"Touch Wood, Everything Will Be Ok": Gay Men's Understandings of Clinical Markers in Sexual Practice

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- difficulties that may be experienced by HIV (known or self-assumed) negative gay men in articulating their sexual practices in relation to risk and the potential this may have for maintaining condoms in anal intercourse
- difficulties that HIV positive gay men may face when disclosing serostatus to regular and casual partners, including risk of discrimination
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02. THE MEDICAL PROFESSION, SPECIFICALLY HIV TREATMENT PRESCRIBERS, NEEDS TO BE AWARE OF THE IMPACT OF CLINICAL MARKERS ON GAY MEN'S ASSESSMENT OF HIV TRANSMISSION RISK.

03. THE ROLE OF THE MEDICAL PROFESSION, SPECIFICALLY HIV TREATMENT PRESCRIBERS, IN NOTIONS OF RISK NEEDS TO BE EXAMINED IN RELATION TO CLINICAL MARKERS AND POST EXPOSURE PROPHYLAXIS.

INTRODUCTION

The aim of this study is to explore gay men's thinking about anal intercourse and risk in the presence of medical technologies. It was developed in response to the proposition that unprotected anal intercourse, UAI, may be on the increase due to the presence of anti-retroviral therapies and associated technologies such as viral load testing. In addition to primary source research material, this report also draws on data obtained through other recent and related studies.

Objectives

- to explore gay men's thinking on protected (with condoms) and unprotected anal intercourse
- to explore the inter-relationship between sexual practice and social relations
- to investigate the way in which medical technologies contribute to gay sexual culture and practice
- to explore the role and nature of disclosure in gay men's thinking and doing sex

Background

This research study was conceived in a context understood as 'Post-AIDS'. The term 'Post-AIDS' was coined to describe what has been figured as a second phase of living with HIV within the West (Australia, North America and Europe).[1] It refers to a period in which the communal experience of AIDS-as-crisis has ended. While the use of 'post' is in no way intended to imply that the epidemic of HIV is over, it does give emphasis to a changed and changing cultural context to that of the first phase of the epidemic. Primarily this change is understood as the effect of living with the virus for more than a decade and, in association with this, the impact of educational campaigns on gay men's understanding and sexual practices. 'Post-AIDS' also includes the development of strategies such as 'negotiated safety' (unprotected anal intercourse within seroconcordant negative relationships) and 'positive-positive sex,' devised by individuals prior to policy and education initiatives.

The 'Post-AIDS' understanding of the cultural context of the epidemic has, to some extent, framed concerns about the current impact of anti-retroviral treatments, otherwise referred to as HAART (highly active anti-retroviral therapy). The recognition that gay men may devise their own risk minimisation strategies for dealing with risk of HIV transmission and that a changed experience, or sense, of the epidemic may alter practices has been important in considerations of the impact of medical technologies.

HAART became available in Western countries in 1996. This development coincided with the 'Post-AIDS' reconceptualising of gay sexual culture. Although the 'Post-AIDS' thesis did not address the impact of medical technologies on the changing sense of the epidemic and, most critically, represents an HIV negative perspective on the epidemic (for positive people the crisis is not over), there was already a recognition amongst researchers, policy makers and educators that medical technologies could affect risk assessment and practice.[2]

The development of 'negotiated safety' was made possible by knowledge obtained with the introduction of the HIV antibody test in the mid 1980s. The test enabled men to bypass the requirement of 'use one [a condom] every time' or 'if it's not on, it's not on' by establishing seroconcordance with a known partner. The strategy provided strong evidence of the role that clinical markers play in constituting HIV identity and, in turn, the sexual field.

On the basis of the impact of the HIV antibody test and debates about the risk of oral sex in relation to viral load, it was suggested that the new viral load test might be taken up in the devising of a new risk minimisation strategy.[3] Testing that showed an undetectable or low HIV viral load in blood, (according to the sensitivity of the test) was postulated as possible grounds for

both positive and negative men to interpret 'undetectable' as 'low risk infectiousness.' The repositioning of HIV as a 'chronic manageable illness' rather than life threatening, due to the presence of HAART, was further postulated as providing the conditions of possibility for a diminished fear of contracting HIV and, hence, contribute to a decline in safe sex practices.

Findings of large-scale quantitative research, undertaken within this understanding of a changing cultural context, has given support to the above concerns. The research surveyed changing sexual practices as well as developing attitudes to HIV/AIDS in relation to HAART. It found a statistically significant steady increase in UAI by both HIV positive and HIV (known or self-assumed) negative men in some parts of Australia. To date, this increase has been most significant in Sydney.[4] The findings of the quantitative studies have raised questions about whether and, if so, in what way the following might be contributing to UAI: [5]

- an end to a sense of crisis
- complacency
- safe sex fatigue
- treatment optimism
- optimism about the likelihood with low viral load of transmitting HIV
- all or none of these

In addition to the large-scale quantitative research, two qualitative studies were conducted to investigate the impact of anti-retrovirals on gay sexual culture. In 1997, Significant Others Marketing Consultants produced a report titled 'Unprotected Gay Anal Sex in Sydney in 1997' for the NSW Health Department. In 1998, Slavin et al at the National Centre in HIV Social Research produced the 'Sex Culture Project' for the Commonwealth Department of Health and Family Services. While neither of these studies found the development of new treatments and associated tests to have had an impact on unsafe sex practices, Slavin et al (1998) did find that there was an expression of optimism about the long term control of HIV. This was expressed in terms of men's awareness of fewer deaths, fewer friends having obvious signs of AIDS and less talk of HIV and AIDS. Slavin et al also found that men in focus group situations gave expression to a desire for intimacy as an explanation for having UAI.

Further contextualising the research documented in this report is a history of HIV prevention policy and education. Prevention policy and education has been the primary cultural force for reducing HIV transmission within the gay male population and, by implication, within the broader Australian population. To date, the key message for the prevention of HIV transmission has been 'use a condom every time.' This message, accompanied by a notion of shared responsibility, sought to avoid the need for disclosure of serostatus and the potential this might have for increasing discrimination against positive men. Shared responsibility, in practice, was to involve both partners taking responsibility for not transmitting HIV by always using condoms (excluding seroconcordant relationships). Underpinning these educational messages, similar to other western countries, has been the presumption of a target population in possession of the capacity for rational decision making and 'responsible' action. While the effectiveness of education campaigns in preventing HIV transmission gives support to the appropriateness of this presumption, it remains difficult to explain actions that do not accord with its intended public health outcomes. The practice of UAI appears to take place outside the three variants of self-protection, altruism, and egalitarianism that constitute the presumption of responsible rational action in relation to HIV transmission. While individuals are simultaneously understood to exercise choice, the sort of choice they are required to make must conform to an assumed link between HIV negative status and self-protection, HIV positive status and altruism, both resulting in egalitarianism. When gay men engage in practices that appear to fall outside the sort of actions assumed to follow these linkages, they are at risk of being understood as not rational and deviant.[6] To some extent, this understanding may also affect individual self-assessment whereby

non-legitimised actions may be construed as immature/rebellious on the part of HIV negative men or constitutive of a type of sub-culture on the periphery of authorised safe sex practices.

In light of the introduction of HAART and early predictions that understandings of risk may alter, it has become important to re-evaluate the way in which pre-treatment education messages may have altered in meaning and, more crucially, in practice. While significant advances have been achieved in halting or reducing viral replication within an individual body through the use of HAART, treating regimes are difficult and the side effects can be toxic and disfiguring. Paradoxically, clinical tests measuring viral load and T-cells (crucial immune cells) in the blood may show relative 'good health,' yet the actual experience of a person on a treating regime may be one of serious illness.[7] Further, one of the effects of medical technologies on being HIV positive is a form of pharmacological surveillance. Since the identification of modes of HIV transmission, people with HIV have been held responsible for potential transmission of the virus. Now, in addition, there is a more individualised responsibility inferred on those with HIV that requires keeping the virus in check within one's own body by 'complying' with heavy and strict treating regimes. Besides having to adhere to a rigid regime of pill taking (in private if the individual wishes to escape disclosure of status), there is also the imperative of retaining an undetectable or low viral load as recorded in the space of the Clinic. [8]

While the technology of HIV anti-body testing divided the gay community into two sorts of bodies – those with the virus (potentially posing risk) and those without (potentially at risk), the serodivide has now become more differentiated. Viral load and T-cell tests have fragmented the positive/negative dichotomy as the scenario of risk has become less certain.[9] In this new context, distinctions based on the presence or absence of HIV antibodies may, for some men, be eclipsed by testing that does not show virus particles in blood.[10] The links between negotiations of risk and medical technologies have, as indicated earlier and, to some extent, evidenced by the focus of this research, provided the basis for a range of hypotheses attempting to explain increases in UAI. However, this hypothesising risks reinforcing prior modes of understanding and evaluating risk of HIV transmission. It has been noted that much of the hypothesising about UAI already positions it as a negatively sanctioned stigmatised activity.[11] When outside the field of HIV/AIDS, this negative sanctioning is imbued by an insistence on heterosexuality. In gay attached research, policy, and education, this negative sanctioning could be viewed as based on a pre-treatment understanding of HIV transmission risk.

In this report, the question of whether medical technologies are impacting on gay men's assessment of risk and on their sexual practices is addressed bearing in mind that UAI is already negatively sanctioned and stigmatised by public health promotion and that this may affect the way in which gay men speak about such sexual practices. The analysis of the findings also takes into account whether gay men may be considering advances in HIV treatment as a viable explanation for UAI. The term UAI is distinguished from its potential conflation with unsafe sex thereby avoiding, to some extent, the negative sanctioning of UAI. Further, following the work of others, the relationship between clinical markers and sexual practice is approached within a framework of 'HIV risk minimisation.' This framing is intended to move away from a focus that treats individual agency and risk as self-evident and, instead, seeks to contextualise the multiplicit nature of sexual practice at the intersection of the imbricated human subject and body, gay community/s, education, and medical technologies.[12]

METHODOLOGY

The research was designed to sample understandings and practices amongst both HIV positive and tested or self-assuming HIV negative gay men. It involved thematic analysis of semi-structured, face-to-face, in-depth taped interviews with HIV positive gay men and HIV negative (known or self-assumed) gay men in Sydney and Brisbane. The inclusion of Brisbane provides a comparison with Sydney, the centre of gay community and the HIV epidemic in Australia. The primary data informing this report are derived through an interview schedule designed in accordance with the above aims of the Clinical Markers Project (see Appendix A). Additional data have been drawn from the HIV Post Exposure Prophylaxis (PEP) study, a joint project between the National Centre in HIV Social Research and the National Centre in HIV Epidemiology and Clinical Research.

Areas covered in the primary source interviews included personal attitudes to using condoms, sexual practices and partners, knowledge of clinical markers and their relationship to infectivity, gay community attachment, the practice of disclosure, attitudes to UAI, and knowledge of PEP. For purposes of brevity the findings on PEP are not included in the body of this report. A summary can be found in Appendix B. Additional material from the PEP Study that specifically addresses the aims of this study has been included in the findings.

Recruitment

The interviewees were recruited in Sydney and Brisbane. A variety of methods were used. All involved individual self-nomination. They included snowballing through personal email networks, articles in the gay press, and letters to participants in the SMASH (Sydney Men And Sexual Health) research project. After the target number of negative men and positive men had been reached, specific targeting was used to ensure inclusion of men in serodiscordant relationships. The total sample included men ranging from 18 – 54 years of age, all gay community attached. It also included men engaged in different sorts of sexual relationships for anal intercourse: anal intercourse with anonymous partners; anal intercourse with familiar casual partners; anal intercourse with regular seroconcordant partners; anal intercourse with regular serodiscordant partners.

Total number of men interviewed: 56
Sydney: 42
Brisbane: 14

Sydney breakdown
HIV positive men: 17
HIV (known or self-assumed) negative men: 25
HIV positive men in serodiscordant relationships: 4
HIV (known or self-assumed) negative men in serodiscordant relationships: 2
HIV positive men in seroconcordant relationships: 2
Gay men (all known or self-assumed HIV negative) under 25 years: 6

Brisbane breakdown
HIV positive men: 6
HIV (known or self-assumed) negative men: 8
HIV positive men in serodiscordant relationships: 2
HIV (known or self-assumed) negative men in serodiscordant relationships: 0
Gay men 25 and under (all HIV known or self-assumed negative): 4

Method of interviewing

The interviews were conducted by three interviewers in Sydney and one in Brisbane. In order to ensure consistency across all interviews, each began with the same opening question. The question functioned to encourage the interviewee to express his attitude to condoms, prior to recounting his usage and/or non-usage of them. In doing so, it permitted a discussion on individual practice to take place in relation to a prophylactic normalised within safe sex education but which may not be valued and utilised by all gay men. In the ensuing discussion, each interviewee was given the opportunity to raise the topic of treatments and or associated tests without prompting. Where medical technologies were not raised by the interviewee, specific questions on treatments, viral load and infectivity were posed by the interviewer. This structuring of the interview process allowed for the expression of knowledge and attitudes on medical technologies without pre-empting the nature of their significance in individual men's risk assessment.

The questions sought to:

- map the usages of condoms and the way in which usage is spoken in experiential terms
- identify the nature of condom investiture
- investigate ways in which the meaning of condom use is relational to different sexual encounters (including sites as well as partners)
- elicit understandings of and practices around UAI
- elicit attitudes and beliefs about infectivity, immunity and well-being

Mode of analysis

All interviews were transcribed and de-identified. The interview material was then treated as reflective of certain ways of thinking and making sense of embodied gay identity at this moment in the history of the epidemic. Analysis proceeded with the aim of revealing the inter-relationship between sexual practice, somatics, HIV education and clinical markers. This involved identification of recurrent themes as well as differences in attitudes, knowledges and practices related to personal history and style of self-representation.[13] In contrast to quantitative research, there was no intention to establish and/or verify how much UAI was taking place.

Throughout the analysis, specific attention was given to a conceptual tension that may arise in the production of qualitative findings. This tension arises from, on the one hand, the recognition that individuals do make decisions and that their accounts are valid as a source of insight into the way the epidemic is lived at this point in time; on the other, that individual decisions are historically informed by the cultural context in which they are located, their own personal history, and lived experience of being HIV positive or negative. In response to this tension, the findings of this report give consideration to individual style of expression by the informant as well as to how this is informed by contemporary historico-cultural modes of sense making. The latter includes the content of HIV prevention education, epidemiological findings on risk, and the research context itself which was structured by questions already informed by public health discourse.

The methodology selected in order to undertake this type of reflexive inductive research is based on Glaser and Strauss's model of grounded theory. This model was selected for its ability to develop theory and conceptual understanding from the data in contrast to a logico deductive model reliant on hypothesis and a *priori* theoretical assumptions. Grounded theory offers an approach open and available to developing analysis from findings gathered from detailed discussion across a range of themes and which may generate unanticipated findings. The collection of, and ability to give considered recognition to, the unanticipated is particularly important to extending prior assumptions and theories inherent to the research objectives and design.[14]

Throughout the report, understandings of risk and the translation or non-translation of this into practice are highlighted to assist policy makers and educators to respond to what has already been identified as a changing epidemic in Australia.

FINDINGS

This section consists of interview extracts selected for their ability to shed light on attitudes to UAI and the extent to which clinical markers may be contributing to this practice. For this reason, interview material that focused solely on sustained protected anal intercourse or no anal intercourse, has not been included. It should be noted, however, that the material on UAI formed a smaller amount of data than that on protected anal intercourse.

It is also important to note that no specific attention will be given to material provided by Brisbane men compared with that by Sydney men. This is because no significant differences were noted between these two sample groups. However, this should not be assumed to indicate that there are no differences to be found between men in the two cities. Rather, it may be due to the relatively small numbers of men interviewed and the focus of the research. While men in the two cities may hold different understandings of risk which, in turn, give rise to different attitudes to practices around condom use, this difference is not evident in relation to the impact of clinical markers on UAI.[15] The sample group of '25 years and under' will be discussed within the structuring of the material according to serostatus. All those within the sample group of '24 and under' were HIV (known or self-assumed) negative. Their responses revealed no differences from the majority of other negative men in the sample in relation to clinical markers and UAI.

The data most able to shed light on the impact of clinical markers on UAI are those drawn from a comparison between the sample groups based on HIV serostatus. For this reason the distinction of serostatus is used here to structure the findings. The first part of this section contains material drawn from interviews with HIV positive gay men. The second contains material drawn from interviews with HIV (known or self-assumed) negative gay men.

Risk minimising from a positive perspective

The following interview extracts are illustrative of how individually tailored risk minimisation strategies are employed by positive men when engaging in anal intercourse, including anal intercourse without a condom. The sample included men who always use condoms; hardly ever use them because they rarely engage in anal intercourse; use them when insertive but leave it to their partner when receptive in anal intercourse; use them with a known negative partner but not with a casual partner who 'consents' to UAI; or use them with a casual partner but not with a negative regular partner. While none of the positive interviewees directly discussed the role of clinical markers in their use or non-use of condoms, some did make reference to viral load in relation to the notion of risk, although this was expressed with uncertainty. Within the range of material provided here, there is evidence to suggest that undetectable or low viral load may provide for a reduced sense of 'infectivity.'

The diverse modes of negotiating anal intercourse across the sample of positive men and sometimes also evident within the practice of an individual are, nevertheless, structured by a series of themes. The most obvious is the sense of potential risk of HIV transmission posed by the positive man's body and the knowledge that using condoms is the only authorised practice when engaging in anal intercourse. Not using condoms when having anal intercourse requires explanation, possibly justification. Each of the following extracts reflects these themes. They also evidence the way in which the notion of responsibility invariably plays a part in the negotiation of both protected and UAI. Further, within the notion of what constitutes being responsible or engaging in 'shared responsibility' there may a whole set of assumptions based on

notions of individual agency and choice, attributed to the partner, in UAI.

Errol, in his early 30s, HIV positive for ten years and on treatments with low viral load, spoke openly about adopting a risk minimisation strategy. His approach is derived from his long term experience of having been positive, his recent efforts to be actively involved in many areas of social life after having been more isolated, difficulty with condoms, an approach to sexual practice that does not privilege anal intercourse, and the likelihood (acknowledged as possibly wishful) that low viral load could translate as low infectivity. His risk minimisation involves full disclosure of his positive serostatus which he refers to as an effect of how he has incorporated being positive into his life. He also states that he usually takes the receptive position in UAI. Importantly, his approach could be interpreted as a style of 'shared responsibility.' It is based on a consensual model of risk taking. This model is mediated by the possibility that his low viral load reduces risk as does his positioning, as receptive, when UAI takes place.

> I feel two things about condoms. One is the need for them, for protected sex. Um so that's, I suppose, my professional aspect. Personally I don't choose to use them any more. I was in a relationship with a negative partner for three years, so I used them all the time for that time um and I guess, I then went through a stage of not having sex for a while and out of that I've just decided for myself that I've got this far and I suppose in that I mean that I'm HIV positive, but I've also had the virus for ten years, um and I'm prepared to take those risks. There always are risks that are based on a certain amount of knowledge of the other person. So, I suppose I use harm reduction. I'm really up front about my status and if someone wants to have unprotected sex and this only happened a few weeks ago, they said they were negative and we ended up having unprotected sex. And I know some people have unbelievable problems with that. Um I have no problems with it. I suppose HIV, after ten years, has moved into my life in a way that it's just so much part of my life that it's not an issue um really, in a lot of ways. So, that's the way I think about it and I guess that allows me to feel that way about having unprotected sex with negative people. It's just not an issue for me ... I tend to be a receptive partner if it's just – if you're just talking about fucking ... My sexuality and what I like in sex is pretty broad. So, fucking ... most probably used to be fairly major and now it's not so major.

WOULD IT MAKE ANY DIFFERENCE IN TERMS OF RISK WHETHER YOU WERE FUCKING A NEGATIVE GUY OR IF HE WAS FUCKING YOU?

> Well, there's less chance – there's a much higher chance – I'm not good at stats and figures, but there's a much higher chance of him [negative partner] becoming infected if I come inside of him as opposed to the other way around. I also wonder about viral load levels, you know. They say – I know they don't include plasma, but they get viral load counts and – it could be higher in other parts of the body – and maybe it's just me playing games.

In the course of seeking UAI, some men may devise a set of criteria that enable them to make an assessment of the likely status of a casual partner. This assessment is informed by the spatial context. It may also be informed by a sense of managing the virus through medical interventions. Howard, in his mid 40s and whose seroconversion had taken place within the time frame of HAART, indicated that the availability of treatments had enabled him to come to terms with being positive. His outlook was also contextualised by establishing himself within a positive community and going through a process of change in attitude and practice. In places where UAI is the norm, he does not use condoms. In a context where there are no cues to indicate the serostatus of a casual partner, that is, where the absence of condoms is not normalised at the place of sex, he uses them. While he is concerned about risk to another, and recognises that he may not be entirely certain of his partner's serostatus, his coming to terms with being positive has involved allowing himself to move beyond 'a sense of duty', as he puts it, to have UAI with someone he finds attractive and willing.

I started having sex before AIDS so um I just wasn't ever used to them [condoms]. Um and I find them obstructive. I quite often lose a hard on with them. I don't feel the same sensation and I think there's a um it's just a feeling of clinicalness or hardness that goes with them.

WHAT SORT OF CIRCUMSTANCES WOULD YOU USE THEM IN?

Um well if I'm having – only with anal sex if either um the person I'm having sex with insists on them or if um if they're more comfortable with them and expresses that. Um or yeah, I never elect to use them. I don't force myself on anyone either. Um if I don't know them then I don't know their status. Um I usually will not try and initiate to fuck them or to be fucked by them without initiating some sort of conversation ... not necessarily about status, but about whether or not someone wants a condom. I won't just let it happen.

WHERE DO YOU NORMALLY HAVE SEX?

Oh all over the place, if I can. Um a variety of sex on premises venues and people's places. My place when I've got one. Um yeah, various places.

DOES THE PLACE MAKE A DIFFERENCE?

Um I used to think it didn't, but it does. Say if I'm in a sex on premises venue and there's a whole lot of fucking going on and someone wants to fuck me or wants me to fuck them um and clearly either they have already just been fucked by somebody else and there's no condom around then I'm not going to even blink an eyelid and won't use one. In fact I don't recall, recently anyway, using a condom in a place like – I recall not having sex there because there might have been a problem, but I don't recall using a condom.

DO YOU THINK MOST PEOPLE THERE ARE POSITIVE?

No and I mean I've seen – I've also observed quite a few people using condoms there. Um but not in situations that I've been involved with. But um my assessment is that a lot of them are. But that's just – I mean a lot of them tell you they are and you get to know them. I know I'm a regular at those places, so I know, not a lot, but I know quite a few people. ... Um and I – and you make assumptions about the way they present themselves, the way they behave in there, their body language and I make – equally I make assumptions that they're negative if they look a bit green or uncertain or unsure of themselves, or they don't look, you know, like I've seen them at a favourite haunt. If they don't look part of the furniture and they sort of start to run out of the place ... it's not his looks ... I think it's things like just how comfortably they walk, move, respond, whether they're like um bold or um or whether they look a bit tentative. People do language things rather than looks. Looks come into it. Um some people come looking who are really out of place and you just think well, they're either so cool about it that they just don't care or they've almost come to the wrong place and they're just checking it over. Yeah, well – I mean very young. Kids I always assume are negative unless something else gives me a signal that they're not.

IS IT ALSO WHERE YOU PICKED THEM UP OR WHERE YOU HAD SEX?

So, I mean if I pick someone up at the beach and went into the bush then I would assume they're negative. I mean I wouldn't even start from the assumption that they might be positive. I just wouldn't and it would have to be a blatant, you know, biohazard sign or something on their arm before I would make that assumption. So, yeah it's really in the context of the place they are in that is a big tip ... OK, well the back room at a party ... I mean I'm not going to start thinking about somebody's safety there. Just not – that's just a given – and I'm sure I'm not necessarily right, you know, but that's – that maybe just my attitude on it and a don't care attitude on it, but I still think ... someone who puts themselves in a sort of prone position or something in a sling room ... or something like that with all the gear there and maybe even has a blindfold on or something and lets someone come in and fuck him has got to be positive or else, you know, or he's a bug chaser...

HAVE YOUR SEXUAL PRACTICES CHANGED OVER TIME?

I found out I was HIV positive about three years ago and um I went through a huge depression for a while and didn't have sex probably for nine months um and didn't think I ever would, you know, it was the end of the world. I wasn't sick so um and then I realised I wasn't probably going to be sick for a

while and I might even live. Um and gradually started going out again. I had for the first time hooked into some of the support systems that are there and through that I only met positive people for a while then I completely – all my professional working world and all my family and all my friends knew that I was positive. It was you know, no secret and that and I just thought oh well, I've probably got to start all over again and so I cut myself off and started joining in anything I possibly could and also did volunteer work and got right into it because I didn't know any positive people before. That's not true, I knew some, but I never really was close to any ... so ... it was a long time before I ventured back into the ordinary world and thought of having sex with somebody who is either negative or I didn't know. So, yes, it had changed considerably and I got a bit militant about it for a while. I thought well, you know, I'll only ever fuck somebody who is positive and, you know, that didn't last very long. As soon as I fucked someone – a cute guy ... I feel I have a duty not to put somebody at risk, you know. I've broken all of those at different times. Um but I feel quite differently, you know, about it all and certainly than I did before.

The role of clinical markers in the development of risk minimisation is difficult to assess. However, in the absence of a low or undetectable viral load, a notion of 'infectivity' may be strong. This does not necessarily mitigate against the practice of UAI with a casual partner. Other factors may be used to minimise risk. Pierce, diagnosed a year ago, with a very low T-cell count and having recently ceased treating because he could not maintain the treating regime and fears drug resistance as a consequence, provided an account of how he negotiates casual UAI. His use of condoms is in response to a known negative partner. His non-use of condoms is based on careful reading of a series of cues and may include asking the partner if he has a condom. He also mentioned some of the difficulties with disclosure of his serostatus undertaken in conjunction with a sense of responsibility for the partner. It appears from his account that he, like Errol and Howard, is practising a mode of shared rather than sole responsibility, although this mode may be different from that intended to underpin HIV prevention education. Moreover, the slogan 'assume every partner is positive' may now translate for positive men as UAI is safe with someone who appears to consent to UAI. One precaution taken by Pierce, similar to Howard, to ensure a casual partner is positive, is the context in which the sex takes place. But, in contrast to Howard, he gave expression to a strong preference for UAI with someone whose status he already knows. This provides more complete assurance that he is engaging in pos/pos UAI.

How do I feel about them [condoms]? I don't like them myself. Um but I've used them um and it's not really – it's not really a problem if I have to use them, but I prefer not to ... you do lose sensitivity. Um they get in the way. What else is there? Um [pause] that's about it really. Um yeah, they just really get in the way. You've got to stop and – yeah, put them on. ... I'm positive. So, if someone were negative then I would use them definitely.

DO PEOPLE OFTEN TELL YOU THAT THEY'RE NEGATIVE OR POSITIVE?

Um not usually, no. So, it's not always easy to tell. Um I don't – how do I explain it? ... if they volunteer it then that's fine. If they don't then, I don't know. Just play it by ear and see what happens ... I try in some way to work it so they will tell me whether they want to use one or not and yeah ... usually I will ask them and say, "do you want to fuck me" and they'll – most of the time they'll say, "do you have a condom?" And most of the time I will have one on me and will use it. But sometimes guys say, "yeah, let's go for it" and then I ask them if they have condoms and they go, "no." Then I'll say, "oh no, don't worry." So, yeah, that's one way. I'm not sure of other ways, I can't think of any more off my head. So, yeah. ... um I use them less and less and because it's easier having sex with someone else who is positive than it is negative because then you don't have that problem with condoms. Um if the other person wants to use condoms that's fine, but I mean usually um I don't use them if I can help it.

DID YOUR VIRAL LOAD TEST INFLUENCE YOUR USE OF CONDOMS AT ALL?

> Um that's an interesting question. Um mm, that's a hard one. Um I'm not sure.

DID YOU FEEL UM MORE OR LESS INFECTIOUS WHEN YOU HAD A LOWER VIRAL LOAD?

> No, I thought well, um I can infect anyone at any time. So, you know if they're negative then I don't really want to have sex with them, I don't want to infect them.

DO YOU REVEAL YOUR HIV STATUS TO YOUR SEXUAL PARTNERS OFTEN?

> Um not all the time. Sometimes it's just a head job and um that's it and I don't really think that's ... it's a small risk, but I think it's a very very small risk and I don't feel a need to tell them at all. Something like that. If it's getting into more serious sex then it depends on the situation ... well, if he tells me whether he's negative or positive. Whether he wants to fuck. Um yeah, you know and basic things like that ... I try and put myself into the right situations where I don't have to worry about that. Um people I know and I already have sex with, it's far easier than trying to go out and pick someone up and – not that I do that anyway. But yeah, it's just easier knowing the person already.

Despite extensive education campaigns, it is evident that men may hold different ideas about what constitutes risk. This may, to some extent, be contingent on the nature of their relationship to the Clinic. Graeme, in his early 50s, positive since the beginning of the epidemic, never having been on treatments but having recently commenced having his viral load and T-cells monitored due to a significant decline in his health, expressed a different notion of risk to the above accounts. It appeared to have remained consistent throughout the epidemic. While similar to some other interviewees in using positive/receptive with negative/insertive in his calculation of risk in UAI, he was the only man to state that he could see no risk for a negative insertive partner, including ejaculation. Importantly, this assessment was based on an understanding of the one-way flow of bodily fluids and, presumably, informed by a highly gendered notion of body boundaries in which the penis is not conceptualised as 'receptive.' It is consistent with, more dominant, modes of thinking the body outside HIV/AIDS education.

> Yeah, I just sense – I don't go out hardly at all now. So, maybe I'm just barking up a tree. But um if – I guess if you're positive and you're active – sorry, if you're negative and you're active sticking it up somebody that is positive I can't get a handle on whether there's any risk. I don't think there is myself.

RIGHT AND IF THEY EJACULATE INSIDE A POSITIVE PERSON WOULD YOU SAY THAT THERE WAS RISK WITH THAT OR NOT?

> Well I wouldn't think so, no, if the person that is doing the blowing is negative. You know where's the risk? It's not as though it's just some – sort of hanging around inside your rectum waiting to get out or to attach to something. It's not, it's in blood and bodily fluids and so, I think if there was less scaring about it all and attempts to scare – freak people out, you know and I think there have been – you know, whoever the powers of be have been pretty successful in doing that and more educating um maybe it might be a different situation.

For men who have experienced the epidemic since the beginning and watched many, if not all, of their close friends die, the meaning of 'infectivity' may well be informed by a history of having observed what, in the past, was a direct causal relationship between HIV and AIDS. Walter, in his mid 40s, positive since the beginning of the epidemic, and on treatments with low viral load, revealed this was his experience of the epidemic. Throughout his interview he expressed a strong commitment to protected anal intercourse with all men – positive and negative. His intense dislike of condoms, based on the difficulty of using them, was negotiated by being receptive or, as he put it, passive and a position evidenced by epidemiology as low risk. Especially interesting was his citing of the safe sex message 'assume all partners are positive.' In contrast to some of the other positive interviewees and for whom this

might be a starting point in their negotiations for UAI, Walter stated it was the reason he would not have UAI. In his account, being on treatments was a reason to protect himself while also expressing a high concern about not infecting a partner – positive as well as negative partners. The articulation of these concerns, combined with the 'passive' position, provides yet another variation on the meaning of shared responsibility. His agency in this was based on his taking up being receptive or, as he put it, 'passive'. Within this strategy there is, though, the possibility of variation in relation to drug taking. In a situation where he is not confident of maintaining his 'passivity,' he will disclose his status. The act of disclosure in relation to using recreational drugs extends risk minimisation to an area that might otherwise be deemed high risk for HIV transmission.

> From my point of view I have ceased being an active partner completely because I just hate it [using condoms]. Um being a passive partner isn't so bad because it's not quite as noticeable, but it's just – it loses that intimacy and that spontaneity and there's always, where's the condoms, where's the lube, where's – so it takes away that instantaneous type thing. For me, anyway.

YOU'VE OBVIOUSLY DONE IT WITHOUT CONDOMS IN THE PAST?

> Oh god, yeah. Well, before all this started ... And it doesn't get any better. I mean I've tried. I've met partners, but it's like OK, right there, lie back and it's like sorry, I can't. I just can't.

WOULD YOU NOT USE THEM WITH SOMEBODY WHO WAS POSITIVE?

> No.

WHY NOT?

> Because of the risk of cross-infection and because I've been healthy for so long um and I don't want to compromise and I mean don't for one minute think that I'm going to remain healthy forever. But when you're on a good thing I think you should stick to it.

WOULD VIRAL LOAD AFFECT WHAT YOU DO? WOULD SOMEBODY ELSE'S VIRAL LOAD AFFECT WHETHER YOU WOULD THINK THAT THERE WAS A RISK OF CROSS INFECTION?

> Um no because I'd never actually – I never ask partners whether they're HIV or not, ever. I always assume that all partners and anybody that I have sex with is and I always expect that other people would expect me to be. I never offer my HIV status as a matter of course unless – the exception to that would be ... if I go to a major party and that's when I'd probably do a lot of recreational drugs. When I know that my sensibilities are compromised and that there is a great risk that one or the other partner could do something that would put one of us at great danger. I'm usually very up front with someone that I meet at a party. If I'm drug fucked I always say, if it comes to the stage where "let's go back to your place" or "you want to come home with me that's great, but you realise I'm HIV"... I volunteer mine [serostatus] only when I know that there is that risk.

DO GUYS EVER SAY "I'M POSITIVE" WITH THE POSSIBILITY THAT YOU MIGHT SAY "OH YEAH, I AM TOO" AND THEN YOU CAN DISPENSE WITH THE CONDOMS?

> Well, no, if I – a couple of times I've been in that situation – sometimes I've met people and they've actually been up front and said "I'm positive" and I've said, "hey so am I." But, I still practise safe sex. It's never happened um when I've volunteered the information because I've been drug fucked at a party and in that instance I really don't know what would happen. I guess there is a possibility that something could happen without a condom.

WHAT IS IT ABOUT BEING DRUG FUCKED?

> I might get talked into it. It's like OK, if they want me to be active I can't with a condom. I can't and I've just given up trying and if I'm drugged fucked and somebody says, "yes, let's" I might be tempted to do it [be insertive]. And I don't ever want the responsibility of thinking that I might have caused or might be responsible for someone else contracting the disease or even if they're positive I'd hate to think that I'd cross infected them with another strain. So, no. And the drugs that I've been taking now for the last almost three years have been very effective and I have negligible viral load.

> The last test was the less than ten and there was no trace. So, I don't know how long I'll be able to stay on the treatment that I'm on and I want every option that there is.

Walter's account introduces the question of risk to positive men as well as to negative men. The risk of other STIs and the risk of resistant virus are located within a risk minimisation strategy that works to protect both himself and his partner. For the other positive interviewees, who practise UAI, the risk of STIs was assessed against what is understood as a vastly greater burden of carrying HIV. The possibility of cross infection or super infection was regarded as a theoretical possibility but without empirical evidence and, therefore, not sufficient grounds on which to avoid UAI.

It is also important to note that a sense of infectiousness may be construed in ways that are beyond or exceed knowledges provided by medicine and health promotion. Wayne, who became positive prior to the availability of treatments, six years ago, not on treatments due to an already undetectable viral load, spoke of his seroconversion as almost unexplainable. This was conveyed as very difficult in a context of risk assessment informed by epidemiology. He explained that, as part of a clinical study, his antibody status had been monitored closely. The change in his antibody status could not be traced to a designated 'risk' associated activity. This experience may have been responsible or may have, at least, contributed to his lack of trust in current authorised risk management strategies and general abstinence from sex:

> Every time I have sex I have this – I go through this checklist afterwards about what might have happened. That I might have infected someone and stuff like that and um it's annoying me now. Just it fills your head so much, yeah. ... It doesn't make sense to me the idea that, you know, just because I've got low viral load I wouldn't be infectious. ...No. It's more about, I just think it's about the same and in terms of what I can do in terms of avoiding infecting someone else. I think I would do that however my viral load was.

While the above material sheds light on the approaches of positive men and the way in which their practice of UAI is structured by notions of risk, infectivity, responsibility and 'self regard' (leaving aside the more obvious motivator of desire), these approaches may not necessarily coincide with those of negative men to effect risk minimisation.

The following account provides some guide as to how risk may occur in a context where men of different serostatus have different understandings of what is taking place in a sexual scenario. Practices, including the introduction or non-introduction of a condom, may carry different meanings for those oppositionally positioned in relation to risk. In the context of a long history of safe sex campaigns, instructing negative men to always use a condom, some positive men may well assume that anyone who doesn't request a condom before penetration is positive. On the other hand, negative men, well aware of the message of 'shared responsibility' may assume that a positive man would use a condom. In the following account of UAI with a partner of unknown status at the time, Dave, 27, with low viral load (not on treatments) explains how the absence of condoms was read in opposite ways. He also added that, since this experience, he engages in full disclosure and will adapt his practices in response to a partner's requirements for condoms or not. Once again, notions of individual choice and agency inform that of responsibility. Importantly, as will be evident below, his sense of responsibility in relation to prevention of HIV transmission extends beyond the possibility of this occurring in UAI. It includes a concern that the lived effects of the virus on a partner might be worse than for himself.

> Yeah, if um I'm being receptive, if I'm being the passive partner, um and it's a one nighter and the condoms are there um I won't disclose my status, but I will leave it up to the other person who is being the active partner to put on a condom. ... If they don't [use a condom] I figure well obviously they know the risk, the information is out there, boom, I

also know the risk of them getting infected from me is very minimal. If on the other hand I'm being the active partner I'd always put a condom on, you know. I've had one instance where I didn't because um I assumed he was HIV positive because he didn't want to use a condom. He assumed I was HIV negative because I didn't want to use a condom. Don't know how he figured that out, but that's where he was coming from. Two weeks down the track he found out I was positive and went for a test and it was the worst three months of my life. Worrying I'd infected him and merely because I hadn't communicated before the incident. So we're both not having safe sex, but both for the different reasons. So, um I learnt from that obviously it's better to talk than not talk because you can dig a hole for yourself if you don't. Um but yeah on the whole that's who I will stand as – if it's a one nighter and they're going inside me it's their responsibility for a condom. Even though it's my health, if I'm going inside someone else I'll always use a condom because mainly for the guilt. The guilt reason as much as infecting them, you know. Um, I'd feel really bad if I ended up giving someone else HIV and they passed away from it and I'm still alive. I don't know how I'd mentally cope. So, maybe it's preventative measure from my mental sanity that I use a condom as much as safe sex.

Risk minimisation in the serodiscordant relationship

While the study has tended to prioritise the need to understand what is taking place in relation to casual UAI, attention has also been given to the negotiation of risk within a serodiscordant relationship. In this context both partners are aware of their different serostatus. Moreover, clinical markers may have been discussed for their potential to reduce infectivity and, therefore possibly, over-ride associated difficulties with condoms.

The discussion of reduced risk is likely to take place as a result of viral load testing, possibly, some discussion with a doctor on the potential of infectiousness and also in the context of continued debate about the best mode of treating, for example: early or delayed; with or without breaks. Devising a risk minimisation strategy in a context of changing knowledges and changing treatment regimes is difficult. This may be further complicated when individual clinical markers alter. For instance if one strategy has already become well practised and has a personal history of evidence to support it, new medical evidence of risk may require revision of practice. Nigel, 35yo (positive for 12 – 13 yrs) and with low viral load, stated that he always uses condoms in a casual encounter but his partner fucks him without a condom. Since having gone off treatments for a month, this practice has come into doubt. But preference for retaining the practice, after what is perceived as a lengthy time period of practising positive/receptive sex without his partner becoming infected, is a mediating factor:

> We've sort of fallen into this um I suppose that's only happened – I've been on combination therapy for about three years and for almost like the start I had undetectable viral load. Um and that's sort of when it started because there was a bit of information around at the time. You can say that you don't need to use condoms any more if you've got this undetectable viral load and that was a little misleading. Um but it sort of works – it's sort of OK for us. X is still negative and I don't know, I understand that there is a risk, but yeah, with an undetectable viral load as well too I just wonder um you know, we do try to use condoms, but not always. I think if X. was going to get HIV off me after like seven or eight years it probably would have happened by now ... There's more chance now of you being able to do that [not use condoms]. Um but yeah ... if my viral load went back up again most definitely. But even now I just don't think it's – I still don't think – it's not a hundred per cent safe ... It's just not. Although at one point I thought it was OK because there was a lot of stuff in the media saying, you know, that it was sort of OK.

The possibility of presuming low risk in the knowledge of an undetectable viral load and positive/receptive anal intercourse suggests that a certain level of comfort/safety may be derived for both partners informed by 'healthy' indicators. Adam, who seroconverted a year and a half ago,

has an undetectable viral load, based on testing able to identify virus at a level of 50 rather than the usual level of 400, spoke of his partner's unprotected insertive practice as based on the latter's informed choice:

> Um and I'm – he's very comfortable with that. He understands the risks that he's taking, etcetera, etcetera, etcetera and that goes back to the original stance that we were talking about earlier [non preference for condoms]. That it's a sensation, it's the added effect of it and it just means that we don't – and he's being very casual and constantly gets tested every like – every six months or every four months or so, three months. So, touch wood, everything will be OK.

In contrast to UAI with his regular partner, Adam gave emphasis to always using condoms with a casual partner. In this context he was concerned to protect himself and about the legal risks of not using condoms. His approach was similar to Walter's in respect of protecting himself and gives recognition to some of the risks associated with being positive. These risks may be considered to include risk of cross infection, super infection, STIs, and the risk of disclosure in terms of discrimination and legal implications. It is also possible that within a serodiscordant relationship there are different understandings of risk. Where a negative partner is not actively involved in treating decisions, or generally does not engage with current literature on medical technologies within gay and positive communities, the positive partner may be more concerned and more likely to manage risk. Anthony, long term positive, off treatments due to the side-effects and with a detectable but not high viral load and moderate T-cell count (800), said:

> I suppose in my part of the relationship there's um – what we do sexually is more like, you know, arse play. So, there's, you know, quite often there's not the penile contact. But he'll do me occasionally and sometimes he wants to go without the condom because he thinks that's safe. He still thinks it is, so we end up having a fight over it and three hours later he comes around and whatever... [Once] he just slipped it in and I thought he had a condom and we've gone all the way and he's blown and I didn't know and ... he said "I just fucked you raw" and I said, "What!" and I've gone off my head.

The strongest evidence of the effect of clinical markers on positive men's risk assessment is in the accounts of those who do not have low or undetectable viral load counts. In these accounts, the sense of being infectious is strong and the sort of risk minimisation strategies employed are reflective of a period prior to the advent of HAART. Hal, in his mid 30s, positive for 12 years, in a serodiscordant relationship for most of this time, and not on treatments but with T-cell and viral load counts that he described as 'really bad,' expressed strong concern about the possibility of infecting his partner:

> I hate the – everything from opening the packet to fumbling around and having to worry about a water based lubricant and everything. Even at home with like a pump I still find it – yeah, I don't really have a lot of anal sex now. I think half the reason is because I'm sort of over the condoms and being paranoid they're going to break and all that sort of stuff. I had one break about ten years ago and I've always remembered it and it really freaked me out and I thought – I still don't feel safe to go the whole way because I'm worried something is going to happen to a condom ... I'm not into it as much as I used to be.

WHY IS THAT?

> Oh it could be to do with the HIV thing or it could be just – I don't know, I'm just not – yeah, I don't know, I'm just not into it as much, yeah. And I think if I had a positive partner I would be, but being – I'm with a negative partner and I just – it doesn't matter how good it is, it's just not worth my while being nervous about infecting him.
>
> My doctor said I'm like totally in denial, basically. I'm not, I don't think, but I try to run my life and not think about the virus every minute, although I do think about – every time I might be sitting in the traffic I think about it or I'm sitting in the – it's just like a cancer. I know I've got it, but I just don't want to – I don't want it to take over everything I do, you know and I suppose feeling

that once I've got all these tablets it's going to start running me a bit. I'm just trying not to make it run me. That's all, I suppose.

DOES THE VIRAL LOAD MAKE YOU FEEL DIFFERENT IN TERMS OF BEING MORE OR LESS INFECTIOUS?

Yes, I actually gave that some thought this year for the first time. I did because, yeah, I was thinking am I more infectious to my partner? Definitely. Yeah. I don't know if I am or not, but yeah, I suppose I'm a bit more worried about that.

BUT THAT'S NOT A BIG THING? – I MEAN I MIGHT HAVE PUT WORDS INTO YOUR MOUTH?

No, OK, I don't think about it a lot. I have thought about it though, but it's not a big thing.

HAS YOUR VIRAL LOAD CHANGED OVER TIME?

Yeah, it's just gradually gone up. My T-cells have gone down. I got chicken pox because I was Father Christmas and all the kids were sitting on my lap and I was giving them the presents and this was a few years ago. I had like heaps of T-cells, 800 or something and I got this really bad chicken pox and I couldn't even get out of bed and that just knocked me down to 210 or something and then I just went down from there. So, it was all because of that. It activated it.

A further area to consider when assessing the impact of clinical markers is the relationship dynamic. For some positive men, undetectable or low viral load and increased life expectancy may facilitate the possibility of having a relationship and/or experiencing it in a less stressful manner than prior to treatments.[16] One pre-HAART scenario that provides the basis for comparison is provided by Errol, cited earlier. He spoke of a past serodiscordant relationship and the difficulties posed by an ever present notion of 'infectivity' and 'responsibility.'

There are issues that you both have that are very very different. Um I think it's really quite hard for both partners for totally different reasons. I think it puts a lot of pressure on the relationship. That's not what broke us up, but, you know, these are still issues. Even though it might only have been slightly acknowledged at times and greatly acknowledged at other times, there's always the issue that one is negative and one is positive when you're having sex. You're not doing protected sex because you're just having a fuck and it's the thing to do. You're having protected sex because there is a direct possibility of one person infecting the other person that he loves. Um and I suppose for my negative partner that, you know, the person he loves might infect him. So, there's always, you know, and I think that's a lot to carry around. There's a lot of unconscious stuff that's going on.

The above material reveals how varying modes of risk minimisation are constituted within a dynamic space of individual embodiment, gay culture, education, and medical technologies. It is the complexity of these factors that produce context-dependent opportunities and constraints.[17] The opportunities and constraints, as expressed in the course of individual accounts, evidence the presence of HIV prevention education, epidemiological assessments of risk, as well as the role of clinical markers, particularly viral load. HIV prevention education has clearly put in place an awareness of risk and, although it has never sanctioned any form of UAI outside a scientifically based negative seroconcordant regular relationship, the additional presence of epidemiological data may have given tacit consent to a continuum of risks. Negative/insertive and positive/receptive have been deduced by, at least, some men to be of considerably lower or minimal risk with regard to transmission of HIV. This unsanctioned ranking of risk, reflective and therefore supported by epidemiological studies, may now have sufficiently infiltrated the understandings of gay men to be a significant factor in some current practice. Clinical markers, and particularly viral load, may mediate notions of 'infectivity' as, in the absence of high viral load, it is possible to presume lower risk. The notion of shared responsibility for possible viral transmission is, on the basis of the interview material, complex in the space of UAI. It is figured in the context of a range of factors. These may include, not only sexual position, but whether the partner is a lover

or anonymous; located within a space where not using a condom is 'normalised,' such as a sex on premises venue in contrast to a beat; the extent to which choice or consent is understood to be exercised by the anonymous partner and ascertained through the reading of non-verbal cues or response to disclosure of positive HIV status. The differences in practice not only occur across men but may also be operative in the day-to-day practice of an individual gay man.

Risk minimising from a negative perspective

While most of the negative men provided accounts of their sexual practices that conform to HIV prevention, that is, they stated they always use condoms unless they are certain of negative seroconcordance, based on 'talk, test, test, trust', a few did provide accounts of having UAI outside seroconcordant relationships. The latter varied in terms of whether it was with casual/anonymous partners or with a known/regular partner whose status was not absolutely certain. They also varied in terms of whether UAI took place through some form of negotiation and was understood as consensual or whether it was due to what can be summarised as 'a decision of the moment.' The phrase 'decision of the moment' is intended here to include participating in UAI because a partner would not wear a condom or because 'the heart' or 'heat of the moment takes over.' To put this another way, some indicated they were able to get UAI within a risk minimisation strategy, others indicated that they were largely dependent on their partner's approach to risk minimisation.[18]

Clinical markers were not directly influential in these accounts of UAI. Knowledge of treatments and associated testing was limited to those already working in or in direct association with the HIV/AIDS education field. Across the sample there was an almost uniform response of 'no,' to the question of whether undetectable or low viral load might lead them to think a person was less infectious. Moreover, most men volunteered the view that if someone was positive, then they posed a risk no matter what their viral load. This view can be understood as a further indication that negative men are not well informed and not directly influenced by clinical markers. There was only one man, cited below, who stated that undetectable or low viral load might affect his assessment of risk. However, some men in serodiscordant relationships, also cited below, did indicate viral load is influential in risk assessment. Similar to the positive men, sexual position was cited as significant to risk assessment by many of the negative sample.

Kim, 30, recently tested negative, and who spoke of himself as a regular user of beats, provided an account of risk minimisation that was based on an assessment of risk that he knew contradicted health education but which made more sense to him. It also accommodated his own reticence about condoms and difficulty wearing one. His risk minimisation involved what might be termed 'a well practised set of negotiation skills.' It included UAI and, since taking PEP, encouraging his partner to withdraw while wearing a condom. In the following account, he not only reveals himself as a skilled negotiator of risk minimisation but also his view of treatments and ongoing risk:

> Whether I'm topping or bottoming um yeah, no way that I don't use condoms at all. But I don't like them ... I find it very difficult to maintain an erection while I'm wearing one and um yeah, I hate how you've got to like stop and reach for them and reach for the lube and then, you know, you can't roll it on properly and you can't get the packet open, it just breaks that flow of things and then you've got to virtually start again. Which isn't, you know, in a way isn't a bad thing, it prolongs everything, but yeah it still breaks that – yeah, little path that you're going down, so ... I've just come out of relationship about six months ago from three years and we were both monogamous and we both had negotiated safety and I still think back to those days and think how good it felt compared to now and it's like – and now I don't actually particularly like topping when it comes to anal. I prefer to be a bottom because of that ... Um if it's with somebody

I know, and I've had sex with before, generally the roles have been established about who is going to do what to whom and so, yeah, so the person either brings it themselves or I've got them ready. If it's with somebody I don't know um you've generally got to work out who is going to – who wants to be the top and who wants to be the bottom and then you've got to work out whether they're into bare backing or whether they're willing to let you fuck them without a condom or whatever. But some guys will try to, you know, at least find their way in without a condom first, and see how far you're willing to go before you say "no let's get a condom."

SO, WOULD YOU STOP IT?

Oh definitely ... I don't even let any of the guys like rub the head of their dick against my arse before they penetrate me. It's like the instant that it gets to my arse it's like stop, if you want to do that, if you want to go that far, get a condom first please. So, yeah ... I won't even let a guy cum inside me now [after recent condom breakage] with a condom ... He has to withdraw and whatever. But yeah, no

WOULD YOU NEGOTIATE THAT BEFORE YOU START FUCKING SOMEONE?

No... , you can usually tell when – even if I can't tell I kind of suppose judge in my head, like oh they must be getting close by now so I'll say to them "don't come inside me." And it's more of a sexual thing too because um I like to see a guy cum – it's a dual edged sword kind of thing. It's like protection and erotic as well.

WOULD THEY KNOW THAT? IF YOU SAY 'DON'T COME INSIDE ME' WOULD IT BE UNDERSTOOD THAT YOU LIKE THEM TO COME OUTSIDE?

I usually say, "it's like I want to see you cum" and things like that ... in my head I think it's a way of like softening the blow or kind of making the deal look a bit better or something ... for them.

WOULD YOU MAKE ANY DISTINCTION BETWEEN BEING INSERTIVE AND RECEPTIVE IN TERMS OF RISK?

Um that's a hard question to answer. ACON's stance is it's both as equal as each other, but personally I think because of the mechanics of fucking that, yeah, you know, giving has to be just that – I mean I don't know how much safer, but it would have to have less risk than receiving. So, yeah, so um there's a bit of a conflict in my head about that at the moment. It's like who should I believe myself or ...

WOULD YOU TALK ABOUT UM HIV STATUS BEFORE YOU HAVE SEX?

Never ... Um unless they bring it up and some guys do, particularly at beats and young guys do. Except for a few guys that I know, people like ask, you know, are you clean or have you got anything. It's like well as far as I know I don't. So, yeah. But I never ask.

WOULD YOU THINK THAT SOMEBODY WHO WAS POSITIVE, BUT ON TREATMENTS, WAS MAYBE LESS INFECTIOUS?

No. Definitely not, no.

WHAT DO YOU THINK OF THE TREATMENTS?

Um from what I've heard I definitely don't want to go on the treatments for two reasons. For the way they make you feel and the way the take over your life. Because it's like you've got to take these pills at exactly the same time every day and I'm not that organised. Um yeah, so I know that I possibly wouldn't cope with treatments because of that.

SO, YOU DON'T THINK THE RISK OF HIV IS DIMINISHED BY THE PRESENCE OF TREATMENTS OR ...?

Treatments, no definitely not or like, you know, catching it now because in ten years time they're going to have a cure. So, yeah, like I should survive until they find a cure. They'll fix me up ... No.

Aaron, 27, and a frequent engager in negative/insertive casual UAI, could be regarded as similar to Kim in his practice of risk minimisation. In the course of his account he made it clear that he does not presume his casual partner will take responsibility for HIV transmission. He also emphasised not doing something that might hurt someone else. However, it was not clear what this meant as he did not have recent HIV anti-body test results to confirm his negative status. Given his practice of

UAI, based on negative/insertive, it is likely that he does not consider himself as a site of transmission. His account also includes mention of the influence of drugs in relation to casual UAI. Again it was not entirely clear how he understood this influence. While initially he explains UAI as taking place under the influence of drugs, he then states that drugs are integral to his participation in casual sex. UAI may be the product of engaging in casual sex, not necessarily a direct effect of taking drugs. His making sense of his sexual practice in the temporal space of the interview is revealling. It suggests that more accepted and practiced modes of sense making, such as drugs produce reckless behaviour, may be re-worked by ongoing self-reflection. In place of the more conventional explanation and positioning of drugs, a less self-admonishing style of explanation may emerge that gives recognition to more everyday less stigmatised factors such as social unease or, what might be termed, shyness or inhibition. Additional commentary on a previous regular relationship with a positive partner is included in the section on serodiscordant regular relationships. It provides a contrast between risk minimisation in the casual scenario and that in a regular known serodiscordant relationship.

> I certainly have no aversion whatsoever to using them [condoms]. Um but in saying that I have myself and I've certainly noticed with my sexual partners of the last six or twelve months huge drop off in use of them ... I've certainly noticed and um that it's uh – I've just so many times over the last twelve months I've had casual sex with guys and not used a condom and that wasn't – certainly, you know, four five years ago I can remember talking to friends who had got really out of it and done the same thing and this like big shock ... maybe there's a whole generation of guys coming out into the scene and are like – who weren't – who didn't have that experience ten years ago, of having people around them die and ... Um I was on the tail end of it, but I certainly knew a lot of people. I had a few friends and um people.

DO YOU EVER GET FUCKED OR ARE YOU ALWAYS THE INSERTIVE ONE?

> No, not really. I don't hardly ever get fucked and I never get fucked without one [condom].

SO YOU THINK THAT YOU'RE AT LEAST RISK WHEN BEING INSERTIVE?

> Oh yeah, I do.

WOULD YOU EJACULATE INSIDE THE OTHER GUY?

> Um I don't think – as a matter of course I wouldn't. I'm just trying to think have I? I don't think so, I haven't, no.

WHY NOT? BECAUSE IT'S PART OF THE PLEASURE OF ...?

> No, it's probably a bit of both actually. ... No, I think I would – I don't know really. I would normally, yeah, pull out, yeah... Um I dare say there's probably been instances where I haven't, yeah.

WHEN YOU DON'T USE CONDOMS ARE YOU ALWAYS ON SOMETHING?

> Yeah ... Always drug affected ... Not every time I have sex, but any time that I don't use a condom. ... which is a fairly common state for me to be in when I'm having casual sex, because I don't usually have casual sex unless I am drug affected – mainly ecstasy. Ecstasy and speed ... Because um because it's normally pretty simply a pattern of going out, getting off my nut, picking up, going somewhere and having sex. I mean it's a fairly common pattern for me ... Rules aren't important to me but the one rule I always follow is that I won't do anything that hurts anyone else. If I'm risking myself, then I can deal with that. But I wouldn't, you know, do anything to hurt anyone else. So whether that be, you know, financially or emotionally or physically and that's always sort of a litmus test for my behaviour. If I'm putting anyone else at risk then I'll stop. But if it's just me being silly then I can deal with that ... In the whole eight, nine, ten years, I've been having sex with gay men I've never once asked anyone whether they're HIV positive or not ... I don't think it's my business really. If they want to tell me they can ...

Ben, 23, recently tested antibody negative spoke of difficulty in negotiating for condoms to be used

by a casual partner. This was related to his preference for being receptive and the consequent reliance on an insertive, potentially positive partner, to wear a condom. His account of how he has been 'read' by a partner as positive, suggests that non-verbal 'cues' may not necessarily be an accurate guide to serostatus. Although relatively young, Ben demonstrated a knowledge of the varying effectiveness of anti-retrovirals but was emphatic 'that has not in any way changed my perspective of sex and it hasn't in any way reduced my perception of HIV as a threat or anything.'

> I've often found that with a lot of those guys, when I have refused to have anal sex without a condom, it's then come up that, OK, we won't have anal sex. It's almost like they won't have anal sex unless it's unsafe. And that to me, in terms of my own sex life, represents a big problem because I really really like anal sex and to me it's sort of – I almost feel as though I haven't had sex unless I've actually gotten to the anal sex stage. Like I feel as though ... if I walk away from a sexual encounter and I've had oral sex and mutual masturbation or whatever, it's almost like it's not fully sex ... But those have often been the terms in which it's been presented to me.

Later he said:

> There was something I was wanting to add ... the other thing that has um offended me personally when I've been asked my HIV status is that it's normally coming from someone who is actually assuming that I'm positive and that assumption is normally based on really vacuous grounds. You know, where, for example, one guy who once asked me whether I was positive or not and I said, "The last test I had was negative." He said to me, "oh I thought that you might have been" And I was like, "what made you think that" and he said, "well I've seen you out a fair bit and a lot of the time when I've seen you, you've been on drugs or I've seen you go home with other guys and that sort of stuff" ... So, they sort of had typecast me as promiscuous junkie.

Robert, 24, stated that there have been a few times when he has not used condoms in a casual situation. His account gives emphasis to a non-conformist attitude on his part that is simultaneously acknowledged and juxtaposed with what he understands is required of a successful sexually experienced gay man. He is the only one to say viral load might make a difference to his sexual practice.

> I've probably not used condoms about three times, excluding like a boyfriend where we sort of um yeah we had like tests and things and sort of did that talk test trust thing, whatever ... yeah, it's been with sort of one night stand sort of ones where I just uh been out all night and really couldn't give a damn or a fuck really. Um and they have sort of been available um not readily next to the bed sort of thing, but in the bedroom probably, yeah. But I just thought, oh well, why not. I suppose enjoyment factor does come into it and sort of the me sort of being younger as in invincible um yeah, naughty, do not do, sort of thing comes into it as well.

IS THAT LIKE A REBELLION AGAINST ALL THE SAFE SEX MESSAGES OR HOW DO YOU SEE THAT? LIKE BEING NAUGHTY?

> Um being naughty would be um kind of challenging myself more. Not against safe sex messages, against my own beliefs. Well, yes, I mean yes we've been pumped that, you know, condoms, you know, um you know you must use sort of thing and yeah, well majority of times do um yeah, in those moments though it's been um ... yeah it was just more a thing that I knew I should be doing, but yeah, you know, it was more – yeah, just sort of rebellious – an inward rebellious thing ... Yeah and just sort of thinking, oh well sort of for the moment, sort of, yeah.

WHEN YOU ARE USING CONDOMS WHO HAS BROUGHT THAT SUBJECT UP? WAS IT YOU OR THE OTHER GUY?

> Um usually the other guy ... Yeah, it would be ... I don't know. [laughter] You know, I'm sort of too busy doing other things. [laughter] You know, it's a last minute sort of thing. It's not a planned forward, "have you got condoms?" or anything. It sort of that happens or, you know, sort of getting into it, sort of thing ... Yeah, but, you know, I have the knowledge that if it's at my place or whatever, I have the knowledge that they are there and they're behind the bed sort of thing. You know, easy to grab sort of thing.

HAS YOUR VIEW OF CONDOMS CHANGED OVER TIME?

Um it is becoming more should use condoms, yeah, like as in being more responsible, I think. But, you know, also it's part of growing up as well, um but yeah being more responsible.

IF YOU WERE HAVING SEX WITH A GUY THAT YOU KNEW TO BE POSITIVE AND HE SAYS, 'MY VIRAL LOAD IS REALLY LOW OR UNDETECTABLE' WOULD THAT HAVE ANY BEARING ON THE ...?

Um it may. It depends on the situation I suppose ... How comfortable I was and ... even though it's stupid and sort of doesn't matter if you're, you know, uh doing the deed or receiving it, but um yeah, usually I'm doing the deed and I don't know, it may have some bearing if at some point I just couldn't be bothered.

SAY HE SAID HIS VIRAL LOAD WAS HIGH, BUT HE STILL WANTED TO, YOU KNOW, FUCK YOU WITHOUT CONDOMS, WHAT WOULD YOU SAY?

I would say, no.

It is difficult to assess whether Robert's response to the question of viral load and reduced infectivity came from a similar position to that of positive men and the extrapolations they are making about their infectivity from tests on blood to virus in semen. However, in the course of presenting himself as somewhat 'irresponsible' he indicated an interest in media that addresses issues about treatments. He also reveals that the gay press is an important source of information for him.

DO YOU THINK YOUR ATTITUDE TO HIV/AIDS HAS CHANGED SINCE YOU FIRST HEARD ABOUT IT?

Yeah, I mean definitely I know more sort of about it and ... I'm sort of not a person that knows everything about it. But yeah, I suppose just through all the different ways of being hit, you know, with stuff and ... while I don't read like Positive Living, for instance, all the time,.. I will flick through it and read bits and pieces occasionally. But if something takes my eye I'll read stuff and yeah ... I'll sort of like gather information here and there. I suppose specially just through uh through gay media, yeah, sort of get stuff ... now I'm thinking and being more responsible about it, well, I'd say definitely the um information side has had like a bearing on that ...

HOW WOULD YOU DESCRIBE THE HEALTH OF YOUR POSITIVE FRIENDS?

All fine ... one is sort of, yeah, very low viral load, another one has been HIV positive for like twelve years and yeah, no, he's cool.

IS THERE ANYTHING ELSE YOU WANT MENTION?

Yeah, I don't know if this makes any sense, but the unsafe sex has always been with an older guy [laughter] Probably about, yeah, about 30 – 32, along those lines. Um I suppose safe, secure, I don't know, yeah.

SO YOU THINK THAT THEY'RE OLDER, THEY'RE MORE RESPONSIBLE, THEY'LL LOOK AFTER ME OR ...?

They'd be responsible, yeah, you know, not some half baked [laugh] clag. Yeah.

Drew, 35, similar to the above accounts of Kim, Aaron and Robert, also indicated that he knew his practise of UAI did not conform to authorised modes of safe sex. His attitude, however, is similar to Robert's as he, too, speaks of himself as rebellious and not, like Kim and Aaron, acting on the basis of considered risk assessment. In contrast to all of the above whose UAI was discussed in relation to a casual partner, Drew's experience of UAI has been with a regular/known partner whose status he was not sure. He explains this as due to his 'heart' taking over, but it is imbued by self-admonishment for an absence of 'common sense' and a refusal to be told what to do.

SO, WHEN AND WITH WHOM DO YOU USE CONDOMS?

Well (pause) – I'd say everybody except the occasion where I've sort of slipped up ... most of the time if I have sex with someone that I don't know. Definitely the first time. Definitely always use

them the first few times, but then sometimes I might slip up and sort of not use one, but not for very long because the guilt sort of takes over and I stop.

DO YOU USE CONDOMS IN YOUR CURRENT RELATIONSHIP?

No. We both had blood tests when we started going out about a month into it. We were previous to that, most of the time again [using condoms]. But because I trusted him, I just had a – it depends if I have a feeling for someone or not. That sort of influences me. If I really like someone I won't use them. I tend to sort of – my heart takes over. So, but if I don't care about them or know them very well I definitely use one. But I just had a good feeling for him and I just – which is not a good excuse, but that's just human nature, I suppose ... if I went to like a place and had anonymous sex and someone wanted me to fuck them I would definitely use one ... I've always been pretty good. I've always been pretty good. I think it's been consistent over the years. Like as I say over the years probably 90 per cent I've always used one, but then there would be times when something takes over and I'd just like think oh fuck it and I wouldn't use one. I think it's just a combination of like the excitement of, you know, feeling it and something new and just being turned on and common sense just flying out the window and in a way rebelling against all that you must do this, you have to do this, you should do this and I think that you just think oh fuck that, who are you to tell me when to use one or when not to use one.

Precisely what is meant by expressions of 'the heat of the moment' of 'the heart takes over' may vary and certainly in the practice of minimising of risk. Vincent, 50, long time gay attached since the before the epidemic, explained his practice of UAI, which could also be described as sexual play, as the effect of 'heat of the moment.' But it is also something that he stops before it becomes risky in his view.

Um sometimes I do insertion without a condom for about maybe 15 seconds and then pull out and put a condom on.

AND THAT'S WITH YOUR REGULAR PARTNER?

Any partner.

WOULD THAT BE KIND OF PART OF THE SORT OF SEXUAL PLAY?

Well, yeah, things lead up to sort of activity and then you kind of get going and then suddenly you think oh hang on ... And so you say, wait a minute I'll just put a condom on ... it would be mostly in a sauna or a sex venue and the heat of the moment, you get carried away um suddenly insertion occurs. How's that for a scientific term. [laugh] And then you suddenly realise that hey this is not – this is really silly and so after a few seconds you pull out and you say, hang on a sec, you know. So, it's that kind of thing. That's the way it occurs.

In contrast to individual risk minimisation, based on personal assessment and negotiation, or 'being rebellious,' another set of explanations for UAI involved notions of low self-esteem. Neville, 34, provided a clear account of now always using condoms although, in the past, this was not the case. His explanation for the change centred on a period of low self-esteem during which he used heroin. Importantly, drug use is not explained as a mind-altering state that lead to him being less able to use condoms. Rather, the explanation gives emphasis to an attitude of lack of care or regard for himself.

HAVE THERE EVER BEEN TIMES WHERE YOU'VE NOT USED CONDOMS OR WANTED TO NOT USE THEM?

One, not having condoms with me. Second maybe um um the heat of the moment. Uh third, um I think in early my um early at the time, I am talking about 21/22, um I had some sort of belief that um, you know, that person doesn't look like they'd have AIDS therefore I could probably have sex and not get AIDS.

WHEN YOU HAD ANAL SEX WITHOUT A CONDOM WHAT WAS DIFFERENT?

Um I think more than anything it was about my self-esteem. My self-esteem has been up and down and I've also been a drug user as well. So, I found that the use of condoms on some level has been based on also my self-esteem ... low self-esteem made it possible to not use condoms ... I think when I used drugs and I was a heroin user, that I um would get to a point like who gives a shit, you know what I mean.

> Like I'm going to live anyway – I'm going to die anyway and ... I've had situations where I've had sex through drugs with people and walked away and thought, shit what have I done ... I'm talking about the possibility that person would be infected.

HAS IT CHANGED OVER TIME

> Well, I found that my unsafe has actually become less, a lot less. In fact the situation, for instance, I go to beats um I find that um there are people who go to beats uh will have, you know, threesomes or foursomes or god knows whatsomes and um I find myself actually giving people condoms because they're just about to have sex, anal sex, with someone and not have condoms. I'll say, oh maybe you should use that. You know what I mean? So, I think I'm becoming more vigilant ... I think that most people who go to beats often don't have condoms and therefore that stuff about, you know, the um the heat of the moment seems to be one of the most important things about beats.

IF A GUY TOLD YOU HE WAS POSITIVE AND THEN TOLD YOU THAT HIS VIRAL LOAD OF HIV WAS UNDETECTABLE AND HIS CD4 COUNT WAS GREAT, WOULD THAT CHANGE YOUR ASSESSMENT OF HOW RISKY IT IS TO CATCH HIV OFF THIS GUY AND MAYBE PERSUADE YOU NOT TO USE CONDOMS?

> No. Because it's not just AIDS, I mean there's also gonorrhoea, all these other um possibilities that you can have when you have sex, do you know what I mean?

WHAT ARE YOUR THOUGHTS ON GUYS THAT ARE POSITIVE TAKING RESPONSIBILITY FOR EITHER TELLING THEIR SEXUAL PARTNERS THAT THEY'RE POSITIVE OR BEING THE ONES TO INITIATE SAFE SEX?

> Mm, ... at the end of the day it's up to me. I mean really at the end of the day it's my decision to look after myself, ... like um through drug use I've got hep C, I've had various things, you know, like at the end of the day I have to look after myself

Oliver, 29, also provided an explanatory account that centred on what might be understood as low self-esteem or, perhaps, low care of self. After stating that he had had over 5000 partners since coming out and most of this had involved UAI, he said that he was now trying to incorporate condoms. The change in his approach was attributed to a change in his medication for depression. Throughout the interview he also made reference to the possibility that he might be immune to HIV on the basis of his sexual history and continuing to remain negative.

> I used to go on massive benders um because of depression where I'd go to sex on premises and be fucked by anything that breathed ... the anti-depressants I was on got changed. Um we didn't realise but I was having blackouts and everything ... Half the time I didn't know what was happening ... Then I found out I had this reputation of being a slut and I was like, how did I get that?

SO YOU DON'T MIND BEING THAT, BUT YOU WANT TO KNOW YOU'RE DOING IT?

> Um I like to know what I'm doing because, you know, finding strange um welts on your arse um or around your neck or wherever it's like oh no where did I get this? How did I get that? And I'd also had um a few sexual um how can you describe them? Not sexual transmitted diseases. Sexual uh damages, handcuffs, um ... clamps and all those sort of things.

SO YOU THOUGHT YOU MIGHT ACTUALLY END UP GETTING HURT OR ...?

> Getting severely hurt where I didn't know how I got it done to me.

Negative serodiscordant issues

Aaron, cited previously, drew a comparison between the casual/anonymous partner scenario and that which involves someone with whom there is an emotional investment and is known to be positive. In his account the use of condoms in a serodiscordant relationship is more straightforward than in a casual encounter in which the partner's status is unknown and the latter may be willing to not use them. He says he had no knowledge of his partner's viral load and that his partner took responsibility for not transmitting HIV.

WOULD YOU HAVE BEEN BOTH INSERTIVE AND RECEPTIVE OR ...?

Yep, we were.

DID HIS VIRAL LOAD EVER KIND OF MAKE A DIFFERENCE TO WHETHER YOU ...?

Didn't really discuss it.

HE NEVER TALKED ABOUT HIS TREATMENTS OR ...?

Oh a little bit, you know. ... it was a bit of an issue because he was on a really regimented diet, when he could eat and when he could take his pills and stuff. So, that always governed what we did and where we went. He would say, "oh look I've got to have dinner at this time" and we'd just work around that or, you know, he'd say "oh look I'll catch up with you later because I've got to eat earlier" or whatever ... But I mean we never talked about his viral load or I had no idea what treatments he was on.

SO, YOU WOULDN'T HAVE THOUGHT, "I'M FUCKING THIS GUY WHO IS POSITIVE, BUT HE'S ON TREATMENTS SO THERE'S LESS RISK IN THIS SITUATION"?

No, I didn't think that because he was on treatment, that it lessened the risk at all. That wasn't part of my thinking. Like it was just like I know he's HIV positive and we'll take the appropriate precautions which we did. Um yeah, which in the context of my behaviour since we've separated it's odd. Because it certainly – it means with, you know, people I have no idea who they are or what. Well, I know what they get up to, but ...

SO, WAS HE THE MORE RESPONSIBLE ONE THEN?

he was very – he was very aware of it and he certainly wouldn't have done anything that he would consider put me at unnecessary risk. I mean I acknowledge that there's always a risk regardless of, you know, using condoms because, you know, with oral sex and whatever else, but it's just like being together and being two grown ups and sort of saying "OK well there's this situation, we'll do what we can to ..."

BUT AREN'T CONDOMS A NUISANCE?

Well, I think less so because in the context of a relationship where, you know, when we were having sex we'd be in his bedroom or my bedroom and, like we knew where things were and also because it was part of the relationship anyway, because of his status it just wasn't an issue. Whereas the things I was talking about before it's all a bit less definite, which probably means you should be more careful. But also just not knowing the other person's view on things and that sort of thing. So, it probably becomes easier not to address it ... To sort of sit down and discuss or negotiate or come to some sort of common understanding is just sort of a bit out of the realm. Whereas if it's someone you're engaging with and, you know, have an emotional attachment that's a lot easier.

The effect of clinical markers on risk assessment, particularly low viral load rather than HAART, not surprisingly, may be more evident amongst negative men in serodiscordant relationships. Andy, HIV negative in serodiscordant relationship and 'out' for only two years says he fucks his partner without condoms twice a year, on a special occasion. His partner is not on treatments and has an undetectable viral load. There was speculation that the absence of detectable viral load was an effect of suppressing it from thought. An injector of steroids, along with his partner (they have completely separate gear), Andy said it is easier to catch hepatitis and he would deal with HIV seroconverting if it should happen, although extremely unlikely.

Additional data drawn from interviews with HIV negative men, after seeking HIV post exposure prophylaxis due to an incident of risk in a serodiscordant relationship, offers more insight into the impact of clinical markers on sexual practice. Lewis, cited below, provides an account of risk minimisation devised in response to his partner's difficulties with condoms, desire to be insertive, and undetectable viral load. Particularly striking is that he attributes his negative status not to PEP but to his partner's undetectable viral load which he refers to as 'zero load.'

> Well occasionally, yeah you think be careful and pull out before you cum which is probably incredibly stupid but you do it particularly when you get to know someone. um, you start to take calculated risks. You say to yourself, "Well X doesn't have any precum ... as long as he pulls out before he cums then the risks aren't nil but minimised" ... X has trouble getting an erection, putting a condom on and keeping an erection which is why he's a bottom because he has trouble getting an erection and nearly loses it all the time if he puts a condom on. So um, you know, if you love someone then you take the risk. You calculate the risk.... calculating the risk is trusting him, zero viral load. I don't know what that means where sperm count is concerned but it seems to me that I've survived two encounters and not been infected. It doesn't mean you're going to take any extra risks and start to say, "It's safe to have unsafe sex because of zero viral load" but I think it must reduce the risk and you take risks because you love someone. That's what it all boils down to. You take risks because you love them and you weigh up in your mind what are the pros and cons and, "Well I love this person". He gets terribly frustrated by the fact that condoms basically destroy his erection and yet would love to be the active person occasionally. So you think well you're willing to take that risk ... [later on he says] I think what was responsible for me not testing positive was S's zero viral load.

Another interview from the PEP study, with Nick, suggests the positive partner made a link between undetectable viral load and reduced or no 'infectivity.' It may be that this sense making creates an easier context in which to disclose, not necessarily only after UAI as recounted below, but possibly also before.

> I had unprotected anal sex with him. It wasn't receptive. It was insertive and unprotected and um, then, some time after that we were having lunch he told me he was HIV positive and so um, the next day I got him to take me along to his doctor. He told me his viral load was not detectable, that he'd assessed that there was no risk um, which he had no right to do of course. So I went along with him the next day to his doctor and he was just coincidentally receiving his results from the previous test and his viral load was still not detectable.

In contrast to the positive men's ready and highly articulate explanation of the practice of UAI, negative men demonstrated considerable hesitancy in speaking about it and were not always able to explain the practice as an act of definite choice. Those who were able to do so also indicated they were proficient in undertaking the practice according to their understanding of risk minimisation. The apparent confusion amongst the few others, sometimes to the point that they were not able to fully explain what level of risk took place (eg whether they or a partner ejaculated), suggests that negative men may be experiencing a type of isolation from debate and information on the nature of the current epidemic. This is further supported by their general lack of knowledge about HAART and associated tests such as viral load tests and their ability to reconfigure the meaning of being HIV positive in terms of levels of infectivity.

CONCLUSION

In this concluding section specific attention will be given to research findings that shed light on the relationship between clinical markers and UAI. The main focus of discussion will be differences between the positive and negative samples, including serodiscordant couples. Since there were no specific findings arising from the other sample groups, '25 years and under' and 'Brisbane compared with Sydney', as explained earlier, these groups will not be discussed as such.

The findings of this study suggest that clinical markers are having an impact on the practice of UAI. This impact is most usefully understood in relation to the serodivide. While clinical markers are directly affecting the lived experience of being positive, with implications for sexual practice, this affect is not shared by negative men. Negative men are, however, living within a sexual culture affected by the change to the lived experience of being positive. The diverse and, as will be outlined below, complex way in which the impact is taking place cautions against any proposition that there may be a simple causal relationship between clinical markers and UAI. Rather, it is necessary to understand the impact as constituted by the coming together of a range of factors at this time which, in turn, may provide for an increasingly diverse gay sexual culture based on different attitudes, knowledges, and practices.

Prior to discussing the impact of clinical markers on UAI, it is important to recognise that the term UAI refers to a multi-varied sexual practice that can be viewed in many ways. For some men the practice may involve full insertion with or without ejaculation. For others it may involve short penetration in terms of length and/or time without ejaculation. The practice may also be mediated by sexual position. The association between any of these forms of UAI and understandings of risk may be contingent on whether penetration is undertaken by a negative or positive partner. Penetration by a negative partner was generally reported to pose less or no significant risk compared with being receptive to a known or potentially positive partner.

The negative sample included men who: always use condoms; have UAI in a seroconcordant relationship; have insertive UAI in a serodiscordant relationship; have had a 'one-off' or 'heat of the moment' experience of UAI with a regular partner of uncertain serostatus; have receptive UAI with casual partners; have insertive UAI with casual partners.

There was no evidence to suggest that clinical markers directly effect the diversity of UAI except for those in serodiscordant relationships. For the latter there may be a trend towards the practice of UAI with a positive partner who has undetectable viral load. The positive sample included men who had undetectable viral load and who do not practise UAI; practise UAI in a serodiscordant relationship and with casual partners; practise UAI in a serodiscordant relationship but not with casual partners; do not practise UAI in their serodiscordant relationship but do so with casual partners. Within the range of approaches to UAI, not all positive men with undetectable or low viral load practised UAI. However, there was evidence to suggest that those who practise UAI are more likely to have undetectable or low viral load than high viral load.

The impact of clinical markers in producing an increasingly diverse gay sexual culture is evidenced by the different style of interview response provided by the respective sample groups of positive men and negative men in relation to questions on condom use, UAI, clinical markers, and infectivity. From the outset of each interview, positive men were extremely candid about their attitudes to condoms, difficulties they may experience with erections, and the specifics of their sexual practice in terms of whether they disclose their serostatus to sexual partners, where, with whom and how, if at all, they have anal intercourse. Most of these accounts included UAI. Evident in their reporting was the use of individually tailored risk minimisation strategies which incorporated some or all of the following: the results of viral load tests; epidemiologically proven reduced risk according to sexual position and non-ejaculation; full disclosure and/or reading non-verbal cues to indicate the positive serostatus of a partner and/or consensual participation in UAI. All spoke of clinical markers in terms of their own personal experience. With the exception of one interviewee, the entire positive sample was well aware of clinical markers and could provide a considered response to questions about viral load and its effect on infectivity. None of the responses demonstrated an absolute conviction that infectivity was reduced but some did indicate that this was

regarded as a real possibility. Strongly demonstrated by the responses was a skilled and well-versed practice of obtaining UAI with likely positive partners.

Undetectable or, possibly low, viral load was indicated to provide for a level of comfort/security against risk within some serodiscordant relationships although this comfort may not be equally shared. The data suggest that the positive partner may be less willing to engage in UAI (receptive as well as insertive) than his negative partner. In casual sexual scenarios, undetectable or low viral load may enable some positive men to proceed with UAI with a consensual partner. However, positive men who practise UAI with a regular negative partner may not necessarily do so with a casual partner or vice versa. In the former case, this difference in practice may be dependent on perception of risk posed by a casual partner of cross infection or STIs and/or by the ability to negotiate risk minimisation compared to full consensual participation with a regular partner. In the latter case, some positive men may not engage in any level of risk practice with a regular partner but may presume that a casual partner, willing to participate in UAI, is also positive.

On the basis of the comprehensive detail provided through lengthy discussion with those in the positive sample it seems that clinical markers, and more specifically, viral load counts may provide the conditions of possibility for a reduced sense of infectivity and, in association with this, a sexually active mode of living with HIV including some form of UAI. Most of the sample with undetectable viral or low viral load engaged in some form of UAI. There were two men with a higher viral load who had engaged in long term casual UAI, but the remainder with a significant viral load did not practise UAI. The men who reported engaging in UAI with casual partners included both those on treatments and those not. While viral load may be reduced due to treatments there were some men in the sample whose undetectable or low viral load was not due to being on treatments. The reasons for not being on treatments ranged from having undetectable viral load to the difficulty of managing a rigid treating regime or, for some long term survivors, a view of treatments as a last resort to be delayed for as long as possible.[19]

The conditions of possibility provided by clinical markers can be understood as a type of potential for a different sense of being positive to that prior to treatments and inevitable progression to AIDS including, for some, an altered experiential meaning of carrying HIV. This 'sense' can be understood to encompass what might conventionally be thought as an inter-related psychological and physiological series of effects. Amongst the factors contributing to this potentially newly constituted experience of being positive are increased immunity demonstrated by T-cell testing, improved sense of health and vitality due to the effectiveness of treatments in long term positive men, and the prospect of a longer future. However, other factors that may undermine the positive experiential effects of clinical markers are rigid treating regimes, drug side-effects and the development of viral resistance to treatments.

In relation to the practice of UAI, the prospect of a longer future and a conjectured reduced infectivity may bring into question the prospect of always having to use condoms. If being positive has altered in meaning and lived experience, it may also be difficult to conform to public health policy on HIV transmission risk that is based on a prior meaning of being HIV positive. This is not to suggest that the risk of HIV transmission is necessarily reduced by clinical markers. Rather, it is to acknowledge that this is a possibility recognised by many in the HIV/AIDS field and by individual men living with HIV (including negative men in serodiscordant relationships discussed below).

While it is not appropriate to deduce from the data whether an increase in UAI has occurred due to treatments, the detailed accounts of individually tailored risk minimisation strategies in conjunction with statistical data on UAI, gives weight to this proposition. However, it is important

to note that while some long term positive men indicated that their practice of UAI is associated with the introduction of HAART and associated testing, others stated that their practice of either AI with condoms or UAI has not altered over time.

The impact of clinical markers on the practice of UAI by negative men is less discernible. The majority of the sample began their interview with the claim that they always use condoms. The claim was evocative of continued HIV print-campaign slogans. Later, usually after the question of why they had recently undertaken an HIV antibody test, a few then revealed they had UAI with a partner of uncertain serostatus. The discussion of UAI by this latter, slower to reveal, group was hesitant and/or not always provided within a clear account of why and how it had taken place. Three of the sample, at the outset of the interview, reported having casual UAI. These accounts differed from each other in style of UAI practice and apparent skill in negotiation for preferred sex. They respectively included a prior repeated practice of being receptive, regular insertive not receptive, and occasional receptive. The latter interviewee reported sometimes having difficulty convincing an insertive partner to use a condom and having been mistaken as positive.

Very few of the negative sample demonstrated knowledge of clinical markers equivalent to that of positive men, not surprisingly. Those who did were closely linked to the epidemic by a positive regular partner or by working in an area related to the HIV/AIDS field. Few of the entire sample had given consideration to the potential significance of viral load in HIV transmission. Almost all, excluding those in serodiscordant relationships, stated that if a person has the virus, they are potentially infectious – irrespective of viral load.

The interviews with the negative sample gave support to the Post-AIDS thesis. Some interviewees, not directly involved in the HIV/AIDS field, stated that prior to the treatments there was frequent discussion of people being sick and dying with AIDS. Within their current social circles there is now no mention of HIV, AIDS and risk. This absence of discussion, in light of the continuing presence of HIV, medical technologies and changing sexual practices, may mean that there is little opportunity for men to engage in dialogue on questions arising in relation to sexual practice and risk at this time. Given the hesitancy by some negative interviewees, it may be difficult to think about and account for having unprotected sex in ways specific to being a negative man in the context of a history of 'if it's not on, it's not on.' To not use a condom as a negative man, after being told to do so many times, is to lapse. This was evidenced in the way those who mentioned having UAI spoke of themselves as either having acted 'unwisely,' 'stupidly' or even as 'rebellious.'

The non-involvement of most negative men in debates about whether undetectable or low viral load means reduced infectivity, or the refusal to consider that this possibility could provide for UAI, indicates an understanding of risk framed in pre-treatment terms. It also suggests that, following from the Post-AIDS thesis, the invisibility of HIV for negative men limits awareness of what being positive may now involve. For instance, negative men may not be fully aware of the difficult decision-making terrain that must be negotiated on treating regimes, the toxity of treatments including short and long-term side-effects and, more generally, what is proposed here as a different sense of being positive. With specific regard to the risk of HIV transmission in a context of increasing UAI, some negative men may be unaware of how medical knowledges, specifically clinical markers, may be giving rise to an increasing sexual subcultures of UAI by positive men.

The differences between the way in which positive and negative men are approaching UAI points to a community divided by a different relationship to knowledges and the effects of the Clinic. If most negative men are not engaging with medical knowledges, they may not be assessing risk from a similar basis as a potentially positive partner. To put this another way, if being positive has changed in ways not yet evident to many negative men, this may be played out in sexual scenarios based on different understandings of

who is doing what and why. Whereas the use of individually tailored risk minimisation strategies by positive men informed by viral load tests, epidemiologically proven reduced risk according to sexual position and non-ejaculation, full disclosure and/or reading non-verbal clues are important, there remains the possibility that HIV transmission may occur due to the presence of different understandings and assumptions informing partners of different serostatus.

The strategies employed by positive men to have pos/pos casual UAI often rely on reading cues about the other partner. However, cues such as the person is a regular user of a venue in which UAI is a regular practice can be misleading. Further, in a space where the lived practice of serostatus is changing, sexual practices may be interpreted in different ways. For instance, a negative man may assume, on the basis of general community understanding of infectivity, and prior messages of 'shared responsibility,' a positive man would use a condom. Therefore, when a partner does not use a condom he can be read as negative. Conversely, in light of a long history of education aimed at promoting condom use, a positive man might well assume that a sexual partner, who does not introduce or request a condom, is also positive. At a more theoretical level, assuming a casual partner is participating in condomless intercourse by choice ignores the contingent nature of choice. Choice and agency may be constituted by desire for intercourse on the one hand and, on the other, lack of skill in negotiating for condoms, the presence of treatments, and lack of public visibility of HIV.

The devising of individually tailored risk minimisation strategies can be understood as a similar innovation as the use of HIV side-effects testing for establishing seroconcordance and UAI.

However, the strategies are diverse and may require experience and skill as well as luck in their deployment. Some key issues for further consideration are the role of condoms in risk minimisation in light of the linking of serostatus with sexual position; the extent to which the meaning of 'shared responsibility' is shared by sexual partners; and the function of disclosure of serostatus in relation to responsibility and risk.

Despite the almost self-evident recognition of condoms as an essential means of preventing HIV transmission, dislike or and/or difficulties with condoms was reported by men in both sample groups. Condoms were reported by some to hamper sexual performance as their usage may be disruptive to the sexual dynamic and/or they may induce erection difficulties. For this reason they are avoided by some men. This avoidance may be negotiated differently according to serostatus. Positive men may adopt the receptive position only or seek out consensual insertive UAI. Negative men may avoid condoms by not participating in casual UAI; they may adopt the insertive position without condoms but require condoms when receptive; if unable to negotiate condom use by an insertive partner, they may not engage in receptive UAI. The linking of serostatus to sexual position in UAI (negative/insertive and receptive/positive) reflects the epidemiological assessment of risk. In light of the problems, nominated by many men, about condoms and the increase in UAI, particularly the apparent development of, what might be termed, a pos/pos sub culture of UAI, condoms may lose ready acceptance in a sexual scenario. For some men, positive as well as negative, it may become increasingly difficult to incorporate a condom in anal intercourse. Negative men participating in sexual spaces where condoms have, to some extent, become de-normalised may not prioritise condom use over 'getting the fuck'.

Another area for further consideration is the notion of responsibility and, along with this, what constitutes consensual participation in UAI. It is evident from the findings that there are many ways of understanding and acting on the meaning of 'shared responsibility.' Shared responsibility for a positive man may mean consensual participation without serostatus being established. Shared responsibility for a positive man may mean taking the receptive position. Shared responsibility for a negative man may mean a positive partner will always use a condom.

Conversely, the HIV prevention message 'assume every partner is positive' may translate for positive men as assume a partner is positive if he doesn't request a condom. Related to the way in which notions of responsibility are enacted is the level of experience and negotiation skill by respective partners in casual and regular relationships.

Included in a notion of responsibility might be the disclosure of serostatus. Interestingly, this is not practised by negative men nor, according to the research data, do negative men expect it of their casual partners. However, some positive men did state they disclose their status to a casual partner. For some being 'out' about their serostatus takes the stress off having either AI or UAI. It is seen as giving the other person the opportunity to decide for himself whether he wants to participate and is likely, but not certain, to ensure pos/pos UAI. However, revealing positive serostatus can place the positive person at risk. His serostatus may be communicated to others including work associates leading to discrimination and its potential effects on livelihood and other associated difficulties. In a sexual scenario it can jeopardise getting the fuck.

In summary, central to the way in which both positive and negative men understand and negotiate sexual conduct is the educational messages they receive. The effect of medical technologies now shaping individual practices and the new questions they raise about risk will require new or revised messages to cater to this change. Policy on education as well as educational materials will need to address the diverse ways in which notions of infectivity, responsibility, condom presence or absence, and serostatus are now understood if risk minimisation is to be supported.

REFERENCES

Brotherton, A. (Unpublished) *Sex, Drugs & Community: Implications of New Treatments for Gay Educators*.

Crawford, J., Kippax, S., Rodden, P., Donohoe, S. & Van de Ven, P. (1998). *Male Call 96: National telephone survey of men who have sex with men*. Sydney: National Centre in HIV Social Research.

Davis, M. D. M. (Unpublished chapter forthcoming PhD thesis) 'HIV prevention rationalities and serostatus in the risk narratives of gay men living in London.'

Dowsett, G. and McInnes,D. (1996) 'Gay Community, AIDS agencies and the HIV epidemic in Adelaide: theorising "Post-AIDS."' Paper presented at Out There Too, Adelaide, March 14 & 15.

Dowsett, G. W. (1996) *Practicing Desire*. Stanford: Stanford University Press.

Flowers, P., Duncan, B. and Franks, J. (forthcoming) 'Community, responsibility and culpability: HIV risk-management amongst Scottish gay men.' *Journal of Community and Applied Social Psychology*,10.

Flowers, P. (forthcoming) 'Gay men and HIV/AIDS risk management.' *Health*.

Gold, R. S, Skinner, M. J. & Ross, M. W. (1994) 'Unprotected Anal Intercourse in HIV-infected and Non-infected Gay Men' *The Journal of Sex Research*, Vol 31, No.1, p.59 (19).

Kellehear, A. (1993) *The Unobtrusive Researcher: a guide to methods*. Australia: Allen & Unwin.

Kippax, S. (1999) *'New Treatments and Prophylactic Vaccines: Changing Meanings of Risk.'* Paper presented at the 10th Conference on Social Aspects of AIDS, South Bank University, London, June.

Knox, S., Van de Ven, P., Prestage, G., Crawford, J. and Kippax, S. (1999) *Sydney Gay Community Surveillance Report, Update to December 1999*. Sydney: National Centre in HIV Social Research.

Krug, G. J. (1995) 'Hepatitis C: Discursive Domains and Epistemic Chasms' in *Journal of Contemporary Ethnography*, Vol 24, No.3, pp.299-322.

O'Donnell, D (1995) 'Sero-status and Community' in *Living in an Epidemic: a report from 2nd National Gay Educators Conference*, Sydney: Active Publishing University of Sydney.

Prestage, G., Van de Ven, P., Knox, S., Grulich, A., Kippax, S. and Crawford, J. *The Sydney Gay Community Periodic Surveys 1996-1999: Changes over time*, Sydney: National Centre in HIV Social Research.

Race, K. (forthcoming) 'Incorporating Clinical Authority: A New Test for People with HIV.' In N. Watson (ed) *Reframing Bodies*, London: MacMillan.

Race, K. (forthcoming) 'The Undetectable Crisis' *Sexualities*.

Race, K., Cristeaudo, P., Wilkins, R. and Prestage, G. (1997) *Pills, Health, Capacity: the significance of HIV health practices*. Sydney: National Centre in HIV Social Research.

Van de Ven, P., Prestage, G., Kippax, S, French, J., Horn, G. and Brotherton, A. (1998). *Melbourne Gay Community Periodic Survey: February 1998*. Sydney: National Centre in HIV Social Research.

Van de Ven, P., Kippax, S., Knox, S., Prestage, G. and Crawford, J. (1999). 'HIV treatments optimism and sexual behaviour among gay men in Sydney and Melbourne.' AIDS, 13, 2289-2294

NOTES

[1] Dowsett, G. and McInnes, D. (1996).

[2] See Race, K. (forthcoming) for a detailed critique of the Post-AIDS thesis in 'The Undetectable Crisis.'

[3] Brotherton, A. (Unpublished) 'Sex, Drugs & Community: Implications of New Treatments for Gay Educators'

[4] Crawford, J., Kippax, S., Rodden, P., Donohoe, S. and Van de Ven, P. (1998); Knox, S., Van de Ven, P., Prestage, G., Crawford, J. and Kippax, S. (1999); Prestage, G., Van de Ven, P., Knox, S., Grulich, A., Kippax, S. and Crawford, J. (2000); Van de Ven, P., Prestage, G., Kippax, S, French, J., Horn, G. and Brotherton, A. (1998); Van de Ven, P., Kippax, S., Knox, S., Prestage, G. and Crawford, J. (1999).

[5] Kippax, S. (1999) New Treatments and Prophylactic Vaccines: Changing Meanings of Risk.

[6] For a more extensive discussion of these positionings and their implications see Davis, M.D.M. 'HIV prevention rationalities and serostatus in the risk narratives of gay men living in London.'

[7] Race, K. (forthcoming) 'Incorporating Clinical Authority: A New Test for People with HIV.'

[8] See Race, K. (forthcoming) 'The Undetectable Crisis' op cit.

[9] Flowers, P., Duncan, B. and Franks, J. (forthcoming) 'Community, responsibility and culpability: HIV risk-management amongst Scottish gay men.'

[10] Flowers, Paul (forthcoming) 'Gay men and HIV risk management,' *Health*, London: Sage Publication.

[11] Flowers, P., Duncan, B. & Franks, J. (forthcoming) op cit.

[12] This framing has been developed on the basis of research by Flowers, P., Duncan, B and Frankis, J. ibid. p4.

[13] For a discussion on this method Dowsett, G.W. (1996) 'Practicing Desire.'

[14] Kellehear, A. 1993; and Krug, G. J. (1995).

[15] See O'Donnell, D (1995) p.101. In this report O'Donnell states: 'in Queensland, reaching for a condom suggests that you are HIV positive, whereas in Sydney it suggests that you *are* HIV negative'

[16] Eric Rofes writes of men returning to work and of a rebirth of sexual cultures including sex clubs, bathhouses, and circuit parties in many North American cities. Rofes describes a series of friends who, after going on treatments, were able to resume going to the gym and rebuild their bodies while returning to an active social life with increased libido. Rofes, E. (2000) 'Barebacking and the new AIDS Hysteria' F***sheet: *The Journal of Gay Men Fighting AIDS*, No 54. pp.12-15; See also unpublished transcripts from PLUTO study. One female respondent stated that it was not until she had a viral load test that she experienced herself as positive. Prior to going on treatments she did not think the virus was doing much to her: 'it wasn't until I got the viral load test and I realised that I had this huge amount of virus actually in my blood that it was in there doing something ... I'd seen sort of diagrams on how the virus actually, you know, entered the blood and you know, the cells and that sort of thing, but I didn't connect it with what was going on inside my body ...'

[17] Flowers et al (forthcoming) op cit.

[18] See Gold, R.S, Skinner, M.J. and Ross, M.W. (1994) for a quantitative study on gay men's self-justification for UAI.

[19] This is consistent with the findings of PLUTO study. One female respondent states that going on treatments signals the end for her as it means she is 'on her last leg'

APPENDIX A: INTERVIEW SCHEDULE

The interviews will begin with the following introductory statement:

The purpose of this interview, as you probably already know, is to contribute to a study into how gay men are thinking and doing sex at this point in the epidemic. The way we have decided to focus this is on condoms: how men feel about condoms, what place they do or don't have in people's lives. Before we begin, though, I want to reiterate that I am going to be asking you about some very personal aspects of your life: your HIV status, who you have sex with, how, where, when and, may be, why? I want to reassure you that you will remain anonymous in the transcript of this interview and that the tape itself will be destroyed after it has been transcribed. But please feel free to ask me to stop the tape or even the stop the interview if it makes you at all uncomfortable.

Start with any opening that you feel comfortable with and then move into the following area of inquiry, you could mention in asking these questions that men express different views about condoms – some hate them, some don't care, some prefer them for different reasons and some have difficulty in maintaining an erection when putting on a condom ...

1. I'd like to begin with a question how you 'feel' about condoms?

2. Have you ever used them?

3. When and with whom do you use them?

4. Have there been times when you haven't used them or would prefer not to use them?

5. Do your partners always use condoms?

6. Has your usage of condoms changed over time?

HIV STATUS IF THIS HAS NOT ALREADY BEEN COVERED ABOVE

7. If negative, have you tested for HIV?

8. If negative, how often do you test?

9. (If positive) are you on antiretroviral treatments?

10. In what situations would you know the HIV status of a sexual partner?

11. (If positive) is he or are they on treatments?

12. Does your or your partner/s HIV status or viral load influence your use or non-use of condoms?

DISCLOSURE

13. Do you reveal your HIV status to all your sexual partners?

14. Do you expect them to tell you their status?

15. Do you think the presence of testing for HIV, for viral load, T cells or even other medical tests makes a difference to how you think about sex?

16. Do you think there are other things that affect your or, if negative, your partners' viral load and semen?

17. Does this sort of information influence your sexual activities?

18. [highly provocative, may need modification] do you think positive men should take responsibility for HIV transmission?

EPIDEMIC

19. Now I'd like to ask you some general questions about your experience of the epidemic beginning with your age?

20. Do you think your attitude to HIV has changed since you first learnt of it?

21. Do you know of anyone who is positive?

22. How would you describe their health?

23. Have you known anyone who has died from AIDS?

24. If yes, how long ago was that?

25. Do you know about PEP (Post Exposure Prophylaxis)?

26. If yes, what do you know?

27. Are there any other things that we haven't covered that you think may be relevant to the study?

28. Would you identify yourself as a member of the gay community? Why do you see yourself in this way?

29. On the basis of your own knowledge of the gay community what would you say is affecting people's lives at this point in the epidemic?

APPENDIX B: SUMMARY OF KNOWLEDGE OF PEP (POST EXPOSURE PROPHYLAXIS)

Most men had answered no to the question 'have you heard of PEP or Post Exposure Prophylaxis?' This included positive men in serodiscordant relationships. Some of these men remarked that they were surprised they did not know about it and would ask their doctor why he/she hadn't told them. However, there were other positive men in serodiscordant relationships, who were familiar with PEP. One of these stated he didn't think his partner would require it. But he also added that his partner lived in another state where it is not available. Of the (known or assumed) negative men, who did know about PEP, most had learnt of it through their association with the sexual health field. However amongst the few others, who had some knowledge of it, there was confusion about whether it was 'a morning after pill,' whether it had to be taken for three months not one as usually prescribed, cost, and effectiveness. One negative man in a serodiscordant relationship stated that he didn't think he would need it but now knowing it was available would give him some peace of mind.