

Morality, responsibility and risk

Gay men and proximity to HIV

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Original Research Report

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1 Background

1.1 GAY MEN, HIV AND SOCIAL NETWORKS

Network analysis and network theory have emerged in various strands of research on HIV. Epidemiological research has used network analysis to map and predict the course of the HIV and STI epidemics among Gay men (Doherty *et al.* 2005; Piqueira *et al.* 2004). It constitutes an advance on cruder epidemiological models of random mixing (see Keeling & Eames 2005). Social network analysis and social attachment have been important concepts in informing more recent HIV prevention interventions (see Fernandez *et al.* 2003; Latkin and Knowlton 2005) and have had specific applications in the case of disadvantaged communities such as injecting drug users and sex workers (Latkin *et al.* 2003; Rhodes *et al.* 2005). Moreover, network analysis has been useful in understanding social support of disadvantaged groups living with HIV such as African migrants and ethnic minority women (Hough *et al.* 2005; Asander *et al.* 2004; Sivaram *et al.* 2005).

Considering a Gay man as part of a social network involves engaging with the social and cultural factors that shape his experience. Rather than thinking of his relationships as essentially random, we characterise them as being profoundly influenced by his social environment; an environment made up by other individuals who share common understandings and social norms. This social network is generally self-perpetuating and limited. Individuals come into contact and hence derive friends and partners from this finite network. Network analysis is especially valuable when examining a population that is highly heterogeneous and made up of individuals who enter that population as autonomous adults. Gay men are such a population being made up of socially mobile individuals deriving from a range of social, ethnic and geographical backgrounds.

Social networks are central to our understanding of the dynamics of HIV risk among Gay men. The nature and density of social networks have been found to be connected to sexual risk practices and susceptibility to HIV infection in Gay men (Smith *et al.* 2004). Moreover, networks influence Gay men's perceptions and understandings of the HIV epidemic (Grierson 2005). In addition, social networks may have a role in influencing an individuals' knowledge and understandings of, and access to new technologies such as PEP (see Dodds & Hammond 2006; Korner *et al.* 2005). Social norms have been found to be important in influencing Gay men's attitudes towards safer sex and risk-taking especially among groups that have been traditionally disempowered or marginalised such as young Gay men (see Amirkhanian *et al.* 2005a) and Black/ethnic minority Gay men (see Wilson *et al.* 2002; Peterson *et al.* 2003; Zea *et al.* 2005). Finally social network analysis has been useful in describing social support for Gay men living with HIV and their carers (Shippy *et al.* 2003; White and Cant 2003; Cant 2004; Zea *et al.* 2005).

A range of HIV prevention interventions have been based around social networks and innovation diffusion theory (see Amirkhanian *et al.* 2005a). Such interventions would seem to have most salience with disadvantaged groups of Gay and Bisexual men and have achieved some success (see Amirkhanian *et al.* 2005b). Other authors point out the limitations of network interventions in reaching men at relatively low risk or stress limitations in their efficacy over time (see Martin *et al.* 2003).

Findings from the 2003 *Gay Men's Sex Survey* (GMSS) highlight the importance of proximity to HIV. That is, men in certain social and cultural networks had limited experience of HIV in their social network and these men tended to have greater HIV prevention need (see Reid *et al.* 2004). GMSS 2003 established a range of indicators to measure personal and social proximity to the epidemic.

These included:

- Having tested for HIV.
- Not having tested positive, but believing you are or could be infected.
- Being in or having had a sero-discordant relationship.
- Personally knowing someone with HIV.

At the population level proximity to HIV was mediated by a range of demographic factors.

- Area of residence: Men resident in London had greater proximity than men resident elsewhere, although men with low proximity to HIV were present in every city and town and in every area of the UK.
- Age: Men in their 30's and 40's had greater proximity than either older or younger men.
- Ethnicity: Black men and White men of ethnicities other than British had greater proximity than men in other ethnic groups.
- Education: Better educated men had greater proximity (even though less well educated men were more likely to have HIV).
- Income: Men in higher income brackets had greater proximity than men in lower income brackets.
- Gender of sexual partners: Exclusively homosexually active men had greater proximity to HIV than men who were behaviourally bisexual.
- Numbers of male partners: Men with greater numbers of partners had greater proximity than men with fewer partners.

While these differences are important it is essential to note that they denote difference at the population level. In fact, there are men with low proximity to HIV in every city and town in the UK (including London); in every age group and ethnic group; with every level of formal education and at every income level; and with a range of sexual identities and sexual practices.

These population differences in proximity to HIV present an interesting health promotion dilemma. Those men with greatest proximity have less unmet needs but are more likely to be involved in HIV exposure. Those with less proximity have the greatest unmet need and will therefore be vulnerable if they do come into contact with HIV (either knowingly or unknowingly) but they are probably less likely to do so. In response, the original research recommends "a diverse portfolio of interventions that are encountered by men with a wide variety of relationships to HIV" (Reid *et al.* 2004).

The study presented in this report is in response to these findings. That is, a qualitative examination of social proximity to the epidemic among Gay men. However, we must start with a caveat. Neither GMSS nor this study measures *actual* proximity to HIV, that is the numbers of social and sexual contacts an individual has who are actually HIV positive, or the percentages of a social network who are actually positive. Rather, GMSS sets up a range of proxy markers to indicate proximity (such as testing history, beliefs about one's own status and beliefs about the HIV status of social and sexual partners). Likewise, this study measures perceptions of proximity to the epidemic rather than actual proximity (to study actual proximity would require an ambitious network analysis where we recruited all the social and sexual contacts of respondents and asked them about their actual or known HIV status). Studying men's perceptions of their proximity to the epidemic allows us to examine the ways in which men's perceptions of their social surroundings influence how they experience and negotiate sexual risk. Moreover, an individual's perception of the world around him influences the types of information and messages he is likely to notice. The purpose of this study is to inform the nature of interventions targeting men based on their perceived proximity to the epidemic. We will do so by exploring how their perceptions of proximity influence management of HIV-related sexual risk among men who assume or know themselves to be HIV negative.

1.2 RECRUITMENT AND METHODS

We were keen to recruit sexually active men who lived in urban areas with relatively high local HIV prevalence. We therefore chose Greater London and Birmingham as study sites. To qualify for the study, men had to meet all of the following criteria:

- Currently lived in Greater London or Birmingham.
- Had 5 or more male partners in the previous year.
- Believed themselves to be HIV uninfected (negative).

Men were recruited online via banner advertising placed in the London and Birmingham chatrooms on www.Gaydar.co.uk. Seventy-nine men volunteered to be interviewed and 36 were recruited to the study and took part in in-depth, face-to-face semi-structured interviews. 19 of these lived in London and 17 lived in Birmingham.

Interviews covered the following topics:

- Perceptions of their social network (including the likelihood that they may unknowingly be in social contact with others with HIV).
- Perceptions of their sexual contacts (including the likelihood that they may unknowingly have been in contact with a partner with HIV).
- Perceptions of the lives of Gay men with HIV.
- Attitudes towards and expectations of disclosure of HIV status from sexual partners.
- Attitudes towards and expectations of disclosure of HIV status from social contacts.
- Attitudes towards social and sexual contact with others of the same / different HIV status to themselves.
- Accounts of critical incidents of sex in the previous year.
- Accounts of critical incidents of unprotected anal intercourse in the previous year.

Interviews were audiotape recorded and fully transcribed. Transcripts were subjected to a case-by-case and thematic content analysis by two researchers.

At interview, men were assigned to one of two groups:

Perceived high proximity group (18 men)

To qualify for this group, respondents had to meet both of the following criteria:

- Currently personally know someone with HIV.
- Have had a sexual partner who they knew or believed to be HIV positive in the year prior to interview.

Perceived low proximity group (18 men)

To qualify for this group, respondents had to meet both of the following criteria:

- Never have personally known anyone with HIV and,
- Never had a sexual partner who they knew or believed to be HIV positive.

1.3 SAMPLE

The demographics and sexual risk behaviour of the sample is presented in the table below.

Variable	High proximity men (N= 18)		Low proximity men (N= 18)	
Age	<20	0	<20	0
	20-29	3	20-29	7
	30-39	10	30-39	7
	40-49	3	40-49	2
	> 50	2	> 50	2
City of residence	Birmingham	9	Birmingham	8
	London	9	London	10
HIV status belief	Probably negative	9	Probably negative	10
	Definitely negative	9	Definitely negative	7
	Couldn't say	0	Couldn't say	1
Number of regular partners in the last year	1	2	1	8
	2 to 4	8	2 to 4	5
	5 to 12	8	5 to 12	5
Number of casual sexual partners in the last year	1	0	1	0
	2 to 4	1	2 to 4	1
	5 to 12	4	5 to 12	7
	13 to 29	5	13 to 29	4
	30+	8	30+	6
Number of AI regular partners in the last year	0	2	0	4
	1	5	1	7
	2 to 4	4	2 to 4	4
	5 to 12	7	5 to 12	3
Number of AI casual partners in the last year	0	4	0	6
	1	2	1	0
	2 to 4	3	2 to 4	4
	5 to 12	8	5 to 12	5
	13 to 29	1	13 to 29	1
	30+	0	30+	2
Number of UAI regular partners in the last year	0	3	0	8
	1	6	1	4
	2 to 4	5	2 to 4	4
	5 to 12	4	5 to 12	2
Number of UAI casual partners in the last year	0	7	0	8
	1	5	1	3
	2 to 4	2	2 to 4	4
	5 to 12	4	5 to 12	3
	13 to 29	0	13 to 29	0
	30+	0	30+	0

The two samples were similar in terms of age and city of residence. A slightly higher proportion of perceived high proximity men had both a casual and a regular UAI partner in the previous year and those who did so had higher numbers of UAI partners.

However, it is essential to recall that we are not talking about a young or naive sample in the perceived low proximity group and an older more experienced sample in the perceived high proximity group, but rather these samples are of all ages and similar sexual experience.

1.4 STRUCTURE OF REPORT

The remainder of this report describes the experiences of the men in our two groups: their social networks and the social norms which they generate; their attitudes to sexual HIV risk and finally their management of, and response to, actual HIV risk.

Chapter 2 describes the men in the perceived low proximity group. Chapter 3 presents an analysis of men in the perceived high proximity group. Finally, Chapter 4 outlines our conclusions and recommendations.

2 Perceived low proximity men - Stigma, morality and risk

In this section we present our analysis of the perceptions and experiences of the eighteen men who comprised our perceived low proximity group. We first describe their social networks and the ways in which they manage social interaction in relation to HIV. Here, we explore the role of stigma and morality in shaping the attitudes of these men. We then move on to look at how their social attitudes influence their perceptions of sexual risk; how they think through the concept of responsibility within the sexual encounter and how they assess their own and others' HIV status. Finally, we conclude with an analysis of critical incidents of unprotected anal intercourse (UAI).

2.1 SOCIAL NETWORKS AND NORMS

We asked the men in the perceived low proximity group about the nature of their social networks, their attitudes towards disclosure and what they felt about the social disclosure of an HIV positive diagnosis. Friendship networks tended to consist of longer term friends (made during childhood or at college or work) followed by family and finally Gay friends. What was noteworthy, of course was the absence of HIV positive friends or acquaintances. We asked men to discuss why they felt that their social networks did not contain any positive men. Some men felt that this was a function of their age. Younger men tended to think either that they had not been on the Gay scene long enough or that their predominantly young friendship network was unlikely to contain men with HIV.

I tend to keep a close network of friends [unlike] other people having loads of acquaintances. I am not really much of a scene queen [...] it may be my age. I tend to go out with younger people, but then I guess I can't really assume that everyone over the age of twenty five is positive.

London, Mixed Black Caribbean/White British, 24 years old

Others felt that as they did not socialise much in Gay scene or community contexts, their access to Gay men with HIV was limited.

... I don't very often go out on the Gay scene so I don't really meet many Gay people, not that only Gay people can [have HIV]... so I have not really got the exposure.

Birmingham, White British, 35 years old

It was common for men to talk about the notion that improvements in treatment means that men with HIV show less visible symptoms.

But I don't know anybody that looks ill, I don't know anybody that's dying. I don't know anybody that's actually dying of HIV. And I think that's probably something to do with the drugs that are out there now as well to a certain degree. It's like in the eighties it was more apparent. There wasn't so much control over the disease as there is at the moment.

Birmingham, White British, 23 years old

We went on to examine men's discourses around their (lack of) social contact with people living with HIV. We found that social stigma played a large part in defining these men's attitudes towards HIV. That is, moral discourses were used in a variety of ways in order to understand HIV and indeed to control and define the role that HIV played in their social and sexual lives.

It was common for respondents to talk about how men with HIV were obligated to conceal their positive HIV status. HIV was seen as a highly stigmatising condition and there were perceived to be substantial disincentives to being socially open about having it.

How many positive people have you known ... or not?

I think for my age probably I should know more.

[...] Why is that?

Just being what three years off forty. So you know I've been on the scene [for a] long time really. But you think you'd know more. But I don't think people are honest about it, to be honest. I think they avoid telling people.

Is it .. um...

You do... stigma.

Birmingham, White British, 37 years old

Others perceived the stigma attached to HIV to be serious enough to deter a person with HIV from disclosing to all but their closest family or friends.

...to be honest with you I think my sexuality and my age is irrelevant. I think the amount of people that have actually got HIV in the country, I think we should all know somebody that's... and support somebody that has actually got it. But because it is such a disease... uh because it is such a disease that's got such a stigma attached to it, what person's going to really admit to having HIV? Really. There's very little people out there that'll have the strength to admit to even their closest friend.

Birmingham, White British, 32 years old

Thus, men who perceived themselves to have low proximity to HIV tended to emphasise the role of stigma in controlling the spread of information about HIV and preventing open social interaction between men with HIV and others. However, such emphasis also served to perpetuate stigma. In other words, many men were unwittingly colluding with stigma rather than resisting and overcoming it.

It was common for men in this group to talk about how Gay men and Gay social networks generally excluded Gay men with HIV. Often, Gay men were seen to be more culpable than others in terms of negative attitudes to people with HIV.

It's hard telling anyone. It's very difficult in fact, especially on the Gay scene, very very hard. If someone was HIV to come out and tell someone they were positive [...] Because even though it's seen as a Gay disease and Gay [men] should know more about it than straights, I mean I personally think they should know because it affects us more right because of the stigma around it. You still get the problems and the bad attitudes from your own people as it were. [...] It's not just the straights that are shouting it's a Gay disease. It's our own people saying they're dirty.

Birmingham, Asian, 20 years old

Among men in this group, discourses about morally correct ways of talking about HIV status were very common. In a social context where the norm was not to be open about one's HIV status, men often talked about the role of secrecy and gossip in the circulation of information about someone's HIV status. Individuals were rumoured to be HIV positive. However, most low proximity men stressed that listening to, or being the source of, such rumours was seen to be morally unacceptable.

...I've heard rumours that one person has HIV that I know. But I would never personally listen to them and confront him. If he wants to tell me about it let him tell me about it.

Birmingham, White British, 32 years old

The consignment of knowledge about HIV status to the realm of rumour, gossip or confrontation illustrates that, for these men, being positive was the source of significant social stigma. Moreover, to talk openly about HIV would be to violate social norms. Overwhelmingly, the men in this group saw this stigma as emanating from others.

I don't think people are honest [...] Just like if somebody tells you it soon gets around. And then that person's just labelled and no one goes near them.

Birmingham, Asian, 20 years old

This was contrasted with the moral self. Men considered themselves to be accepting of people with HIV, as opposed to others who were not.

I've got absolutely nothing against HIV or AIDS [...] I've got nothing against having a friend who'd have it or whatever [...] they'd be more welcome in my home than anybody else would. But I don't think people tell you the truth. That's why.
Birmingham, White British, 35 years old

Although men were averse to listening to rumours about HIV status, it was considered permissible to divulge suspicions about a man's HIV status to his sexual partners.

But [name]'s done it a couple of times with people he knows, he's actually told us to protect us.
Oh.
I think I'd probably do that. I think if my best mate is going to go with someone... I'd probably tell him.
Birmingham, White British, 37 years old

Although in theory, men believe they would be supportive of friends or acquaintances with HIV, often, when they talked of those known to them, they talked in highly negative terms. The same man remembers an acquaintance whom he was told had HIV and continues...

Honestly I do know someone... [name] down in [town]. He got it just before Christmas. [...] Yeah. I forgot about him. He's just like a mate of a mate. Acquaintance. I do know him but... um. Even then I was disgusted with him. Because he went to the sauna and he was just going round shagging everything.
Oh really?
Which I thought was a bit irresponsible. So that put me off him a bit.
Birmingham, White British, 37 years old

The concentration on stigmatising or moral aspects of HIV in men's discourses meant that the concept of HIV was not normalised. That is, HIV was discussed solely in terms of what it may or may not indicate about the moral character either of the person who has HIV or the person who talks about HIV. Because men had no day-to-day relationship with HIV, they had little knowledge of what life with the virus might be like. Rather, their knowledge and experiences of HIV were restricted to considerations of safer sexual activities and conjectures about living with the virus.

Overwhelmingly, HIV was discussed in terms of sexual practices that may or may not lead to exposure and transmission. Moreover, such discourses were overlain with others about the moral character of the individual with HIV or his sexual partners.

How unusual do you think it is for you to not know someone who has HIV.
I think that people don't talk about it much. There is a group of people who do talk about it all the time and will only do bareback sex. I don't know how I would be if someone I was having sex with told me he is HIV positive. A friend had bareback sex with a man who much later told him that he was HIV positive. [He] does not want to know his HIV status.
London, White British, 32 years old

Stigma emerges as the main theme of our analysis thus far. The role of stigma is to maintain power inequalities between groups. One of the ways in which individuals collude with stigma is to establish themselves as moral actors by comparing their own actions with those of seemingly immoral actors. The question of morality informed low proximity men's responses to HIV, both in terms of the circulation of information about HIV and in terms of their own sexual behaviour and how they assessed the sexual behaviour of others. We can draw two conclusions from this analysis.

First, the question of who discloses in what context, and how such disclosure is managed is essentially a moral one. That is, disclosure of a positive HIV status is not merely the exchange of information which allows the actors to behave in one way or another. Rather, the act of disclosure (that is whether or not disclosure occurs) and who takes part in that disclosure (whether a person discloses his own or someone else's positive HIV status) attaches certain moral attributes (good or bad) both to the person who imparts the information and the person who receives it. The reason why HIV disclosure is so morally weighted and socially difficult is because it is a highly stigmatising condition. However, what is clear about the men in the low proximity group is that they are themselves heavily implicated within these stigmatising discourses. We see therefore, that stigma compels not only people with HIV to remain silent about their condition and their experiences, but it also compels those around them to maintain and support this silence.

This leads us to our second conclusion. The stigmatising silence around HIV is maintained through a process in which HIV is constructed in a highly reductive and overly dramatic way. What is remarkable about the accounts of the men in this group is the way in which they describe men with HIV as either victims of social stigma, unwitting vectors of infection, or as morally reprehensible. This reductive construction of Gay men with HIV allows the individual to differentiate and hence distance himself from the reality of life with the virus. It therefore acts as an insulation between the (presumed) uninfected self and the infected other. Moreover, this construction assumes a fundamental disconnection between normal life as lived by the respondent who does not have HIV and that lived by a man who has HIV. It therefore discourages men from considering the extent to which they share the same social spaces, same life experiences and same world view as men with HIV. This construction of a man with HIV as 'other' and as 'exotic' overcomes representations of positive men as 'normal' or 'just like me'. Any understanding of the banal aspects of everyday life with HIV was completely absent from the accounts of the men in the low proximity group.

We are not indicting or criticising men in the low proximity group. Although stigma serves to maintain and perpetuate power imbalances, everyone is implicated within it. Those who we might consider stigmatising in their actions are equally implicated within a broader social process. Moreover, stigma serves as a vital means of protecting the social self from sanction.

2.2 SEX, RISK AND DISCLOSURE OF HIV

Questions of personal morality and stigma influenced the attitudes of the men in the perceived low proximity group towards sex with men with HIV. Specifically, men employed moral discourses when they talked about the likelihood of a positive sexual partner disclosing his HIV status to them and the desirability of such disclosure.

For a minority of men, the question of an over-arching sexual morality came into play. These men made value judgements about the sexual activities of their partners, tending to equate being HIV positive (and hence posing a risk) with sexual permissiveness or promiscuity. The following respondent is asked about how he would assess whether a partner might have HIV.

But this is the way I do it. I mean I don't have many partners myself. And the people that I sleep with um, I won't do straight away. If I meet them on the one-off like I say which is rare and I take them back or whatever, but if I sort of meet them off the internet or whatever, I meet up with them and get to know them, maybe in a week's time or whatever, uh I mix with their friends normally. Because you know how it is on the scene, everybody knows everyone. So if I mentioned to someone I've met, you know Joe Bloggs, and they'll be like 'Oh I know Joe Bloggs' you know. And I'll ask him a bit about him and how many partners... is he a slut. Is he whatever. [...] you have to don't you? You know, you don't want a slut on your arm.
Birmingham, Asian, 20 years old

However, a far more common discourse concerned personal morality. The majority believed that a partner with HIV should disclose to them precisely because to do so was a moral act.

Would you expect a man who knew he had HIV to tell you before you had sex?

If that was where things were going then yes I would.

And why?

I just think that, it would just be nice to know, and I would expect it because I would imagine they would feel a sense of duty.

Birmingham, White British, 35 years old

Often men mentioned that this is what they would do themselves if they were diagnosed.

So would you expect a man who knew he has HIV to tell you before you have sex?

Mm. I would do because that's what I would do for other people.

If you were positive?

Yeah.

Birmingham, White British, 25 years old

Therefore, the likely behaviour of others is assessed against a real or imagined personal moral code. This assessment is underpinned by a particular notion of personal responsibility. Most of the low proximity men were clear that both the positive and the negative partner have joint responsibility to ensure that risk is managed or minimised within the sexual encounter (to try to ensure that HIV exposure does not occur). However the question of where such responsibility resides is vexed.

In the eyes of our respondents, positive men are presumed to have a responsibility to disclose. This expectation is influenced by the kind of sex (and its attendant sexual risk) on offer. Some would expect disclosure if they were going to engage in unprotected anal intercourse while for others, any possibility of anal intercourse should trigger a disclosure, whether or not a condom was likely to be used.

So would it make a difference if he's fucking you without a condom or with a condom?

I think so with or without, just cause even with [a condom] they can break, anything can happen. I mean I'm not saying that I wouldn't do it [...] if someone has HIV then they should say if you are going to do something that puts somebody else at risk, to a great, you know, a large amount of risk, potentially large amount of risk. [If it's] a very small risk then OK maybe there's a discussion to be had but if you're going to, if they are fucking you or your'e fucking them, I think you know, then certainly you should have a conversation about it.

London, White British, 32 years old

Others expected disclosure if they were going to engage in receptive oral sex, or if they were going to engage in oral sex to ejaculation. However, most low proximity men believed a partner with HIV should disclose in most sexual contexts. Moreover, most believed that a partner with HIV would disclose to them. That is, they justified the notion that they have had no positive partners in the past by the fact that none of their partners had disclosed.

How sure can you be that none of your sexual partners have knowingly had HIV?

Have knowingly had it and not told me?

Yeah.

Of the sort of intimate friendly ones that I might have met up with more than... either my long term relationships or with somebody that I know and occasionally do that with, um I don't think any of those would knowingly have it and not tell me.

OK.

It's quite possible that perhaps a one night thing has... yeah.

Right.

Knowingly had it and not told me. But you know [...] if it was a casual thing then no. But if it was something perhaps, you know, a friend who beforehand was a bit or whatever... I think that they probably would tell me.

Birmingham, White British, 32 years old

Among men who perceived they were in low proximity to HIV, many felt their responsibility was in choosing whether or not to proceed with sex once positive disclosure had occurred.

...I guess, if it was going to be fucking, then I would expect them to tell me because I suppose because I feel they have a responsibility to, to A give me the choice whether I still want to go ahead and B... Well I don't know... Its pretty tough I think, I just...[...] I haven't really thought about it in any great depth before I've just always thought they should tell me if that's the case. It doesn't mean I'm not going to sleep with them, it just means that I'll probably be a bit more careful.

Birmingham, White British, 35 years old

Where positive disclosure was expected, most men in the low proximity group were clear that disclosure from a partner would, in all likelihood, lead them to terminate the sexual encounter.

Say if you went home with some guy and he said, 'One thing you need to know before we go any further, I'm positive'. How do you think you would respond?

In all honesty I probably wouldn't continue. [...] Because for reasons that from... I think just the risk for myself. Even if it was... I mean even using like a condom isn't totally safe.

Is there a sense in which you would prefer not to know?

I guess yeah. I guess I prefer not to know.

London, Mixed Black Caribbean/White British, 24 years old

For low proximity men we can construct a very particular notion of responsibility, in the case of disclosure. The responsibility of the partner who knows he is infected is to disclose to all sexual partners. There are two reasons for this. First, to do so is an intrinsically moral act - a good and proper thing to do. Second, the positive partner has a responsibility to protect the negative man especially if certain risky acts (especially unprotected anal intercourse) are likely in the sexual encounter.

The responsibility of the partner who believes himself to be negative is far less clearly articulated. Certainly, his responsibility would appear to be solely in relation to his own HIV status. He therefore must assess whether or not to proceed with a sexual encounter if his partner discloses he has HIV. However, there is no sense in which such a responsibility has been considered or rehearsed. In other words, many men who perceive themselves to be in low proximity to HIV expected positive disclosure but had never experienced it and had not thought through how they would respond.

Moreover, the men in this group did not address the feasibility of disclosure in a sexual context. Although they understood how difficult it was in a purely social context they had not applied this understanding to their sexual lives. When they discussed the need for positive disclosure, they did not place it within the contexts in which they normally had sex. That is, they did not rehearse the interaction that might lead to a disclosure in a sauna, in a backroom, with a casual partner at home or in a developing relationship. Again because disclosure was outside of their social norms, there was no capacity for it to be introduced into normal social interaction.

Do you think a man with HIV should tell you he is positive before having sex?

I guess, penetration is the rule thing I think or if, I think blow jobs probably, I think it would be, I would be uncomfortable if I'd given a blow job to somebody who then afterwards told me they were HIV positive. Do I think they should tell me? I think it would be up to them, but I, I would be uncomfortable and tell them so if they hadn't told me, but I guess you know, they have their own issue to work through and I think, I dunno.

London, White British, 32 years old

For some, positive disclosure introduces into the sexual encounter a concept which is so far outside of the norms and experience of the respondent that it precludes the possibility of sex.

Is there any reason you can think of that you've not had sex with someone, a positive man who's told you?

Is there any reason that I think that all of my partners were negative?

Yeah.

It's just an assumption that I make really. I mean...

No man's told you that he's positive before sex or anything like that?

No. Except for that one occasion, but then we didn't have sex.

Birmingham, Asian, 20 years old

When pressed to bring their assumptions to their logical conclusions, men often said that, of course they wanted disclosure, but they had no frame of meaning or course of action within which they could respond to that disclosure. In view of this, it is hardly surprising that partners do not disclose to them.

There are two assumptions underlying the strategies employed by the men in this group in relation to risk. The first is that disclosing in this context is regarded as a moral action. That is, a positive sexual partner should disclose because he is a decent and moral individual. This is often reinforced by the assertion that if the respondent were to be diagnosed, he would disclose because such actions are consonant with his sense of a moral self. The second is the notion that disclosure allows the respondent the choice about what kind of sex to have and whether or not they would continue with the encounter. This latter assumption is based on a certain double-think. On the one hand, our respondents have a commitment to practising safer sex with their partner. On the other hand a disclosure of an HIV diagnosis will make that sex *even safer*. When asked to elaborate on this, the notion of 'even safer' sex is dependent on an impossibly restrictive range of sexual activities or an awareness of the possibility of transmission that would make sex possibly unfeasible and certainly not enjoyable.

2.3 CRITICAL INCIDENTS OF UAI

In order to ground our analysis, we conclude this chapter with an examination of men's experiences of UAI. That is, the circumstances in which they engaged in UAI, their perceptions of the risks involved and their responses to these incidents. We start with UAI with casual partners and move on to examine UAI within regular contexts.

2.3.1 UAI with casual partners

When the men who perceived themselves to have low proximity to HIV described unprotected anal intercourse (UAI) with casual partners, they generally described incidents that they perceived to have been risky or not as safe as they would have liked. In the majority of cases, UAI was a spontaneous event. In all cases, the use of a condom was considered by one or all of the men involved. A variety of reasons were identified as to why a condom was not used including being unable to use a condom, lacking confidence and being under the influence of drugs and alcohol.

Assessments of a partner's social and moral character played a part in men's considerations as regards the likelihood the partner had HIV. In the following example, the partner was judged to be negative based on assumptions made about his testing history, educational and employment status.

Did you say anything? Did he express any concern about not using condoms?

No, he didn't seem particularly concerned. The first time he'd sort of seemed a little bit anxious about it. But I think it was my attitude that made him relax. So in a way it was the attitude and almost air of responsibility and sort of well we should be sensible. That suggested we're both generally responsible, so we can assume that we're both negative. It was a sort of a guess and sort of feeling we probably shouldn't be too concerned. [...]

Did you assess his status at all because he was being responsible?

I suppose I sort of made a few assumptions about him. He's a trainee psychiatric nurse and he'd said he's tested on a regular basis because of some of the work and placements he has to do. He seemed very confident that he was negative. I guess the fact that he was well educated and he knew about the risks and I was making some sort of assumption about if he knows about the risks, he knows how to protect himself.

Birmingham, White British, 30 years old

In some accounts, the partner was judged to be positive. Here the assessment was made on the partner's sexual behaviour and his clear lack of concern for sexual safety. In the following encounter, the assertiveness of the respondent's partner in ensuring a condom was not used (even though the partner was receptive) diminishes the control and responsibility of the respondent.

So who fucked who?

I fucked him.

You fucked him and did you come inside of him?

Yeah.

Would you say that one or both of you made a choice to not use a condom?

Yeah. We both knew that [we] weren't using condoms, [but] he actively put me there.

What did he do?

He took hold of me and put me in.

Were you thinking about condoms at the time?

I wasn't even thinking about fucking. I was at such a point where he sort of ... didn't cross my mind. Well it did cross my mind [...] So was it quite sort of heated, I can't actually believe that I actually did it. I still find it really difficult.

I mean was it the fact that was he quite hot?

Yeah, lots of things. I don't know how I felt about myself at the time.

So he was definitely sort of being assertive about not needing condoms.

Which makes me think even more the fact that he was probably HIV.

Do you reckon?

Looking back at the precise moment it happened, it happened in two or three minutes. It wasn't a long session. Looking back I think I'm sure he must be HIV. If he does that all the time why would he be doing it if he wasn't HIV positive.

Birmingham, White British, 32 years old

It was common for men to have negative emotional reactions to these incidents. Respondents were concerned about the consequences of having UAI with a casual partner, but their reactions varied in severity. Severity was dependent on their assessments of the likelihood that their partner had HIV. For the most part, respondents came to the conclusion that their partner was not infected. Again questions of social and moral character came to the fore. In the following case, the respondent talks of how his evident concern might have served to reassure his partner. Paradoxically, the respondent also found his partner's calmness (his seeming lack of concern) reassuring because it denoted a certain sense of responsibility and self-confidence.

...I was anxious about it and not happy that I had been so weak in not disciplining myself and being unrestrained. He was very calm and rational about it. I mean in some ways I think seeing me concerned about the prospects might have been reassuring him that I didn't do this on a regular basis. Seeing him sort of being very calm and seemed very certain, well no he was negative. So I didn't need to worry and that was reassuring.

Birmingham, White British, 30 years old

For other men, what mattered was their own capacity to manage occasional risk. Again, moral discourses emerged. This respondent compared himself to others who 'don't bother'.

So that's the two episodes in the last year. So have those incidents had any impact on your sex life now?

I've got away with it basically haven't I? So you're not always going to get away with it, are you?

It depends on how well you manage the risk too though, doesn't it?

I think I manage it quite well compared to some people I know. Some people just don't bother. There's a friend I know who I saw last week and he doesn't even use them for casual or anything. So I think I am pretty good to be honest. I just take risks now and again.

Birmingham, White British, 29 years old

However, the majority of respondents found that these incidents showed up their lack of preparedness in terms of UAI. It was common for men to describe ongoing anxiety and guilt.

So you were concerned during the sex or after the sex?

I still did it. I think I was more concerned towards the end of the sex because he actually bled on me.

Oh did he?

I washed it off straight away and it was only a small amount, but ... it was there. So I think that did worry me quite a bit.

Birmingham, White British, 37 years old

The same man described how he subsequently felt unable to renegotiate safer sex with a partner with whom he previously had UAI. The precedent had been set with this particular causal partner and he felt unable to avoid UAI in future sexual encounters with this partner.

...it's something that, you know, each day I've sort of thought about and 'sod it I did it'. It's that I really should go and get tested. It tends to be each day I've sort of spoken to him on the net or he's texting me or whatever. I mean one of my own issues with him if we do meet again and have sex because I do think we will meet again. The majority of people I have met off the net, I am most worried about this lad. I worry what happens next time if he wants to do the same thing again. I don't really think I can insist next time because I was so willing to do it without. It seems that's sort of coming into play as well. Will he expect me to not use a condom again and I'm so weak-willed and well what do I say to him?

Birmingham, White British, 37 years old

This respondent was typical of many men in the perceived low proximity group in his lack of skills to negotiate condom use or employ other means of HIV risk reduction. The dominant discourse he was using was based on himself being weak or having no resolve, rather than avoiding infection. Moreover, he found it difficult to raise the issue of HIV with his partner because for him, HIV was very highly stigmatised.

2.3.2 UAI with regular partners

Very different accounts were given by respondents who engaged in UAI with their regular partners. In all cases UAI had been discussed previous to its occurrence. Moreover, in spite of never having tested either prior or subsequent to UAI, all respondents expressed confidence that they and their partners were negative and (unlike the casual accounts) none felt concern about the possibility of HIV and STI transmission or remorse following UAI. Despite discussion, the initial incident of UAI was described as having happened spontaneously. For example, this incident of UAI was put down to a happy mis-communication about whether a condom would be used.

Whose choice was it not to use a condom?

I think he was too eager and wanted to and couldn't get it on so I said 'Oh leave it'. I said 'Oh leave it' I was meaning leave it and not take the condom off. I think he took it as leave it without a condom.

London, White British, 45 years old

In the absence of tests, men talked about the qualities that a partner had which convinced them that he was probably uninfected.

**I have asked him about sexual partners. He hasn't been nowhere near [the number] I had. [...] But we did discuss sexual partners and apparently before he met me he didn't go out a lot. He doesn't pick up, very rarely picks up. He does use porn a lot.
London, White British, 45 years old**

The type of information used to inform the judgement of negativity varied greatly in some of these accounts. For this respondent, his partner's shyness and lack of experience with anal intercourse reassured him.

**Just in my bedroom in the process of having sex. He's never ever really ever gotten into fucking at all ... so it was just something that he's always been quite a shy person. I just sort of took control and just sort of sat on top of him and said you know 'I want to do this' and it just happened.
How long had you been sexual by that time?
About three months.
Had you fucked previously?
If I'd sort of gone about getting a condom out and putting it on, he would have just freaked out. [...] I had to sort of coax him into feeling really, really comfortable. I think it broke a lot of barriers with him. Now we've broken those barriers I'd like to go further. But I think we'd have to go and be tested, just to be on the safe side.
London, White British, 37 years old**

There were clearly other concerns informing this respondent's decision to engage in UAI. One was his partner's discomfort with negotiating AI and his relative inexperience. In this situation, it was easier not to have to think about condoms in order to make sure his partner was more relaxed. However, the possibility that either he or his partner may be infected was not considered. The HIV test was suggested after the event. Questions of trust emerged again for another respondent who had difficulty describing how or why UAI occurred with his partner when it did, although he and his partner had previously discussed the possibility of UAI. However, the moment they choose to act on this understanding was spontaneous.

***So this most recent incident who fucked who without a condom?*
I was active.
Did you come inside him?
Yeah.
So who's choice was it at that time not to use condoms?
Just happened.
Just spontaneous.
Yeah.
So you didn't talk about it?
No, it was somebody I trust though. So sort of previously down the line those conversations had already been had as it was somebody that I knew. At least I feel I knew that I'd be safe to sort of do that. [...] It was just something I wanted to do with him. It was just like it just happened.
How did you feel about it afterwards?
No problem. I'm assuming it's negative.
What would be your greatest concern about unprotected fucking in a relationship or outside a relationship.
My biggest concern would be that I would only ever go into an unprotected situation if I knew that I could trust that person a hundred percent and that both of us were negative. If I couldn't trust that person or had any suspicions, then I probably wouldn't want to do that with them.
Birmingham, White British, 32 years old**

2.4 IMPLICATIONS FOR RISK PERCEPTION AND ANALYSIS

All of the men in the low proximity group believed that they were HIV negative. None of these men thought they had undiagnosed HIV infection despite many having had UAI with both casual and regular sexual partners.

In their calculus of risk regarding HIV infection, they focussed on the risk to themselves and made judgements based on assumptions regarding the likelihood of their partners being positive. Discourses around personal qualities, morality or responsibility dominated in these men's descriptions of the sex they had and the risks they took. Respondents reported how their assumptions about a partner's qualities informed their partner selection and thus reduced the risk of exposure.

Most of the men who perceived that they had low proximity to HIV demonstrated a strongly held belief that men with diagnosed HIV would either tell a prospective sexual partner or avoid UAI. This places them at particular risk of exposure to HIV as they assume that their sexual partners are not infected due to a lack of disclosure to the contrary. For some men in this group, having a casual sexual partner disclose being positive had resulted (or would result) in them being overwhelmed. In these incidents, men's risk reduction strategies were completely undermined and they often chose to not have sex at all.

Taking this position to the presence of HIV in sexual encounters makes the minimisation of risk all but impossible. That is, whatever the risks they are taking in reality, the men in this group were operationally risk averse. Because they could not allow for their partner to have HIV, they could not clearly think through the risks they were willing and able to take. When asked to consider the possibility that a partner had HIV, all sexual interactions were regarded as unsafe and unacceptable. Therefore, by acting on the assumption that all partners were not positive, they were acting according to a risk elimination rather than risk a reduction approach. However, their position was not carried through to its logical conclusion. If one is to assume that all one's partners are negative, than UAI should carry no risk. However, they all asserted that UAI with casual partners was unacceptable. In short therefore, when the presence of HIV is not a social or sexual norm, men take risks according to pre-set rules (UAI with casual partners is unsafe) rather than engaging meaningfully with risk, calibrating it and reducing it.

3 Perceived high proximity men – Context, response and responsibility

In this chapter we repeat the analysis presented in the previous section for the eighteen men who described having a greater proximity to HIV. We first describe their social networks and the ways in which they manage social interaction around HIV. Here, we look at the concept of social norms. We then move on to examine how these norms influence their attitudes to sexual risk. Finally, we conclude with an analysis of critical incidents of unprotected anal intercourse (UAI).

3.1 SOCIAL NETWORKS AND NORMS

Men in this group were asked how their social networks originally came to include men with HIV. For the most part, first contact with HIV came through friends or partners who were diagnosed. Some men had intimate contact with HIV very early in their sexual careers.

Do you remember when you first heard of HIV?

Yes. I was gob-smacked because it was when I came out, and it was one of my first ever boyfriends and it was like "SHIT!"

What happened, tell me about that?

Well we had unprotected sex and for some reason he told me he was positive and it was like 'fuck' and I knew absolutely nothing about HIV because I was 19 and extremely naive.

Birmingham, White British, 32 years old

Others talked about how men in their pre-existing social networks were diagnosed, became ill and died.

Do you know anybody with HIV?

I know a few people [...] Buried a few.

Buried a few. How many friends?

About six, not close, close friends. But people that you know. I mean people that you would see in a bar and have a drink with. One of my closest friends [name 1], he's got two boyfriends and he's had cancer and HIV. There's another guy as well, [name 2] who's apparently one of the oldest living people with HIV in the country [...] I've known him for eighteen years.

Birmingham, Mixed Asian/White British, 38 years old

The majority of the men in this group described their involvement in supporting friends or partners with HIV. This was either in a personal capacity or through voluntary activities.

I had a very close friend who I cared for, for years. And I used to go to Birmingham Body Positive with him and everything. Went down to London to the THT. And went to the Sanctuary in Bournemouth. And I suppose I got exposed to it a lot more than most people who aren't HIV positive are. It gave me a different outlook on it.

Birmingham, White British, 42 years old

We asked men to consider what affect knowing someone with HIV had on their lives and their attitudes. The majority found this question difficult to answer as, after the initial shock of having a friend or partner diagnosed, change was incremental.

I think my opinions about HIV had begun to change from encountering people who ... I vaguely knew who were HIV positive. So by the time I came across people who I was close to who were HIV positive, I don't think it made a difference about how I saw HIV. But yes meeting the first few people I did... and actually meeting people who'd lived with or around HIV did change my views on it.

Birmingham, White British, 30 years old

Men often found it easier to describe their own experiences as part of a larger social network which generated its own norms and meanings. Such networks were seen to thrive on a range of levels. For example, it was not uncommon for men to talk about their urban surroundings as places where positive men interacted. This was especially the case in the earlier days of the epidemic.

There's a lot of people moved to Birmingham in the middle eighties because we had Birmingham Body Positive and stuff for support [...] So there was quite an influx then of people moving into the area because they could get the help and that they needed.

Birmingham, White British, 42 years old

The phenomenon of Gay social and commercial scene spaces which were obviously populated by positive men depended on the presence of visible symptoms of opportunistic infections or treatments.

That's exactly what I have done. I looked across the room, I assumed somebody was positive. London, White other, 39 years old

However, the ability to read physical symptoms was not considered to be universal. Men often considered this to be a kind of 'insider' knowledge which comes through prior experience with friends or partners who had been ill.

...sounds tough, but there [were] times when you look[ed] at some people and you think... especially being as I've lost friends with HIV. So I know pretty much what they're going... and you look at 'em and you... it's awful, but you think 'Oh they ain't got long'. And you're usually proved right.

Birmingham, White British, 42 years old

With both improved treatments and improved therapies to counteract the physically evident side affects of treatments, such visual cues were described as being less available.

[Treatments] arresting the symptoms [and] arresting the ravages of the medications has made it so it's really much harder to tell somebody that's been on HIV... because it used to be you [...] could look at somebody and say 'Oh they've had some really nasty times on the HIV meds'. And I might have known it. But they might have never disclosed it.

London, White other, 39 years old

However, men were aware of other networks of positive men around them. The following respondent talked about positive networks known to him based around maintaining health and well-being. He also elaborated on how the positive men in his own network had changed from socialising in scene venues to more private social networks.

If you see someone that looks well you don't think [of HIV]. I just recently started going to the gym myself and another friend of mine who's positive as well, [name 1], he was saying that everyone they look amazing but they're still like... their immune system's not as good as it should be and stuff [...] He said that's why. You know if you look well you tend to feel better. [Name 2] has become a Buddhist as well now and he's got like a really good attitude. He's all into this positive thing. We used to go out clubbing all the time. I used to go to London or he used to come to Birmingham and stuff. He kind of like stopped and changed that and got like into holistic health. Now he does dinner parties, just having as much fun at a dinner party than he would have been out on drugs all night until you know ten o'clock the next day. So he just said he enjoys himself as much, but in a different way now.

Birmingham, Mixed Asian/White British, 38 years old

It was common for men to talk about being within mixed social networks of both positive and negative men. This sense came out most strongly when we asked men how they knew that certain friends or acquaintances were HIV positive.

You said you know what about three or four acquaintances and friends who you know are positive?

Yeah. And I often hear of people that I didn't know and I find out they are you know through some way or another.

So HIV is something that's around you?

Yes. Yeah.

London, White British, 30 years old

Therefore, disclosure *per se* does not always occur, but information about an individual's HIV status can be carried through the exchange of information within a network. Unlike the men in the low proximity group, such information was not exchanged as gossip and did not usually infer a moral stance on the person imparting it or receiving it.

...I actually know two who are HIV positive at the moment. I said one because the one person is somebody I'd class as a friend. The other person is their partner who I don't really know as well. And um they found out they were HIV positive last year. They don't know I know.

No, you found out from someone else?

Not in a bad way. It was because [name] was a better friend with this person than me. And when [name] found out he was actually quite gutted himself that one of his better friends. So because of the relationship we had he turned to me and knew in confidence he could discuss it with me. And I would never mention it in front of this guy or anybody else that knew this guy. In fact I never have. Been out with him, spent time with him, chatted, what have you, just carried on as normal. But I do know that he's HIV positive. And it hasn't affected my relationship with him really.

London, White British, 29 years old

It was common for men in the high proximity group to describe how they were often in the minority within social gatherings or networks mainly comprised of Gay men with diagnosed HIV. In these networks, information about individuals' health and HIV status was often freely exchanged.

I'm aware of groups of individuals where there's more than one person who's positive and they're all quite open about it. If you happen to know one of those people you will know and have access to a friendship group that has more people who are out and open about it.

Birmingham, White British, 30 years old

A minority of men described how such networks can be somewhat exclusive or excluding of men who are not diagnosed with HIV.

Yeah, because my experience has been that of not being included. I went out with a HIV positive friend that I used to see in [club name] quite a lot actually. [...] I feel this kind of wall always and I think it's because he wants to open up more with other people who I assume are positive friends.

London, White British, 51 years old

Some saw this exclusivity and openness as a sign that stigma around HIV had abated.

So how difficult do you think it is for someone to tell a new person that they are positive?

Nowadays to be honest a lot of them seem to use it as a badge. You know they're very sort of... it doesn't seem to have the stigma it had going back to '82.

Birmingham, White British, 42 years old

Over time, social network and the exchange of possibly stigmatising information between individuals and groups leads to the establishment of social norms and meanings. That is, certain ways of talking about things and imparting information are better or preferable to others. Men

often talked about breaching such social norms or of talking about HIV in ways which were clearly inappropriate.

I was at the house of [name 1] and [name 2]. They had just brought out a new study about HIV and its overall infectiousness and ability to hide out in the body [...] and that even though your viral load was really low it could still be there. And specifically that it was being pushed further and further into the recesses of the nervous system. And it was more and more likely to cause AIDS dementia. I was talking along about it and all at once [name 1s] face fell and then [name 2] says 'Yeah but there are always new meds coming along blah blah blah'. And I was like 'Fuck!' I just laid out a real horrible future for somebody who was HIV positive that I didn't know [...] And did he ever tell me that he was HIV positive, no, he didn't have to. He also knew at that point that I was not the person to be... to be discussing it with. Because I'd already written a death sentence for everybody with HIV.

London, White other, 39 years old

Likewise, disclosure of one's HIV status takes on social or personal significance. Men in this group would not expect direct disclosure from men in informal social contexts. Rather, disclosing one's HIV status designates a degree of social intimacy and trust between two individuals.

Do you think that you may have met someone with HIV who didn't tell you they were HIV?

Well must have done at some point [...] Well I wouldn't expect disclosure because you wouldn't know if it's going to be a friend.

London, White British, 51 years old

In intimate sexual relationships, disclosure takes on a deep emotional significance. Often disclosure flags up the possibility that a relationship is entering a new phase of intimacy or permanence. For men who have been around others with HIV for a long time, a partner telling them that he has HIV raised many difficult questions about the feasibility of the relationship.

One of the first partners that I had after I moved to [city] was HIV positive. OK. So there was an immediate awareness of HIV. There was the whole mental struggle of 'Do I want to fall in love with someone who may die?' [...] And that seemed to be a more powerful question than the 'Do I want to be involved with someone that might infect me?'

Yeah.

OK. So it was... the emotional question was actually bigger than the physical question. [...] And that was one of the first times and it really just grabbed me and said 'OK you must face this and deal with these questions now. And 'you're going to have to deal with this and deal with them for many years ahead'.

London, White other, 39 years old

For others, disclosure was a sign that the partner wanted to end the relationship or an indication that the relationship could never get too serious.

Do you think... was it... did you ask him or talk to him about why it was so difficult for him to tell you?

The reason he told me was because he felt we were getting serious. And he felt that if we were going to get serious he had to tell me. Because he didn't want to get too serious because of the fact that he knew I wasn't HIV positive. Well he assumed I wasn't HIV positive. Um. And he was. And obviously he didn't want me to be setting my heart on a long-term relationship.

London, White British, 29 years old

There were many differences between men in this group and the men who perceived themselves to have low proximity to HIV. First, the question of HIV status within the social network is always open to debate. HIV status can never be assumed in social interaction. Because of this, the individual is aware of his negative status, not as a default position, but one which is open to question and one which possibly differentiates him from current or future social contacts. It is not that an HIV positive status becomes normative, but rather the differences between being positive

and negative are emphasised. Here we have a process of differentiation that is not imbued with stigma. Differentiation does not serve to distance positive men or make them invisible. Rather, differentiation is necessary in order to negotiate not only sexual risk, but social and emotional interaction. That is to say, the process of differentiating between oneself as negative and a friend or partner as positive is essential to making sense of his viewpoint and interacting with him. As social interaction with other men with HIV becomes more normal, disclosure and the exchange of information leads to the establishment of social norms. These norms are concerned with the appropriate management of disclosure as well as the management of both sexual and emotional intimacy (for example, a developing relationship between a positive man and one who presumes or knows himself to be negative).

3.2 SEX, RISK AND RESPONSIBILITY

We have seen that within the social networks of men who describe having high proximity to HIV, individual differentiation is important. Although men in both groups say that they are HIV negative, the men with higher proximity are aware of this in a way that differentiates them from the men in their social network who are positive. The men who perceive they have low proximity to HIV do not have this awareness. Because HIV does not have a social presence in their lives; is not embodied in their friends and partners; it does not have a social dimension. By this, we mean that these men do not partake in social norms and practices whose purpose is to manage the flow of information about one's own and others' HIV status as well as maintain the difference between individuals. Here we explore the extent to which this sense of individual differentiation and social interaction impinges on the sexual and risk practices of men with high proximity to HIV.

We concentrated primarily on practices of disclosure in sexual contexts. That is, what meanings men in this group attached to disclosure of HIV status from sexual partners, whether or not they expected disclosure and how they responded when it did occur. As in the social interaction, we found a range of norms and practices operating in relation to disclosure and risk which influenced the sexual practices of the men in this group.

We start with some quotes which set the scene for the rest of our analysis and introduce the two main themes.

...with casual partners on a first meeting with somebody I wouldn't necessarily expect them to go round going 'Hey I've got a disease that's ultimately going to kill me in twenty years time maybe'. I wouldn't necessarily expect people to come out with that. I don't think it's reasonable or practicable especially when being blunt about this, some of the people I've slept with I haven't even exchanged names.

Birmingham, White British, 30 years old

This quote shows an awareness of the social context within which sexual contact occurs. Wherever it happens, sexual contact takes place within a system of social norms where disclosure of personal information is more or less appropriate, more or less desirable. This man does not expect disclosure because within the context he refers to, it is neither reasonable nor practicable. Social context emerges as the first key to understanding the ways in which disclosure was managed by men in the high proximity group. The next quote refers to the attitudes and responses of others.

[Men with HIV are] trying to lead a normal life. And if they're going out trying to act... trying to have a normal life as possible, then having sex with other guys would be a normal part of their life wouldn't it? And I suppose if they've got the chance of having sex and they tell the person 'Hey I'm HIV'. Surely they're going to say 'I'm sorry mate, but no offence but I can't do this'.

Would you expect somebody living with HIV to disclose to you say in a sexual situation?

No I wouldn't. It's up to them. If they want to tell me, tell me. If they don't want to tell me, I'm none the wiser.

Birmingham, White British, 43 years old

This man is aware that many men will have a negative response to disclosure and will more than likely terminate the sexual contact. However, he is not indicting others for having a 'bad attitude'. He is merely referring to the fact that sex occurs between two individuals who are more or less known to each other. Not only is disclosure of HIV status often inappropriate to the context, but the likely response of the individual disclosed to is unknown. The ways in which disclosure is managed and the appropriateness of the response to disclosure is something which exercised the men in this group. Thus *context/response* is our first theme which influences the management of social interaction around sex in this area and this relates to our second theme: *responsibility*.

Do you think a man who's HIV positive should tell you?

No. If they want to tell anybody or me then it's up to them. [...] I wouldn't feel that they needed to say because it would be up to me to assume that they were anyway.

London, White British, 52 years old

We are used to thinking about responsibility solely in terms of sexual safety. However, here, responsibility within the sexual encounter extends not only to what sexual risks are taken but also to the types of assumptions one makes and how one acts on these assumptions. Thus, how one acts on what is *not* said within the sexual encounter becomes important for the men in this group.

The remainder of this analysis presents these two themes (social context and response, and responsibility) in more detail.

3.2.1 Social context and response

The context of the sexual encounter emerged as possibly the most important factor mediating high proximity men's attitudes towards HIV disclosure.

In anonymous sexual encounters, disclosure was neither invited nor expected. There were two considerations informing this. The first was the nature of sexual pleasure and interaction in such venues. Disclosure, or indeed conversation of any sort would spoil the feelings of abandonment and anonymity.

So, do you think it would be hard for someone or easy for someone to tell you in those sort of casual environments?

Oh extremely hard. I think in some of the environments its kind of where, lets take [sauna name] and there's like two, three rooms but downstairs you could call it the dungeon sort of room with the more heavier sex and its purposefully lit like that and there's hands going everywhere and arses lubed up. You fall in as soon as you touch them they are so lubed up and the environment is, you are just sort of in that environment where safety and knowledge on occasions go out the window.

Birmingham, White British, 32 years old

However, it was also common for men to talk about the likely nature of venues they frequented. Men perceived that some venues and settings (specific clubs or saunas for example) included a much higher percentage of men with HIV than others. In some venues (or contexts) they assumed that any man with whom they came into contact was likely to be infected. This made disclosure redundant (in those venues and settings).

But do you believe a man with HIV should tell you before having sex?

No, because if I believed that then I wouldn't go out to [club name]. Where for example where obviously statistically people are [positive].

London, White British, 51 years old

Finally, the question of sexual activity emerges. If men are going to engage in sexual activities they consider to be safe for them, then, within anonymous or casual contexts, disclosure is unnecessary.

Do you think that you've had sex with men who have been positive and haven't told you at the time that they're positive?

Um. I probably have. Yeah.

OK. Again why do you think that might have happened?

Um. Well because they're just casual encounters and we've had safe sex. So they've probably not really had any reason to tell me.

London, White British, 37 years old

In casual but not anonymous situations, there is less of a social prohibition on talking and men expect to exchange some more personal information about themselves. Here, disclosure is not expected, however, it would be socially acceptable if it did occur. What is crucial here is the individual's capacity to respond.

How difficult do you think it would be for someone you've just met to tell you that he's HIV positive?

I kind of consider myself fairly approachable and talkative. But if it's in a sexual situation I don't think I'd freak out if I pulled and they said, 'Oh I'm HIV positive'.

Birmingham, White British, 24 years old

Once an encounter has gone beyond the casual, disclosure was generally expected. This could be because a more meaningful or permanent relationship may be established and knowing that one's partner had HIV was deemed vital to managing expectations. The following respondent spoke from the perspective of hypothetical positive man managing the expectations of his negative partner.

I don't think it would be discussed. I think it would be sort of like as things progressed. If it was getting a little bit you know [...] involved. And if it was just a bit of a mess around you know you're not really going to do them any major harm. But then if they start doing things or wanting things, then you'd be like, 'Well hang on!'

Birmingham, White British, 35 years old

However, some high proximity negative men would not consider entering into a long-term emotional relationship with a positive partner.

If someone told me they had HIV, um it wouldn't stop me having sex with them necessarily [...] in terms of a long-term partnership or even a medium-term partnership, it probably wouldn't work. So it's sad, but you know there are plenty of fish in the sea and that's the way it is I suppose. Which is a bit heartless. But that's the way life is.

London, White British, 30 years old

Finally, disclosure was regarded as vital to the development of risk reduction arrangements (such as negotiated safety agreements). This man describes how he was contemplating asking his partner to enter into a negotiated safety agreement, but suspected he may have been positive. His hunch was proved correct when soon after, his partner told him he had HIV.

I mean if I'd trusted him we'd have got to the three months and just say, 'Well do we trust each other, shall we... can we have a test? Do we want to try this? Are we taking it this far?' But I kind of had my suspicions. [...] So it didn't factor that the condom was ever going to come off. The sex was great with the condom on anyway. So it didn't matter.

London, White British, 29 years old

The context was key to whether or not disclosure was expected or acceptable as well as how men were likely to respond. Moreover, the reasons why disclosure within a sexual situation was desirable, and the ways in which that information was used changed according to the context. Importantly, disclosure was often considered undesirable. However, this was neither because the individuals involved were in denial about the likely different HIV status of their partner nor because men harbour stigmatising attitudes about HIV. Rather, it was because the sexual context precluded it. Finally, men sought disclosure or non-disclosure for reasons above and beyond the question of sexual safety. Disclosure influenced the sexual and emotional content and tone of a casual encounter or a developing relationship.

3.2.2 Responsibility

When we talk about responsibility within a sero-discordant encounter, we are often not sufficiently clear about what we mean. On one hand, we may restrict it to meaning that both partners strive to minimise the likelihood of HIV exposure during sex. On the other, we may mean that both partners take responsibility for the consequences of their own actions without blaming or seeking redress from a partner should exposure or infection occur. When men in the perceived high proximity group talked about the sex they had, they tended to dwell on the notion of responsibility. However, this notion of responsibility encompassed more than merely the act of sex itself, but included the setting and context within which it occurred and knowledge about oneself and the social world you inhabit.

On one hand responsibility was described in very basic terms of taking responsibility for your own actions. If you become infected through sex, then you had to take responsibility for that.

...I think everyone's basically the same. Sometimes you do, sometimes you are safe, sometimes you're not. I have always thought that it's like, you know, down to us. If something goes wrong it's your fault.

Birmingham, Mixed Asian/White British, 38 years old

The limitation of this definition of responsibility is that it assumes that 'everyone is the same' when in reality, they are not. One man knows he is infected while the other assumes or knows he is not. Both men have information about their respective HIV status and risk behaviour which they generally do not disclose. Moreover, what constitutes being 'safe' is highly subjective and there are a range of things that might go wrong. More complex notions of the idea of responsibility were discernable.

Men often talked about being aware of the social situation they inhabited. This consisted of an awareness that positive men constituted a significant part of their social and sexual networks. Moreover, certain settings were likely to contain more men with HIV than others. Therefore responsibility consisted in knowing not only about one's own networks, but also about epidemiology: be it on a national or a local level.

And it's just kind of in terms of statistics... I mean every time to go to a sauna if I have sex with five people or maybe two or those people or maybe even more will be HIV positive. So I just... well so what. I know what kind of sex I'm having.

London, White other, 33 years old

So do you generally assess things like the status of a casual partner?

Not really [...] I would say no, because it's too dark in [club name] for example. [...] You just have to be sensible and assume that anybody or everybody might be [positive] there.

Would it make a difference if they didn't offer condoms?

If they didn't have them there then I'd probably take them but they always run out anyway.

London, White British, 51 years old

These two respondents talk of responsibility on a range of levels. Understanding the 'statistics' of the setting, knowing what kind of sex they were having and having condoms because they always run out at the venue are just some of the ways that the notion of responsibility manifests itself. Other ways of being aware of the context included knowing about social conventions on contact websites.

I have realised that on [internet site], if they don't mention... you know there's an option to cut out the one that says safer sex or if it says needs discussion, I know that means they're positive. I presume that means they're positive. So you know I'm learning that [...] you know the first time I asked someone if they'd said safer sex sometimes or something and so I said 'look this is...' I said 'look you know I'm just asking a question. What does this mean?' And he said 'OK it means I'm positive and so it means if the other guy's positive and we don't have safe sex, if the other guy isn't positive we do'. And by then I felt 'Oh well I better go along with this'. So I did [snigger]. We had safe sex.

London, White British, 49 years old

The question of knowing one's HIV status emerged strongly when men talked about responsibility. High proximity men did not expect disclosure because, for the most part, they could not reciprocate with a similar assurance as to their own status. In other words, men were aware that establishing one's positive HIV status required not only testing for HIV, but coping with a positive result. Likewise, establishing one's negative HIV status at a time when one is sexually active means ongoing regular testing and risk assessment. Moreover, doing so means being constantly alive to the possibility that one has indeed contracted HIV. If this level of self-awareness was either undesirable or unsustainable for most men, they did not expect the same level of transparency or accountability from their positive partners.

Do you believe a man with HIV should tell you he's positive before having sex?

No. [...] I don't expect it because I don't surrender that information myself. So it's not fair for me to say well someone should tell me if I'm not going to go and get tested regularly and then offer them. Say look I'm positive or whatever.

Birmingham, Mixed Asian/White British, 38 years old

Within this framework of responsibility however, many men talked about the types of responsibility they would see as desirable from positive men. Like those men in the low proximity group, some saw clear differences in sexual risk behaviours and would value disclosure only when they were going to engage in acts that carried, in their opinion, the greatest risk of transmission.

If a guy's going to fuck you with a condom, should he tell?

With a condom? [...] No. He shouldn't tell. Shouldn't have to. Shouldn't be obliged to because he's... [...] not putting me at risk.

OK, if he was going to come in your mouth, do you think he should tell you?

Um. It's a bit difficult because it's not.... I would like him... I would like to know [...] But I don't think he would be obliged to necessarily tell me. Because it's not really up there with the high risk [and] for him he may think well it's not a risky activity. The chances are very minimal.

What if you were to fuck him without a condom. Should he tell you then?

Should he? Yes [...] oh yes definitely.

London, White British, 37 years old

However, unlike the low proximity men, this straightforward notion of what the trigger for disclosure should be was complicated by the context of the sexual encounter and the emotional content.

Would you expect a man with HIV to tell you before he had sex with you, that he had HIV?

The majority of the time, no.

Why wouldn't you expect him?

Because the majority of the times that I'm having sex these days, it's a one off and there's no point in them bringing it up for a one off. [...] If we had been in a committed relationship where we'd been having unprotected sex for some period of time and then suddenly it comes up, 'Oh by the way I fudged the results.'

London, White other, 39 years old

Men were sanguine about positive men's capacity to be transparent or take such responsibility. That is, a range of factors mitigated against the possibility of disclosure even when it was desirable and appropriate. Most of the time, men referred to actual experiences that contradicted their expectations or desires. Some men mentioned social norms of non-disclosure.

Would I expect a Gay man with HIV to tell me he was positive before having sex? You know what? In this day and age, no. [...] What I would want to happen of course would be yes. It's two different things entirely.

Because?

Obviously I went through this... I've had two experiences whereby this has happened [to me] and I've found out by other means. And just with conversations with people. You know so-and-so's having sex with [a positive acquaintance] and he doesn't know [that his partner

is positive] and blah de blah. And I just think yeah the standard... [non disclosure has] become practice. And whether I've just got a very cynical view on it or whether it's actually happening...

London, White British, 29 years old

High proximity respondents were therefore at pains to distinguish between what they would like others to do (disclose), and what experience had taught them to expect.

Do I think a man with HIV should tell me before having sex? For me that's quite a difficult question. It sounds simple doesn't it? But I think what are we having sex for? Are we having sex because we're starting a relationship, are we having sex because it's a casual fuck? Do we just want to get our rocks off and clear off? I know I'm going to have safe sex. However what happens if a condom splits? He doesn't tell me and it was causal sex and he clears off. And I don't realise say it's split until after. I don't know. Can I say I'd like him to tell me?

London, White British, 29 years old

The uncertainty that is being expressed in this case is not one borne of risk avoidance but rather exhibits a careful determination of when, in a sexual encounter, is it appropriate for either partner to intervene with information about HIV status or past sexual risk? This may be before sex, before certain sexual acts or after unforeseen circumstances (such as a condom failure). It is here that the more general notion of responsibility lies. That is, the nature of responsibility is influenced by the context and timing of the sexual interaction in addition to the relationships and likely sero-status of the individuals involved.

When men discussed whether or not partners should disclose to them, the question of social appropriateness emerged. It was clear that, just as disclosure was more or less appropriate depending on the sexual and social context, the ways in which disclosure was managed both by the person disclosing and the person being disclosed to was equally important. The question of when and where disclosure occurs had two dimensions. Within the sexual encounter, disclosure had to be managed carefully. Men often talked about others disclosing to them at inopportune moments. The result was generally that they had difficulty maintaining sexual interest.

And just as he was about to start having sex with me he said, 'Oh by the way I'm HIV positive'. Literally on the point of doing this. And I thought [...] I always assume all my partners are HIV positive. But he just said that at the wrong time. So I was like totally shocked. [...] I would have actually continued to have sex with him had I known, but I would be particularly careful. And I was really um... you know I sort of lost my erection. I was like 'Oh my God' and I felt so sorry for him.

London, White British, 30 years old

Therefore, even for men who described being in high proximity to HIV, disclosure at the last moment could generate unwelcome or unnecessary thoughts about risk and transmission which were an obstacle to sexual enjoyment.

The second dimension to socially appropriate disclosure was the question of when to disclose in the context of a developing relationship. For some this meant disclosure before any sexual contact. However, the majority were aware that this was not always feasible as sex generally occurred at the outset of a relationship. The problem then became, at what point after first having sex was disclosure appropriate. The following respondent describes this dilemma.

I think in a long term relationship [disclosure is] mandatory [...] There was one guy that I went out with. We went out three times. We had sex twice and then he told me. And it was too late. *In what way was it too late?*

Too late. I reacted very negatively. [...] And that's how I know it was too late. Because I reacted so negatively. Um. You know if it's going to be a relationship it needs to be disclosed before sex.

London, White other, 39 years old

Men were also highly aware of the ways in which they elicited information about their partner's possible HIV status. It was common for respondents to describe incidents where they had accidentally found out their partner's HIV status.

I was working in [name] hospital. So of course we treated kids with HIV. And one of the things we did was mix their medication with a particular antacid. Now I went back to this guy's house who I'd met, had sex with him protected and then we were stood in the kitchen and I spotted the same brand of antacid on top of the fridge. And said without thinking 'Oh that's what we give to our kids with HIV'. And of course his face turned white. And then obviously he had to admit there and then he was HIV. And I was actually quite mortified that he hadn't told me. I couldn't understand why he hadn't told me.

London, White British, 29 years old

Men were equally aware of the need to moderate their response to a disclosure. This man discussed how he felt when a partner disclosed to him.

It's a bit tricky. I mean [...] to suddenly say to someone 'Oh you're positive, don't come anywhere near me' [...] It might kind of ruin the moment [...] So probably... I probably wouldn't [react]. I'd probably just do a bit more... a bit more aware. Be a bit more careful.

London, White British, 37 years old

Some men in this group were anxious about sex with a positive partner and conflicted about their response to direct disclosure. Some men recounted very negative responses to disclosure of which they were subsequently ashamed. This respondent decided not to have sex with a partner who disclosed to him.

I met him in the West End. And I agreed to go back with him. And he told me when we got back to his place. [...] And that just spoilt the whole... it just ruined the whole thing for me. [...] And I just didn't want to go through with it.

OK. How did he tell you?

Well he was... he kind of gave me the option really. He said, 'Now that I've told' he said 'I'd understand if you didn't want to take this any further'. And I said, 'Well I'm sorry but I don't. Can I go now?' [laughs nervously]. It sounds really horrible. But that was my mind-set at the time. I couldn't help it.

OK. What was... what is horrible about it?

Well just kind of rejecting him like that. And leaving. I mean he must have felt awful. He must have felt absolutely dreadful. Having somebody walk out on him because of that.[...] Although he said it has happened before.[...] maybe he just shrugged and thought 'Oh well another one bites the dust' you know [...] I don't know. But at the time I felt pretty shitty about it [...] Not very pleased with myself. [...] I've now got a three hour journey on God knows how many night buses to get home. And it serves me right really.

London, White British, 37 years old

Others were clear that although a partner's HIV status would not influence them in terms of whether or not to have sex, their physical condition will. If a man looked ill or thin, they were unlikely to desire him. However, this was not about HIV status *per se*.

No, if somebody turns up and they do look gaunt or they don't... then I'll kind of like knock them back. That's not like assessing their status. I just think if someone doesn't look right then I'm not going to sleep with them.

Birmingham, Mixed Asian/White British, 38 years old

3.3 CRITICAL INCIDENTS OF UAI

We complete our description of the experiences of men who describe living in high proximity to HIV with an analysis of their accounts of unprotected anal intercourse (UAI) with casual and regular partners.

3.3.1 UAI with casual partners

Eight respondents gave accounts of UAI with casuals in a range of contexts (including at home, cruising grounds, saunas, sex clubs and parties). Respondents mentioned a range of social, historical, situational, and practical factors which influenced them. The majority of these men were the insertive partner in UAI with only two being receptive.

Two factors seemed to be pertinent when these men engaged in UAI with casual partners. The first was the modality of the UAI, the second was an acceptance of the possibility that infection may occur. The first is a risk reduction strategy. The second is an acceptance of the presence of risk. We received some accounts where men had engaged in UAI with men who they knew to be positive. In these accounts, men generally expressed regret.

Somebody had... well the [online] profile was safe [sex] and I was... and then when I got there he said, 'Oh don't use a condom' and I said, 'Well yeah I've got to'. So I did and then I took it off and had penetrative sex and I think I might have had what do you call it... passive sex as well. And I was mortified after. I don't know why I've done this. But I seem to keep making these mistakes.

London, White British, 52 years old

Have you ever had sex with a man who you knew to be positive?

Uh huh.

When was the last time?

It was maybe two years ago.

And so what happened that time?

Well uh we met a number of times and on one occasion we did have anal sex without a condom. And... well we started and um then I kind of thought this is really stupid. So we stopped.

London, White other, 33 years old

It was more common for men not to know the HIV status of their partners. However, assessments were often made based on a range of factors. For example, this man decided to enter into UAI based on his observations of his partner's previous behaviour and due to a lack of sensation when having anal intercourse with a condom. These circumstances reflect a combination of social and practical reasons for UAI.

I suppose you'd describe it as a sex club. There was a sauna, but we were in the dry area. So again that's sort of slightly less dangerous and I'd met this guy who was Black. We were having a sort of group sex thing and he took me back to his room and we were playing around a bit and he wanted me to fuck him. I had seen him actually fucking someone bareback earlier in the evening so this was quite a high risk. I was just caught away in the moment and I just fucked him and I was like 'Oh'. Because I very rarely do, it doesn't do anything for me and normally I wouldn't fuck at all and so it was just an aberration. I know that if I fuck with condoms it just isn't happening for me, I just can't wear them. I get very little even when I'm doing it without and with them forget it. It's just not happening for me. So that's why I tend generally to be passive.

London, White British, 30 years old

Although this respondent did not use condoms because of a loss of sexual pleasure, the modality of the UAI was clearly important in view of his assessment that his partner was likely to be infected (based on that partner's previous observed behaviour). Modality also contributes to the sense of control the individual has in the situation.

The first time I was a little concerned, but then I thought I can stop this if I want. I didn't stop it. I think as well that's what I tend to do. Kind of think well I can stop this because I'm on the top, you know the men are there saying 'I want you to fuck me'. I can usually say, 'No'. They can't do it themselves.

Birmingham, Mixed Asian/ White British, 38 years old

In the two accounts where the respondents were receptive, both men believed that their partners were wearing a condom throughout the sexual acts. These respondents placed full responsibility with their partner for the condom being removed at some point, unknown to them.

[Last UAI] was about 6 weeks ago. It happened at my place. I met him that night in a bar and we went back to my flat. He fucked me but he didn't cum inside of me. He was fucking with a condom and the condom came off and then he played around and started fucking again without a condom.

At the time were you concerned you were not using condoms?

No, he did use one but I didn't know he had taken off the condom.

What did you think his HIV status was?

I did not assess his status.

Did the two of you discuss not using condoms after the fact?

He mentioned it in the morning but that was it.

What do you think happened in this occasion from other times where condoms were used throughout.

As far as I was concerned he was wearing a condom throughout the sex.

Are you always receptive ?

Yes I am always receptive. For me not using a condom means real closeness and intimacy and also risks as well.

London, White British, 32 years old

The majority of men expressed only a small amount of worry about the incidents of UAI. Their knowledge about the risks involved, their assessment of such risks and the opportunities available for testing resulted in these men accepting and managing the perceived risk associated with these incidents of UAI.

Afterwards you didn't feel much concern?

Angst or worry, no I wouldn't wake up in the morning 'Oh'. Probably I'll wake up first thing, 'Oh damn I did that last night'. It was a bit silly but I wouldn't say there was anything more than that. There was no alcohol involved in that situation so I was sober. I think I was just on holiday having a good time.

London, White British, 30 years old

For a few men, their residual worry focussed mainly around the potential negative consequences of HIV transmission to their regular sexual partners.

I was more concerned about [name] to be honest, my regular partner than myself. Because I thought well you know if it's happened to me it's my own stupidity. I mean I know better. I should have said to him you know, 'Hang on and put a condom on' or something. I said having a regular partner you've always got to think about them as well. So when I told [name] he just fell about laughing. He thought it was hilarious after I'd told him how it happened. I said, 'It's not funny' I said, 'To be honest until I've been tested and I haven't got anything' I said, 'We're using condoms until I get the all clear'.

Birmingham, White British, 42 years old

3.3.2 UAI with regular partners

Six men described UAI with their regular partner. In a minority of these cases, both partners had tested and had formed negotiated safety agreements some time before. These agreements were flexible and a renegotiation of the rules was possible. However, the question of modality was important. This respondent knew the extent to which he was trusting his partner to stick to the rules as he was normally the receptive partner.

We were together for around two years. We started having anal sex without a condom after three months after we were both tested. [...] Even though we both got tested. It was still a very big deal for me. We agreed that we would have an open relationship and we have to be entirely honest with one another about what we were doing. [At first] I was very tense, I was very tense. I think I felt quite tense about it for a long time. [...] I had to kind of question whether it was really what I wanted or whether or not I was being pressured by [name], I think in retrospect I think there was pressure from [name], but I don't have any regrets about it. We were both clear about both of us being tested, both of us going to the clinic, both of us getting the results together. [...] I didn't feel I was manipulated around that.[...] He tended to be the active partner. So for me I was at most risk. I felt as if I was the most vulnerable one. We absolutely talked it through the ground rules around casual partners and also discussing slip-ups.

London, White other, 33 years old

In most cases, agreements regarding unprotected anal intercourse did not provide an absolute guarantee that both partners would remain negative. However, the decision to engage in UAI was often a signal of trust. Within this, there was an acceptance of some risk.

When did you and [name] start to have UAI?

It was, I would imagine two to three months into the relationship..

How was that decision made?

It was made on spec at the time and I think it was a sealing of trust between the two of us in the relationship. It sealed the relationship.

Had you talked about it before?

No.

Spontaneous?

It was spontaneous, but we both knew at that point that was it. That was a commitment because if one of us was, the possibility was the other one was now and like it or lump it we were stuck with. However, we tested not long after stopping to use condoms and both of us were negative. We trust each other and had trusted each other in that relationship and it was fine. I actually used to go once a year, but I haven't been since September 2003. So it's eighteen months now, I've had this long period you know in a stable relationship. It's not that you shouldn't be tested in a relationship because there's other things you can get.

Before you stopped using condoms had you talked at all?

At the time when the decision was made we asked each other, 'Do you believe you're OK?'; and we both said, 'Yes'.

London, White British, 29 years old

However, risk reduction strategies continue. This respondent describes the first time he engaged in UAI with his regular partner.

I woke up and he woke up and we were both sleeping in the same bed. I'd spent the night at his place and both of us naked and just kind of curled up and it was just kind of a natural. I started adjusting and he started moving and that was the way it was, not to the point of my ejaculating.

So you penetrated him.

Penetrated. [...] No not for very long, that's the other thing. Plenty of lube you know. So you minimise the chances for abrasion and I don't do the point of complete ejaculation. As soon as I was done I went to the bathroom immediately to urinate and all of those things. If you're

going to have unsafe sex, there are further steps to minimise.

What was going through your mind, can you remember, as you made that choice?

I know that I was asking myself because I almost always do but you know it was like 'OK I'm going to do this'. I know that the chances of anything happening are minor and I know the basic precautions to do if I'm going to do this. I was topping and I was doing the other things that I know I need to do. I had derisked, derisked, derisked.

London, White other, 39 years old

Men in the high proximity group were less likely to regret any UAI that occurred and were more likely to institute some risk reduction strategies. These strategies were not epidemiologically perfect and the meanings attached to UAI which hamper risk reduction (such as intimacy or trust) still predominated. They were also relatively clear-sighted about the risks in which they were engaging and the possible outcomes. They understood that becoming HIV infected was possible, but strove to avoid it.

3.4 IMPLICATIONS FOR RISK PERCEPTION AND ANALYSIS

The men who describe living in high proximity to HIV present us with a very different viewpoint to the men in the low proximity group. Because they have had positive men as acquaintances, friends, sexual partners and long-term partners, they have lived within social networks where a range of social norms have developed. These norms apply to the ways in which information about HIV status is managed and the meanings attached to that information. The men in this group clearly demarcated themselves as being negative in a way that the men in the perceived low proximity group did not. That is, they are alive to the implications of asserting an HIV negative status; alive to the ongoing contingency of that status. Therefore, the men in this group are more attuned to the social and contextual factors which make disclosure more or less necessary and more or less straightforward. Moreover, they are aware of the different meanings disclosure might take on: from a simple desire to inform a partner of possible exposure to an exploration of the possibility of a long-term relationship. They do not expect disclosure and are aware of better and worse ways of managing the situation when disclosure occurs. Moreover, they are aware of the ways in which a positive HIV status may be 'read' from contextual or situational factors or by what their partner chooses to say or not say about himself. Because they inhabit this social world, the men in the high proximity group tended to engage in risk reduction strategies in the real meaning of the term. That is, they accepted the presence of HIV risk in their lives. They were aware of the possibility that they might become infected themselves. Arguably, their proximity to men with HIV may have the opposite effect than is usually discussed – that is, having HIV may be normalized to the extent that becoming infected is not only a conceivable outcome but a likely one (this is not to say that these men desire to contract HIV or are denying the negative aspects of living with the virus).

Because the men in this group are aware of the possibilities that partners may be or are positive, they are enabled to engage more meaningfully with risk reduction strategies such as strategic positioning (Van de Ven *et al.* 2002) and partner selection. Moreover, they are also more ready to deal with contingencies such as disclosure or condom breakage. As what constitutes safer sex becomes ever more complex, the ability to communicate with partners in a morally neutral way about HIV and risk becomes ever more important. Although the risk reduction strategies engaged in by these men are not perfect, they are fluid and adaptable.

4 Conclusions and recommendations

In the introduction to this report, we emphasised that we were investigating men's perceived proximity to HIV. Survey data leads us to conclude that men with lower proximity to HIV are disproportionately likely to be younger, less well educated and living outside the largest metropolitan areas while men in high proximity to HIV are more likely to be older and live in large urban Gay centres. At a population level this is indeed true. However, there are men at low proximity to HIV in every city and town in the UK (including London); in every age group and ethnic group; with every level of formal education and at every income level; and with a range of sexual identities and sexual practices.

In this study we have recruited our sample to be broadly similar in terms of demographic characteristics. The men in the perceived low proximity group were similar to those in the perceived high proximity group. They were younger and older, but they lived in the same urban centres of London and Birmingham. What differentiates them is their perception of the world around them. What is striking is how that perception differs between the two groups. This alerts us to the strength of social norms in forming and maintaining our perceptions of the world.

In this report, we have attended less to demographic indicators of HIV prevention need and more to how the capacity to manage and negotiate risk might be influenced by relative proximity to HIV. To do this, we have concentrated on social interactions, social networks and social norms. We have found that such networks, interactions and norms can have a profound effect on the perception, management and negotiation of sexual risk.

Our research highlights the point that any analysis of sexual risk and sexual negotiation is enriched substantially by an understanding of social interaction and social norms. That is, where do men derive the beliefs and attitudes that colour their perception of risk? How does the social climate within which a Gay men lives influence his capacity for sexual pleasure, sexual fulfilment and overall sexual health? We have shown that social interactions and environments influence these factors. Thus, we conclude that men in our lower proximity group may be less able to perceive, assess and negotiate sexual risk than the men in the high proximity group. The connections between social interactions, networks and norms and sexual risk are complex. However, we will attempt to summarise them below.

Our comparison of men in low and high proximity groups show major differences in the way that HIV is perceived, the role it plays in their lives and the social norms that emerge around the management of information about it.

For the men in the low proximity group, stigmatising or moralistic discourses dominate their perceptions of HIV. HIV is seen as 'other' or exotic and outside the realm of their normal everyday experience. This perception leads to the development of a social norm of secrecy around HIV. Discussion of HIV status does not constitute part of 'normal' discourse or social interaction. This, in turn, makes it unlikely that individuals with HIV will volunteer information or discuss HIV 'normally' within these networks. In this way social norms are self-reinforcing. The less acceptable a topic becomes, the more discussion of this topic is precluded and the social norm is strengthened. Our low proximity sample is therefore of men within social networks where the exchange of any information about HIV is not normal.

In contrast, men in the high proximity sample have often had long-term contact with others who have HIV, and hence, the discourses which frame discussion about HIV are far less morally loaded or stigmatising. HIV is very much within their 'normal' everyday experience. It makes less sense to talk about disclosure of HIV within some of these social networks, as information around HIV constitutes part of ordinary social discourse. There is no prohibitive social norm in operation.

Among men in the low proximity group, social norms around HIV are underpinned by moralising or stigmatising discourses, and these influence profoundly the meanings attached to disclosure and non-disclosure of HIV infection. This emphasis on the moral aspects of disclosure leads to naivety concerning the practical aspects of disclosure. Moreover, because men in the low proximity group live within social networks where the exchange of information about HIV is not the norm, their moral assumptions about HIV disclosure are rarely challenged.

When we turn to sex and risk, the impact of social norms is complex. In the case of men in the low proximity to HIV group, the social norm which inhibits the exchange of information about HIV is perversely translated into an expectation that positive disclosure will occur in sexual interactions (because it should) and a belief that when positive disclosure does not occur, HIV is not present in the sexual interaction. While safer sex remains the norm for these men, it occurs (or not) without a clear expectation that HIV exposure risk is present in their specific sexual interactions. We could argue that safer sex provides moral protection in addition to protection from HIV exposure. Low proximity men expect positive disclosure because it is the right and proper thing to do, and some undoubtedly practise safer sex for the same reason. However, when they experience positive disclosure they are not well equipped to deal with it - their notions of safer sex are often based on an assumption that HIV is not present in the interaction, and when it certainly is (or would be) flight from the prospective sexual interaction is a common response.

The men in our two groups report very different experiences of sexual negotiation and the management of risk. The men in the low proximity group report rarely, if ever, encountering an HIV positive partner. This speaks less of an assessment of the likely HIV status of partners or an open discussion of HIV and more of a lack of consideration that any partner may be positive if he does not disclose his infection. They were aware of the need to wear condoms and do safer sex, though this seems more of a moral imperative than an act of disease prevention. Moreover, low proximity men's lack of consideration of the HIV status of their partners was problematic in several areas. First, because they were operating within social norms which inhibited the exchange of information about HIV status, they were less likely to receive a disclosure in a sexual context and they were without the social and sexual skills to respond to any such disclosure. Second, in the absence of knowledge of their partner's HIV status, they could not engage in adaptable risk reduction strategies such as negotiated safety, strategic positioning *etc.* This problem becomes more acute as new prevention technologies such as PEP become available. Always expecting, but never receiving a positive disclosure in sexual contexts, undermines assessments of HIV exposure risk as well as men's capacity to know when they need to access PEP.

The men in the high proximity group have no such social prohibition on the discussion of HIV and are thus more amenable and more prepared for disclosure from a partner within a sexual setting. As information about HIV holds less of a social stigma, not only is it allowed ingress into sexual contexts, but moral aspects of HIV disclosure are minimised. This allows both partners to assess and negotiate risk more clearly. They reported disclosures within sexual contexts, and in their absence, often assumed that their partner was positive based on a range of contextual factors (such as the nature of the context or venue, the behaviour of their partner *etc.*). Not only were the men in this group more likely to assume that their partners were HIV positive, but were more aware of the need to draw a distinction between those partners who were positive and those who were not. They considered risk as fluid and mutable and responded with adaptable risk reduction strategies.

Differences emerged between the two groups as to how they perceived their roles and responsibilities within the sexual encounter. For the men in the low proximity group, much of the responsibility within the sexual encounter was seen to rest with their HIV positive partner. He had responsibility not only to disclose his HIV status, but to do so in appropriate circumstances (relating to the social acceptability of disclosure and the levels of risk involved in the sex). Such responsibility is not feasible when a partner is operating within a social system which discourages disclosure. This was shown to be the case when respondents reported being unable to respond to a partner's disclosure. In contrast, the men in the high proximity group's notion of responsibility extends that of the negative partner. Respondents saw it as part of their role to be aware of a range of aspects of the sexual context they were within (such as a backroom or sex club) as well as information about their partner (his age, things he says). In short, they were responsible for actively engaging with the possibility that their partner may or may not be positive rather than assuming that unless they are told to the contrary, their partner was negative. Moreover, they had a responsibility to respond appropriately to such disclosures should they occur and to take full responsibility for exposure to HIV should it occur. Finally, they are responsible for respecting the rights and reasons of their partner not to disclose if he so wished. This enhanced sense of responsibility facilitated positive (and negative) disclosure and hence more effective risk assessment, negotiation and ultimately harm reduction.

4.1 POSSIBLE INTERVENTIONS

The formulation of interventions for a group of men who perceive that their social and sexual networks do not include Gay men with HIV is difficult to say the least. This is because their world view influences not only their capacity to manage and avoid sexual risk, but also the extent to which they will be amenable or able to respond productively to health promotion interventions.

The *Making it Count* aim that this research relates to is:

Homosexually active men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners, including:

- Men know there are both HIV-uninfected and HIV-infected homosexually active men in all areas of Britain and in every country in the world.
- Men know that a man's appearance, age, ethnic group, life experience and behaviour are neither accurate nor 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 are aware that the more men they engage in UAI with, the more likely it is that they will be involved in HIV exposure.
- Men understand that having HIV infection does not depend on whether that infection is diagnosed or not.
- Men know that HIV plasma viral load tests do not necessarily reflect seminal viral load and should not be used as a guide to infectiousness.
- Men know that an undetectable HIV plasma viral load does not mean an HIV positive man cannot transmit his infection.

Making men aware of something suggests the supply of information. However, information giving is generally only effective where there is something new and novel to say. This study reveals that there are likely to be substantial barriers to the uptake of information at an individual or group level. Men's understandings of the world generate social norms which are powerful and reinforced by social networks. These norms generally serve a purpose of self protection. The norms we have described in our analyses are very different. For men who perceive themselves to be in low proximity to HIV, these norms reinforce this perception in a way that strikes a symbolic (and hence social) distance between them and the men with HIV with whom they come in contact. Information alone is unlikely to challenge these social norms and attitudes. For example, although we may be tempted to inform men of the prevalence of HIV in their local area, such information is unlikely to constitute a major challenge to their understandings. This is because it is neither new nor novel (most men would estimate the prevalence of HIV in their area to be higher to what it actually is) and is likely to be used in a way that reinforces social norms and beliefs.

In short, HIV health promotion interventions should seek to supply information, but perhaps more importantly, seek to reduce the barriers to being able to comprehend and act on this information when it is already available. Therefore HIV health promotion interventions should seek to influence men's understandings of the world in ways which lead to changes in their actions and strategies.

A key to this is to think about what the men in the high proximity group have that enables them to negotiate sexual risk that the men in the low proximity group lack (see section 3.2). Low proximity men lack an awareness of, and sensibility to, the contexts within which they encounter their sexual partners and engage in sexual risk. They have not rehearsed the feasibility of disclosure and their likely response within a range of sexual settings. Low proximity men lack the more complex view of responsibility that the high proximity men have. That is, they see the responsibility of the negative partner as very limited. Remedial interventions should concentrate on developing these understandings in men who perceive they have a low proximity to HIV. They should also challenge the assumptions men make about both their social and their sexual environment as well as undermining damaging social norms. Such interventions are likely to be complex and to draw on a range of methods.

Elements of these interventions might include:

- Making men aware of the prevalence of HIV in the social and sexual networks. This must go beyond information campaigns on local prevalence and extend to showing men why they need to know about the likely make-up of their own social and sexual networks.
- Challenging men's assumptions about why or how a man with HIV might discuss aspects of his HIV status socially and sexually.
- Challenging specifically moral discourses as they apply to sexual behaviour and disclosure.
- Reducing the stigma attached to HIV within certain networks of Gay men.
- Promoting more complex notions of sexual responsibility.

Such interventions would require significant community infrastructure development and should seek to influence social norms in order to influence sexual practices. Therefore, they must stress the collective or inter-subjective nature of our social and sexual interactions rather than concentrating on the individual protecting himself or his sexual partners.

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