerbates stigma. It reinforces the pervasive environment of blame and isolation on the part of men with diagnosed HIV infection, while at the same time it exacerbates HIV prevention need on the part of uninfected men.

Finally, a brief mention of prosecutions for HIV transmission under the Offences Against the Person Act in England is necessary. At the time of writing, the future direction of prosecutions in such cases is unclear. One conviction has been overturned by the Court of Appeal which suggests that ultimately this may be a matter to be decided by Parliament. However, what the existing cases have shown is that the matter of non-disclosure of HIV status is now within the purview of the criminal

judicial system. The Appeal Court ruling on the Mohammed Dica case (R v Dica 2004) made it clear that the best defence against a charge of reckless infliction of bodily harm would be to establish consent to the risk of HIV transmission, and disclosure of HIV positive status would be the best way of doing this. However, it should be remembered that in a criminal trial, what matters is whether the jury believes the person who says that they disclosed their status; and the problem is that where transmission has occurred, it may be unlikely for such a jury to believe – after the event – that disclosure was in fact made. In order to impose an actual 'duty to disclose HIV status' before engaging in unprotected sex, a new law would be required. At present, no such law exists. In the meantime, there is a tremendous amount of confusion about who might be made vulnerable to prosecution, and under what circumstances. Needless to say this increases stigma among people living with HIV, many of whom feel that this use of the criminal law makes them even more vilified as a group, and individually susceptible to blame in sexual situations, regardless of the degree of risk involved (Dodds *et al.* 2004).

4 Untested and tested negative men: making assumptions about disclosure

The vast majority of research conducted on HIV disclosure in sexual contexts starts with a presumption that the behaviour at the centre of investigation is the presence or absence of disclosure on the part of the man who has diagnosed HIV (Hays *et al.* 1993, Wolitski *et al.* 1998, Marks & Crepaz 2001, Stephenson *et al.* 2003, Klitzman & Bayer 2003).

It is only relatively recently that the role of the untested or negative partner engaging in sero-discordant UAI has been the subject of closer scrutiny (Weatherburn *et al*. 2000, Petrak *et al* 2001, Davis 2001, Henderson *et al.* 2001, Sheon & Crosby 2004). However, the idea that a man who has recently tested negative for HIV should have any obligation to disclose that information to a sexual partner is still usually dismissed, or framed as a ridiculous proposal. This routine 'ruling out' of negative disclosure is indicative of the presumptions upon which advocacy of disclosure of HIV positive status is premised.

> **Thus HIV negative status is privileged in altruistic discourse suggesting another major HIV status-related separation. HIV negative men are 'free' in the sense of autonomous action, while HIV positive men are bound to 'choose' to disclose, or risk condemnation.**
> **(Davis 2001: 290)**

Disclosure of a negative test result does not ensure that a man is uninfected at the moment of disclosure because he may have either contracted the virus since that test, or he may have tested while in the 'window' period between HIV exposure and sero-conversion. Negative disclosure may not tell everything about a man's HIV status and certainly does not imply any certainty, but it does reveal other things about him. For example, the negative discloser is an individual who believes he is probably not infected with HIV and aims to manage his risk-taking in a way that will maintain that status. For this reason alone, negative disclosure is not as outlandish an idea as some might assume – at the very least, taking it into consideration allows us to regard the sero-discordant sexual encounter from a new angle which opens up new considerations for risk management.

In addition to the issue of negative disclosure, it is worth considering what might be gained from disclosure by an untested man. All that his partner will be able to ascertain is that he can neither be sure that the discloser is negative or positive. Some might call this a pointless exercise, as it gives no certain information. However, it is worth considering that such ambiguity can bring the topic of HIV and risk management into a sexual situation where it would not have been verbalised otherwise – allowing for decision-making by both sexual partners that is not informed by certainty, but is more informed than a situation where there are fixed assumptions of negative or positive HIV status made by one or both partners.

Considering the role of the negative or untested partner allows us to consider the question of disclosure within the context of HIV prevention *need*. In the case of sdUAI, it is the untested or negative partner who is engaging in behaviour that risks his own HIV infection. The positive partner, by definition does not risk becoming infected (although he may risk reinfection should his untested partner turn out to be infected). Although the positive partner may have a range of HIV-related needs, disclosing to a negative partner is not one of them. Therefore, better knowledge or assessment of partners' HIV status is primarily the need of the negative or the untested partner.

Seen in this light, encouraging positive men to disclose their status to new sexual partners in order to meet the needs of other men, is mystifying. Moreover, such a strategy may backfire. Interventions which seek to make disclosure among positive men normative may merely increase the common expectation of negative or untested men that any positive partner with whom they have may have sex will disclose in advance. Therefore, it may be appropriate to concentrate less on encouraging disclosure and more on addressing the various needs evident among negative or untested men in the absence of disclosure. It is worth considering the negative or untested partner's behaviour, thinking process and social context as the focus of health promotion interventions. It is likely that a failure to frame the issue of disclosure within the context of need has limited our capacity to design appropriate targeted HIV prevention interventions on this subject.

Moreover, while saying that the man who knows of his infection should disclose is easy, there are all sorts of reasons why disclosure itself is not so straightforward. Arguably, the same can be said for disclosure by negative and untested men. Just as positive men report that there are sexual settings and contexts in which discussion of HIV, or any discussion at all, is inappropriate, the same is true for negative and untested men in those same settings. There are many reasons why raising the topic of HIV will inhibit the sexual interaction. Some men involved in particular urban Gay scenes (San Francisco in one instance), report that disclosure of HIV negative status risks rejection and ridicule in an environment where the majority of sexual partners are likely to be HIV positive (Sheon & Crosby 2004). Indeed, when we consider the likelihood of disclosure overall, research suggests that men with diagnosed HIV are much more likely to disclose their status in casual sexual settings than negative men (Prestage *et al.* 2001). In situations where UAI is requested or suggested, again, positive men are more likely to disclose their HIV status than negative men.

4.1 BELIEFS AND EXPECTATIONS RELATING TO DISCLOSURE

In three different *Gay Men's Sex Surveys* (Weatherburn *et al.* 2000, Reid *et al.* 2002, Hickson *et al.* 2003a), men were asked the extent to which agreed or disagreed with the statement *I'd expect a man with HIV to tell me he was positive before we had sex*. The detailed findings relating to this question are outlined in the reports relating to these surveys, but it is worth highlighting some of the key features here.

Of men who said that they had tested negative for HIV, 66% expected a diagnosed positive partner to disclose in the 1999 survey (Weatherburn *et al.* 2000: 61), with this figure reaching 68% in 2001 (Reid *et al.* 2002: 44) and 65% in 2002 (Hickson *et al.* 2003a: 50). Proportions are higher among men who have never had an HIV test, with 75% to 79% either *agreeing* or *strongly agreeing* that they would expect disclosure from an HIV positive sexual partner (Weatherburn *et al.* 2000: 61, Reid *et al.* 2002: 44, Hickson *et al.* 2003a: 50).

When men taking part in GMSS 2001 were asked the extent to which they agreed with the statement *If my sexual partners don't mention HIV, I usually assume that they are negative*, a similar pattern emerged. Of those men who had tested negative, 29% agreed that they usually make this assumption, while this figure rose to 39% among men who had never tested (Reid *et al.* 2002: 44). The majority of men who are tested negative or untested expect that a positive partner will disclose his status. Men who have never tested for HIV are consistently more likely to have higher disclosure expectations and to assume negativity in the absence of disclosure. There is also a strong likelihood that a man who agrees with one of these assertions will also agree with the other. Thus, of all the negative and untested men in the 2001 GMSS sample, only 14% would neither expect disclosure from an HIV positive partner, nor assume that a man was HIV negative merely because he had not disclosed he was positive (Reid *et al.* 2002: 42). This indicates a very high level of need across the population of tested negative and untested men in relation to their awareness of the possible HIV-related consequences of their sexual actions.

4.2 RESPONSES TO A PARTNER'S DISCLOSURE OF POSITIVE HIV STATUS

In GMSS 2002, negative and untested men were asked how disclosure of positive HIV status from a sexual partner before sex might impact on their subsequent interaction. Of all men in this sample, 44% said that they would not want to have sex as a direct result of disclosure, 45% would still have sex but would be 'extra careful', and 7% would have the sex they were planning to have anyhow (Hickson *et al.* 2003a: 46).

Analysis also demonstrated that there was a strong association between men's expectations and their reactions to disclosure. More than one third said that they would expect disclosure *and* they would not have sex with a partner who said he was positive (Hickson *et al.* 2003a: 47). Again, this demonstrates that a large proportion of men effectively utilise their expectation that a diagnosed positive sexual partner will disclose his HIV status as their core HIV risk-management strategy. The thinking is: *if he is positive, he will tell me and we won't have sex, and if he says nothing we can go ahead and have sex because he is probably negative.*

The finding that 44% of untested men would halt a planned sexual encounter as a result of a positive disclosure demonstrates that their 'usual' risk management strategies do not allow for the possibility that some of their sexual partners may have HIV. If most men did feel secure and comfortable with the risks they took in the normal course of their sexual lives, then why the need for sudden change when presented with the very real possibility of sexual exposure to HIV? The GMSS data demonstrates very clearly that men who have not tested or tested negative for HIV continue to reveal a high degree of need in relation to their ability to make risk-management judgements about their own sexual activities in which they feel confident, regardless of the status and actions of their sexual partners (*ie*. whether or not partners disclose HIV status).

Making the decision to not have sex with a partner who is diagnosed with HIV, or embarking on 'extra careful' sex in such circumstances can be regarded as a successful means of HIV prevention at an individual level. These are choices that have a high likelihood of meeting the aim of reducing positive to negative semen transfer, and as such we may not discourage them. However, it is the often faulty or incomplete evidence upon which men formulate such decisions that we are obliged to address via health promotion. Untested and tested negative mens' expectations and assumptions relating to positive disclosure represents a key area in which common HIV risk-management strategies fail.

> **Disabusing negative and untested men of the notion that positive HIV disclosure will happen (and that their risk assessments can be based on such an assumption) remains a vital health promotion aim.**
> **(Hickson *et al.* 2003a: 62)**

5 Conclusions

This review argues that interventions that simply encourage men with diagnosed HIV to disclose their infection in sexual contexts are inappropriate. This is because the HIV prevention need we have identified is not for all men to know their own or their partners' status (although this would simplify sexual negotiation). The need is for all men to be aware of the risks they are taking and to be able to negotiate those risks effectively. Discussion of HIV status may go some way towards meeting this need, but it is naive to assume that promoting positive disclosure is the *only*, or even the best solution.

Attempting to eliminate the 'barriers to disclosure' is not sufficient to meet the HIV prevention need men have around negotiating sexual HIV risk. The evidence presented above indicates that rather than encouraging men to disclose their HIV status to each other, we should be attempting to identify and meet men's broader needs regarding knowledge and assessment of their own and their sexual partners' potential HIV status. If we think instead of how we work with the various factors that influence disclosure (personal, interpersonal, contextual and societal), we can better frame the issue of disclosure as something that happens within the context not only of a sexual coupling, but also a social network. In addition, the way in which disclosure does (or does not) occur will be influenced by social norms and dominant notions of morality. In this context, moral norms are reinforced when men make assumptions about their sexual partners' likely HIV status based on the judgements and justifications with which they construct their own sexual behaviour (for example, "he *wouldn't be in this venue if he wasn't positive like me"; "he wouldn't be engaging in UAI with me if he wasn't negative like me"; "he's a decent guy, he'd tell me if he was positive")*.

Thus, the role of HIV prevention and health promotion might be better defined as encouraging men to question their own assumptions about the HIV status of their sexual partners, with the aim of increasing informed decision-making.

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