

A Research Report on Safer Sex Practices Among High-Risk Men and Men in Couples in Toronto

Renewing HIV Prevention for Gay and Bisexual Men

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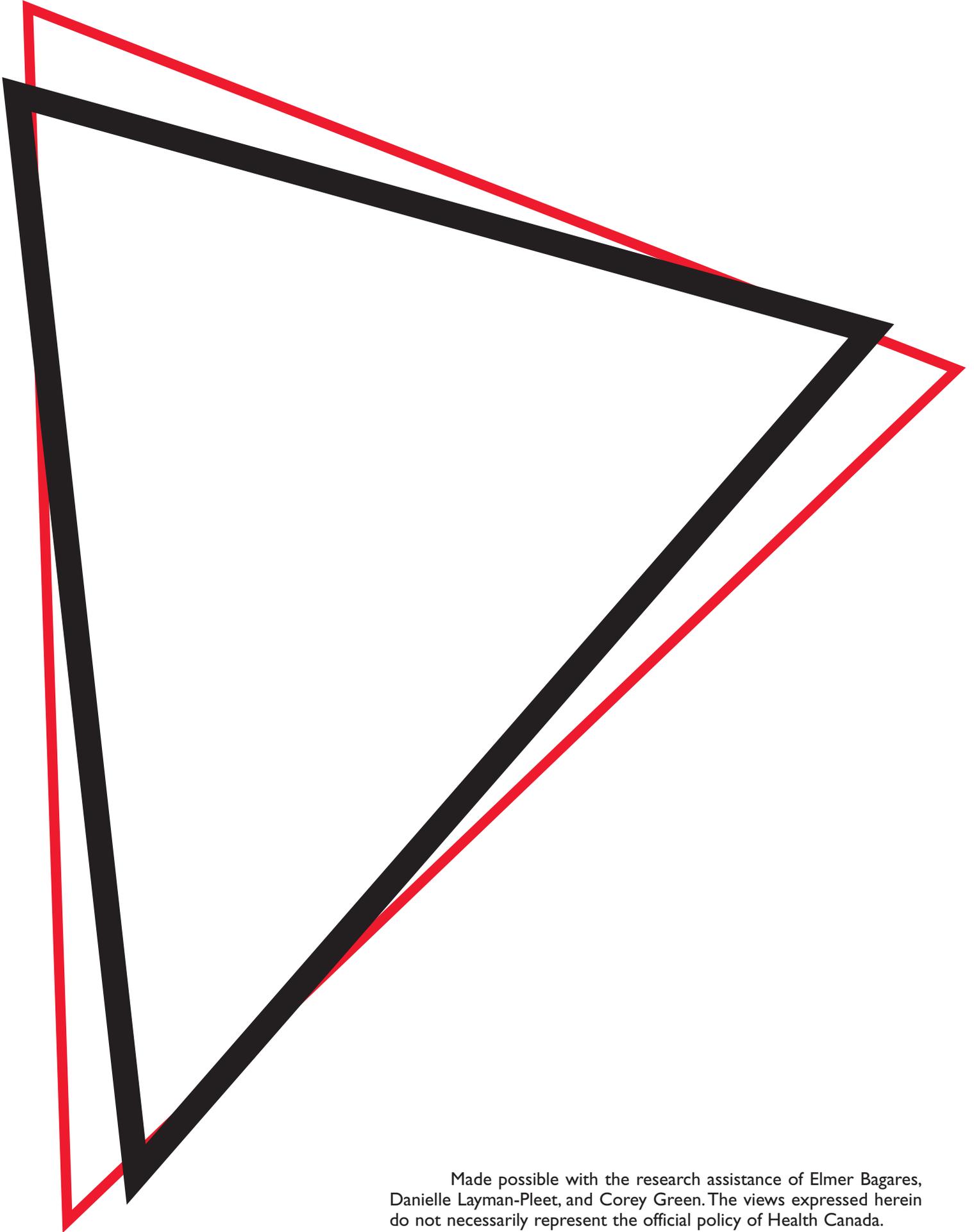
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Financial contribution from the Canadian Strategy on HIV/AIDS, Health Canada



Made possible with the research assistance of Elmer Bagares, Danielle Layman-Pleet, and Corey Green. The views expressed herein do not necessarily represent the official policy of Health Canada.

HIV prevention among gay and bisexual men has been, for the most part, a success story over the last twenty years. Men who have sex with men (MSM) have been one of the populations most heavily affected by HIV disease, and as gay and lesbian communities were among the first to mobilize against the AIDS epidemic, rates of HIV transmission fell precipitously through the 1990s. By the end of the decade, however, transmission rates had reached a plateau, and reports began to appear of worrisome upward trends appearing in several major metropolitan areas of Europe (Dukers, et al. 2001), North America (Kellogg, McFarland and Katz 1999; Ekstrand, et al. 1999; Calzavara, et al. 2000), and Australia (van de Ven, et al. 1998). In the first years of the 21st century, rates of infection of such sexually transmitted diseases as gonorrhea and syphilis have been showing a sharp increase in Toronto and in major cities of the United States and United Kingdom (Kahn, Heffelfinger and Berman 2002; Bellis, et al. 2002) following a decade when transmission rates had fallen so low that some epidemiologists had become cautiously optimistic that syphilis could be virtually eradicated. Depending on the city, HIV-positive men appear to account for 50 to 70 percent of new syphilis cases.

These new trends provoked a good deal of speculation in both the gay and mainstream media concerning “barebackers” and “bug-chasers” as the putative sources of resurgent HIV transmission. Researchers and AIDS service organizations (ASOs) hypothesized that “HIV optimism” and “prevention fatigue” were motives for the new “laxness” in safe sex practice, by imputing motives to MSM based on the fact that epidemiological rates began to rise about the same time that the protease inhibitors were introduced in the mid-1990s. Indeed, the most widely prevailing explanation for rising HIV rates has come to be the “AIDS optimism” hypothesis that claims that gay men are becoming complacent following the introduction of more effective treatments (primarily protease inhibitors), so the sense of urgency surrounding AIDS is declining and there is a reversion to unsafe sex. So rapid and widespread has the AIDS-optimism thesis become that it has almost been converted into conventional wisdom even before the evidence for it is in. A conclusion drawn in this report is that the AIDS optimism hypothesis is at best simplistic, and worse, is misleading in understanding these trends, thereby setting the stage for the development of seriously misguided and ineffective responses to rising transmission rates.

It is in this context that this study, with the assistance of a Health Canada grant, began interviewing gay and bisexual men in Toronto in 2001 and 2002. While the Ontario Men’s Survey (OMS) was at the same time developing a quantitative “snapshot” of the sexual practices of MSM in Ontario, this study was conducting in-depth interviews with “high risk” men and men in couples. With the OMS sketching a portrait of what was going on with (safe) sex among gay and bisexual men as a whole, this study was attempting to find out why some men were having occasional or frequent unprotected sex at this time in the epidemic. This study, then, set out to investigate the narratives of men practising unprotected sex to identify the social circumstances and reasoning processes associated with these events. It recruited three sets of MSM:

- 1 Men who had unprotected sex within six months of the interview date,
- 2 Men who had sero-converted with the last five years, that is, during the period in which HIV rates were moving from a plateau toward an upward trend, and
- 3 Men in couples because one of the clearest findings from HIV research is that men tend to drop condom use as they develop relationships with other men.

Having interviewed a cross-section of MSM (that is both high and low risk men) in the mid-1990s during the plateau period (Adam, Sears and Schellenberg 2000), this study provided an opportunity to identify changes in the ways in which gay and bisexual men are thinking about and addressing safer-sex issues in recent years.

The underlying philosophy of this study is that effective HIV prevention will be possible only if it can engage with social circumstances and reasoning processes of men in their sexual relationships. As this study reveals, neither ignorance, nor obstinacy, nor irresponsibility explain much about unprotected sex among gay and bisexual men today. Most are well-informed, sophisticated calculators of risk, and any prevention message that fails to respect fully the knowledge levels widespread in the community will surely fall on deaf ears. This study shows, as well, that there is no “average gay man” and no single message (or “magic bullet”) that can address the multiple situations and overlapping social and sexual microcultures, each with its own vulnerabilities to unsafe sex. Indeed, one of the striking aspects of hearing gay men talking about their sexual encounters is finding the degree to which ASO messages have been heard, assimilated, thought through, and in some cases “outsmarted” by men attempting to balance risk against a wide range of aspirations and concerns that enter into their intimate relationships. Indeed these interviews show how in some instances, public health and ASO prevention messages unwittingly reinforce discourses that facilitate, rather than inhibit, HIV transmission. One might say that HIV is an opportunistic illness of the predominant discourses of our era just as it is of immune systems.

METHODOLOGY

Study participants were recruited by advertising in the gay press, making appeals at meetings of gay organizations, and through the distribution of recruitment leaflets at gay bars and special events in Toronto. We also invited Toronto-area men with a profile on the website barebackcity.com to participate. The study sought out “high risk” men defined by one of two criteria:

Having had unprotected sex within the last 6 months, N = 51

Having sero-converted within the last 5 years, N=51

A third set of study participants consisted of 70 men in couples, defined as men in a relationship with another man for one year or more.²

Research assistants sought men of diverse educational, ethno-cultural, and social class backgrounds, and made a special outreach to venues and organizations popular with men of colour.

Study participants were typically interviewed³ for 1 or 1-1/2 hours and offered \$30 in compensation for their time and travel expenses. They were asked to call to mind a variety of recent sexual encounters, such as sex inside or outside a relationship, sex in different venues, and safe and unsafe encounters. They were then asked a series of questions about how and why the encounter “worked” for them, and how un/safe sex entered into the

² Five of these interviews were with respondents outside of Toronto, who nevertheless participated in the Toronto gay scene from time to time.

³ Interviews were done primarily by Elmer Bagares and Barry Adam. A few were done by James Murray and Danielle Layman-Pleet.

unfolding of the encounter. Men in couples were also asked a set of questions regarding the development of understandings around sexual openness or exclusivity, and the management of sexual encounters inside and outside the primary relationship. Interviews were transcribed and initially coded by the research assistants. The principal investigator then checked and recoded all transcripts, before carrying out a constant comparative analysis to identify modal responses to each topic.

The demographic profile of the sample is as follows:

EDUCATION	HIGH RISK	COUPLES
Graduate Degree	11	12
University Degree	36	33
Some College/University	39	14
High School Grad	11	8
Some High School	4	3
ND	1	

AGE	HIGH RISK, N=102	COUPLES, N=70
Range	18-66	20-60
Median	34	34

INCOME	HIGH RISK	COUPLES
> \$60,000	11	16
\$40,000-59,999	13	14
\$20,000-39,999	29	15
\$10,000-19,999	27	12
<\$10,000	19	13
ND	3	

ETHNICITY	HIGH RISK	COUPLES
British	20	20
French	6	3
Other European	13	13
Canadian	13	3
African/Caribbean	13	5
Aboriginal	13	1
Asian	12	16
Latin American	10	7
Middle Eastern or Jewish	1	2
Don't Know	1	

HIGH RISK GROUP

SERO-CONVERTING GROUP, N=51		UNPROTECTED SEX GROUP, N=51	
YEAR OF SERO-CONVERSION	NUMBER SERO-CONVERTING	SERO-STATUS	NUMBER
1997	9	HIV-negative	31
1998	7	HIV-positive	15
1999	6	Don't know, not tested	5
2000	10		
2001	11		
2002	8		

COUPLES GROUP

For 20 of the 70 men in couples, we interviewed both members of the couple (i.e. 10 couples), and for the other 50, we interviewed one member of the couple. Since processes of coming to agreement were themselves at issue in this research, we did not want to limit our sample only to couples characterized by high levels of mutual agreement where both partners were willing to agree to participate in research. Forty-six were currently living

together, 22 were living apart (due to work, schooling, or not having “yet” decided to live together), and 2 did not report their current living arrangement.

SERO-STATUS			RELATIONSHIP LENGTH IN YEARS	
SERO-STATUS OF STUDY PARTICIPANT	SERO-STATUS OF PARTNER		RANGE	1-23
	HIV-NEGATIVE	HIV-POSITIVE	MEDIAN	
HIV-negative	37	5		
HIV-positive	15	11		
Don't know, not tested	2			

In the following report, in each section the most common pattern of response is reported first, followed by quotes that give some sense of the variation and nuance among narratives. Quotes from all study participants are accompanied by designation of age category, ethno-cultural background, and sero-status, and for men in couples, with length of relationship as well. When respondents name more than one ethno-cultural category in their heritage, the first-named ethnicity is reported with their quote.

Broad based surveys of gay and bisexual men typically find a wide spectrum of practices, with sizeable portions who consistently do safe sex, men who often or mostly have safe sex but “lapse” from time to time, and men who frequently have unsafe sex or have abandoned safe sex altogether. The high risk study selectively recruited men who fall toward the most unsafe end of the spectrum and is not intended to be representative of gay and bisexual men as a whole. Indeed, in previous work when we drew on a cross-section of MSM, we encountered many younger men who could not comment on condomless sex because they had never had it, and we found older men who had to refer to sexual activity in 1981 or 1982, a time when AIDS was first coming into public consciousness, for the last occasion in which they had had unsafe sex. This pattern emerges as well among some of the men interviewed in the couples study here. Large scale surveys typically find that approximately a fifth of MSM do not have anal sex at all. Others have tried it only rarely or episodically, for example, while in a relationship.

The high-risk men in this study, then, were selected to include only those with recent experience with unsafe sex. While most of the men participating in this study reported multiple incidents of unprotected sex, others commented on occasional or exceptional events when unsafe sex occurred despite general adherence to safe sex norms. We left it to study participants to define what they meant by “unsafe sex.” In a few instances, they mentioned instances of oral sex usually accompanied by an implied question mark, or an explicit qualifier like “if you consider that unsafe sex.” In other words, in the accounts given below, respondents refer to unprotected anal sex when they talk about unsafe sex, unless otherwise indicated. This first section gathers together a series of unsafe events which tend to happen even among those who generally intend to practise safe sex. They are sorted into four broad categories: (1) condoms and erectile difficulties, (2) momentary lapses and trade-offs, (3) personal turmoil and depression, and (4) disclosure and intuiting safety. Issues related to anticipating and building relationships are treated in the next section.

ERECTIONS VERSUS CONDOMS

A sizeable portion, that is about a third of the 102 high risk men, complain that condom use not only decreases stimulation, but often leads to loss of erection. While many of the other two-thirds find it does not inhibit erection, or causes only minor loss of sensation, this number also includes men who consistently assume a receptive role and therefore do not wear condoms themselves, men who do not prefer anal sex, and a significant number who have abandoned condom use altogether and so have no comment on its effect on their erections. In addition, some men who practise receptive sex report that the water-based lubricants required for condom use tend to dry, leading to abrasion. Others experience problems with condom size, either too tight or prone to slippage (that is, presumably too large). Those who have penile piercing essentially find themselves unable to wear condoms as they quickly tear. This man is typical:

It will not stay hard if I put one on, come hell or high water. Believe me, I've tried. So, you know, since I've started having sex, I've basically always had unsafe sex.

(30s, British, HIV+)

In addition to the men who report their own erectile difficulties are those who report them in their partners. The following man was in a relationship with an HIV-negative man.

At the beginning, I said to have sex with a condom because I love him and ...I didn't want to lose him....He told me, "No, I have problems because when I put a condom, my erection, I lose my erection." ... So when he told me "I can't keep my erection with a condom," so I was thinking, "Wow, if I try to use a condom with him, probably things will not work out." And at the beginning I was thinking like this, but then I decide[d] not to continue [the relationship] because I talk[ed] to a counsellor.

(Latin American, 30s, HIV+)

There is no inevitable relationship between erectile difficulty with condoms and unwillingness to practise safe sex.

A condom's important. If it prevents me from having an erection, I'm not sure what would counteract that, you know. Obviously if I lose my erection, well, the other guy is just going to have to understand and, you know, find satisfaction elsewhere.

(30s, British, HIV+)

A few men remark that they have shifted away from taking a "top" role in sex toward having more receptive sex as an adaptation to this problem. These views, however, are somewhat exceptional. Many others struggle between finding enough stimulation and maintaining some condom use.

Recent research in Sydney and Toronto has identified a phenomenon of "delayed condom use" among some gay men; the Polaris study in Toronto found an alarming association between this practice and sero-conversion (Richters, et al. 2000; Calzavara, et al. 2003). These interviews suggest that delayed use, or episodic use during a sexual experience, tend to flow from difficulties in resolving the tension between condoms and erections.

I find this more as I've gotten in my 30s. I find if I'm not into it, once I put the condom on, I can get soft....We'd start with a condom and then if I got soft, I'd take the condom off and I'd put my dick inside and get hard again and then we'd put the condom back on. But sometimes the condom just never came back on.

(30s, French, HIV+)

Similar experiences were mentioned by a significant portion of participants in this study. In some instances, this appears to lead to a pattern of inconsistent condom use, to somewhat "symbolic" but ineffective condom use, or to "pushing the boundaries" of safe sex practice.

It's mutual consent where they want to feel my penis without the condom and I've obliged 'cause I wanted it too...but no ejaculation and then the penis would come back out. Sometimes another condom and sometimes the same condom might go back on and, and then ejaculate.

(40s, British, nd)

About a quarter of the men in the high risk and couples sample remark on some version of ongoing “boundary pushing” practice either in themselves or in their partners, including risk “reduction” practices such as assuming the “top” role in unprotected sex, withdrawal, or not ejaculating in a partner. This is an example of the risk calculus associated with taking the top position in sex:

I met a guy off the internet again and he was over at my place and we were starting to have sex and he asked me to fuck him without a condom and it was fine with me because I wasn't being fucked. I was doing it. And so we did it and then I think it was about two or three days afterwards, we got together again and that's when he disclosed to me that he was HIV positive, which at that time I didn't know that I was. And maybe I wasn't at that time, so that threw me a bit. But he kept on assuring me that, you know, I was safe because I was the top.

(30s, Scandinavian, HIV+)

In the following incident, the study participant considers this sort of episodic use of condoms as critical to his own sero-conversion.

[There was] a maximum of three times where it happened, where we're sort of going at it and doing whatever and kissing and doing everything else and he would have partial penetration inserting into me and it wasn't actual fucking. It was, you know, just sort of going in, okay, let's stop, let's put on a condom, and it went on from there.

(30s, Asian, HIV+)

As withdrawal already has a lengthy and checkered history as a contraceptive method among heterosexuals, it is perhaps not surprising that its effectiveness is less than optimal as an HIV-prevention strategy among gay men.

The tensions and dilemmas posed by condom use are not easily resolved and result in a variety of outcomes. This study participant described a situation where a partner convinced him to assume a top role without a condom.

He literally said, “I want to feel you in me without the condom and then I want you to pull out and put the condom on.” And we got into it andin my head, there's that thought of “Don't. Don't.”...Having unsafe sex with somebody, I can lose my erection once my mind...starts to, you know, ‘don't’. Just shut down. Just, it's gone...we're done here. Pull out, make your apologies, you know, say, “I can't follow through. My...subconscious won't let me follow through. Something about this situation has caused the erection to leave the building.”

(40s, British, HIV+)

Another describes his sense of conflict with a partner who preferred to take the risk of unprotected sex in the top position:

It was pretty traumatic for me that he wanted to take this risk... 'cause I felt so responsible for him only being 18, you know. He's got his whole life ahead of him....I would just hate it if he got it....Whenever we fucked, it was like I always made sure that, you know, I opened myself up first so he never tore me, you know. I took precautions; he wasn't into taking precautions, you know. It was a few times where he just would, you know, ram it in....I didn't understand why he didn't care about himself and why he'd put me in this position.

(20s, Aboriginal, HIV+).

In a number of instances, then, men reported wrestling with a series of dilemmas around condom use: wanting to maintain an erection that refused to cooperate when sheathed, wanting to accommodate a partner experiencing similar difficulties, wanting to avoid exposure to the risk of infection, wanting to assure a partner does not become infected, attempting to keep up some degree of condom use even if consistent use was compromised, and relying on a risk calculus that falls back on withdrawal, taking the top role, or avoiding “tears.” For men who experience erectile difficulties with condom use, these are real dilemmas resolved through actions that may heighten risk.

MOMENTARY LAPSES AND TRADE-OFFS

“Heat of the moment” scenarios are frequently found in the study of unprotected sex and these interviews are no exception. The urgency of passion, and the opportunity to connect with a particularly desirable partner, sometimes facilitated with drugs or alcohol, account for some unsafe encounters.

You’re so caught up in the act that you forget—not you forget, but you push the consequences...to the back of your mind until after the fact it happens. Then you realize that you’ve just risked your life. You can get HIV positive. You can get other sexual transmitted disease so after the accident...reality sort of hits.

(30s, Afro-Caribbean, HIV-)

Another attributes an incident of unsafe sex to

decision-making [having] been blurred due to the lust and the physicalness of the moment.

(40s, Afro-Caribbean, HIV+)

And a third offers a similar account:

I was so aroused and he was well equipped and a good-looking man ..., good body, thin,...I was so, so aroused and turned on by this guy that I threw caution to the wind.

(50s, British, HIV-)

About 15 of the 172 participants in the two studies offer statements of this type in recounting recent instances of unsafe sex.

I did specifically ask him if he had a condom and he said no....I was also really, really horny and he damn well knew it and he also knew that I was really, really high. So... I certainly wouldn’t say that I was out of control. That would just be...blaming someone else for my mistakes so I really think that that’s irrelevant; I was still in control.

(30s, Canadian, HIV+)

Heat-of-the-moment situations can be complicated by “trade off” scenarios where men who feel disadvantaged in some way—be it age, ethnicity, or attractiveness—fear to offend a desirable partner and trade away safe sex lest it prove an obstacle to sexual interaction. This aboriginal respondent felt

unable to assert himself especially with white partners, preferring that they take the lead in sex:

I'm always questioning why anybody would want to, you know, be with me at all, so. And maybe in terms of, you know, searching for that relationship, maybe that's why I put myself in situations [of unprotected sex] where I don't have to worry about those kind of hurt feelings or whatever....The more masculine and a little bit older than I am, the taller, the muscular, that's totally, you know, a better thing, for me anyway, in terms of looking for a partner.

(20s, aboriginal, HIV-)

Trade-off scenarios, then, can index larger social hierarchies that create an economy of risk where a sense of personal neediness, perception of one's own attractiveness, and the wish not to spoil an opportunity heighten vulnerability.

This quote, as well, points toward another complication in sexual interaction. Safe sex is premised on the ability to assert oneself in sexual interaction, yet self-assertion may run contrary to one of the primary significations of erotic connection with men, that of giving oneself over to a partner viewed as stronger and in control (Adam 2000). Preference for partners who are older, taller, and masculine may signal an interest in partners who will "take charge."

PERSONAL TURMOIL AND DEPRESSION

Another set of issues associated with vulnerability to unsafe sex, found here and in other studies (Adam, Sears and Schellenberg 2000; Gilbert, et al. 2000; Semple, Patterson and Grant 2000; Calzavara, et al. 2001), concerns mood state, particularly stress and depression. A combination of stressful factors precipitated a moment of personal vulnerability for several men.

I had a monogamous relationship for 21 years with a man. This was before I was positive. And we had a wonderful relationship and he died of cancer in '89....After he died I was so angry and I was in such an incredible grief and loss response and that's when I overdosed on alcohol and sex and that's how I got infected in 1991.

(60s, British, HIV+)

Another associates an episode of unsafe sex with a series of stressful events.

Very up and down in my world: change of jobs, still grieving, you know, the loss of my partner, change in cities that I was living in, change in homes, selling my home and moving here to Toronto, so a lot of shit going on. Yeah. A lot of emotional upheaval at the time.

(60s, British, HIV-)

Low self-esteem tends to be an explanation for HIV transmission that is especially popular in AIDS service organizations, and some of the narratives offered by study participants draw that link.

When my self esteem is down...or if I'm depressed and just sort of, you know, feeling downtrodden by the world. It's just I...get into that 'I don't care' mode.

(30s, Eastern European, HIV+)

And

Let's say if...I'm feeling, you know, really insecure and this guy is a really hot guy and he just wants to have sex, I won't even think about using a condom, if he won't... think about it....I know that's playing dangerous. I mean, the thing is I'm honest upfront that I'm positive.

(30s, Middle Eastern, HIV+)

HIV prevention messages implicitly exhort people to act safely now in order to preserve themselves for the future. HIV disease is a relatively slow-moving disorder; even left untreated, it may be a decade before life-threatening symptoms of AIDS come about. To be effective, then, the prevention message calls on an autobiographical narrative that life is worth living, and that something done now makes sense because the future will be a desirable place to arrive in. Yet depression and personal turmoil can pull away the underpinnings of this belief. If life does not seem like worth living now, and the future appears bleak as well, then self-preserving actions no longer make so much sense.

Having a relationship is one of the things that can figure prominently in personal narratives about the value of life and of the future. When a current relationship is in trouble, or prospects for a new relationship seem grim, the autobiographical narrative to which prevention messages appeal may crumble.

Any time I'm down like especially when...I felt like something was going wrong [with partner] and I needed somewhere to think. Don't ask me why I ended up at the bathhouse, but that's where I always end up going....I keep saying, if it's something that's not wrong with me, why he's leaving me? Or I'm that repulsive that nobody really wants me, you know. At least, when you go to the bathhouse and then, you know, people be going in after you, it sort of builds up your self-esteem.

(30s, Afro-Caribbean, HIV+)

Similarly,

I feel that people like me who are looking for a relationship and who sometimes feel very depressed about not having [one] and feel very lonely, when it actually comes to performing the sex in that situation,...[they] give in...even if the condom is not there.

(30s, South Asian, HIV-)

Depression also appears as a factor in studies of adherence to therapy for HIV disease (Ferrando, et al. 1996; Singh, et al. 1996; Gordillo, et al. 1999; Holzemer, et al. 1999; Kalichman, Ramachandran and Catz 1999; Singh, et al. 1999; Adam, Maticka-Tyndale and Cohen 2003), and for similar reasons. Taking an onerous and long-term regimen of drug therapy relies on the premise of preserving oneself for a better future, and thus on autobiographical narratives that give coherence and meaning to the self through time. In times or situations where that premise is missing, adherence is not guaranteed to “make sense.”

About a tenth of the men in this study account for high risk activity in terms of personal turmoil or depression.

DISCLOSURE AND INTUITING SAFETY

Unprotected sex also happens through more intentional processes. There are still some men (four in this sample) who comment on using intuition or the interpretation of cues and signs in an attempt to discern the sero-status of a partner. Some seropositive men disclose their status regularly as a prelude to unprotected sex, giving partners the option to continue, withdraw, or employ a condom. Both of these strategies make some attempt to bring sero-status to the fore, and to establish sero-concordance as a reason for dropping protected sex. Only in a very few instances do sero-negative men ask their partners' sero-status, and drop condom use with a partner who assures them he is also HIV-negative.

It's gut feeling and also asking them about their sexual history and I guess, a level of comfort with that person.

(30s, French Canadian, HIV-, 5 years)

Two men preface their remarks by labelling reliance on intuitive strategies as "stupid," but nevertheless confess to having done so from time to time.

It's a stupid thing but if I kind of know that is a person that is HIV negative or young, there [is]...more chance of being HIV negative....And if you're feeling comfortable...When I go to their place, I use the washroom, I check the cupboards to see if they have like lots of medications. If they have lots of medication, the chance [is] that they are on HIV medication. And I look at the face and you can kind of see that they are HIV positive.

(20s, South Asian, HIV-, 2 years)

I guess I have this stupid unwritten rule in the back of my head that somebody who is with me is not out there having sex with other people, 'cause most of the guys that I go for don't usually. And for example, I've had the same fuck buddy for the last 10 years and he hasn't been with anybody else.

(30s, Afro-Caribbean, HIV-)

The attempt to discern another man's sero-status soon falls back on the stereotypes and semiotic binaries that have circulated through the press and the public throughout the history of HIV disease: youth, ostensible heterosexuality, or inexperience may be read as signs of low risk status.

He said, "I'm married and I just lost my wife and I'm also like just new to this game. I was married and everything." And I just trusted him and I had sex with him without condom.

(20s, east Asian, HIV-)

Indeed, the "know your partner" advice propagated by some public health authorities may be a significant contributor to unsafe practices by encouraging people to exempt themselves from the need for safe sex through "reading signs" of their partner's putative "safety."

A few HIV-negative men, then, employ intuitive approaches to try to figure out the sero-status of prospective partners. A minority (ten in this sample) of HIV-positive men assert their sero-status right away as a way of warning prospective partners.

I mentioned it at the bar. That's the way I am. When I meet someone and...there's a good chance that we're going to end up doing anything, I'm right up front with it.

(40s, French Canadian, HIV+)

Many of the HIV-positive men interviewed here considered sex with condoms unnecessary with other positive men, but a priority with negative men.

My choice of partners is by far preferentially HIV positive and I'm always declaring my status up front, even with a complete stranger if we're going to have anal sex. And, you know, if required, we're going to use latex, sure. So I always, I always declare it, I always negotiate.

(60s, British, HIV+)

Some positive men feel quite strongly about making sure that HIV-negative partners practise safe sex with them.

I always disclose my status before I have sex. So I can't physically have sex with someone without disclosing it. It just doesn't work.

(20s, Afro-Caribbean, HIV+)

If you're poz and you don't want me to use a condom, fine. If you're otherwise, like the condom goes on....If I don't know what your status is...I suppose I could be callous and cold and, like, fuck you anonymously and bareback and it's like I'll never see you again...but I'm not generally that way.

(20s, Aboriginal, HIV+)

In most cases, positive men believe that disclosure is enough and that a prospective partner will then take appropriate precautions if negative. Though rare, there are a few instances of positive men reporting that negative partners refused to use a condom after having been told.

I told him "You know, well, I'm HIV positive, you know. This is your risk if you don't use a condom." And he said to me he didn't care. He didn't like using condoms. He had sex with some people that are HIV positive and what not, so I was like, "All right. Well, it's your decision."

(20s, British, HIV+)

These few instances appear to involve HIV-negative men with erectile difficulties and men who have "gotten away" with having sex with positive men, especially in long-term relationships, without sero-converting and who have acquired a sense of invulnerability as a consequence.

Just two HIV-negative study participants mentioned using disclosure to try to find other negative men with whom to have unprotected sex. Inclusion of his sero-status on an internet profile met with rejection by other men.

I actually put in my ad on barebackcity.com that...I only wanted to sleep with guys bareback, guys who are negative. I got emails, I got at least 25 emails from guys saying, "Who the fuck do you think you are saying that you only want to sleep with negative guys?" and..."I would never fucking touch you because, you know, you're one of those negative guys who thinks that they're so hot."

(30s, Afro-Caribbean, HIV-)

The other HIV-negative study participant interviews his partners extensively in an attempt to ascertain their sero-status. He speaks lyrically of his desire to be inseminated and describes his attempt to reconcile insemination with safety this way:

It just is a tremendous physical sensation of feeling that symbol of manhood inside myself, inside my ass, inside my body. In some cases it's a huge high.

(40s, Jewish, HIV-)

Yet he remains well aware of the risks associated with this pleasure, and refrains from pressuring partners who prefer safe sex:

I know I'm playing Russian Roulette but I do try to make an educated guess about the people I do it with. I'm not completely indiscriminate. I do ask that they be negative. I'm aware that they could lie but I'd like to think that in most cases they don't. I tested negative...so far I've been okay...I'd never have pressured them to do it if they're not into it. They'd rather fuck me with a condom? That's okay. It's always okay.

Disclosure, then, may be used as a warrant for having unprotected sex. As will be discussed further below, disclosure grounds itself on a particular vision of the sexual actor that has considerable resonance with moral reasoning in the larger society but which is nevertheless problematic in real sexual interactions.

RELATIONSHIP BUILDING

Perhaps one of the most consistent findings in HIV research is the tendency of couples, whether homosexual or heterosexual, to shift away from safe sex over time. Susan Kippax (1993) coined the term 'negotiated safety' to refer to a process whereby couples first ascertain their sero-status, and then if sero-concordant, proceed through mutual agreement toward unprotected, but nevertheless, safe sex by assuring that HIV transmission could not be at issue. This model of relationship development does occur for many male couples, and some develop complex agreements over time to minimize HIV risk. But this version of negotiated safety depends on a degree of open communication and deliberative rationality that is not characteristic of many relationships. Rather, the shift away from safe sex occurs as part of a set of tacit communications concerning romance, trust, and caring that "just happen" without all of the elements of negotiated safety being in place.

Safer sex decision making in couples often becomes caught up in presumptions and expectations about monogamy, and as monogamy is frequently presumed to be the "proper" way to conduct relationships, it generates a logic that paradoxically creates new opportunities for HIV transmission. As Elisa Sobo (1995) notes in her study of African American women, monogamy discourse may set a trap that blocks the adoption of safer sex practices and can lead to the denial of factors that expose women to transmission. While the monogamy script is less dominant among the men interviewed here than among Sobo's sample of women, where it does arise, it carries a similar romantic discourse that undermines the need to practice safer sex. Unprotected sexual practices may themselves come to be read as a primary sign of the special trust that partners in a couple have

for each other (Silvestre, et al. 1989; Bartos, McLeod and Nott 1993:52; Bartos 1994; Hospers, Molenaar and Kok 1994; Ames, Atchinson and Rose 1995; Flowers, et al. 1997), thereby inhibiting partners from adopting protection lest it be read as an accusation of infidelity.

RELATIONSHIP ANTICIPATION

Anticipating that a relationship will occur, or identifying a new partner as “boyfriend material” is enough to motivate some men to drop condom use as a sign of the seriousness of the relationship.

Situations I have unsafe sex is when I am looking for relationship with that person or I’m looking for a continued boyfriendship with this person. It is during that time it is more likely for me not to use a condom....I will not use a condom if there is hope of—if he shows an inclination of making me his boyfriend or having a relationship. Only then. Otherwise, even if Tom Cruise stand[s] before me, I’ll use a condom.

(30s, Asian, HIV-)

The intensity of a new relationship and an implicit belief in it being monogamous can create the conditions for leaving condoms behind.

We always did it bareback because, I mean, at the time when we were having sex, we anticipated that each one of us wasn’t having sex with anybody else. And to the best of my knowledge we weren’t until 2001.

(40s, Afro-Caribbean, HIV-)

In this instance, the progression toward dropping condoms was so strong that it overcame concerns that the pair was in fact sero-discordant. Having “gotten away” with it in a previous relationship, the sero-negative partner showed a willingness to avoid condoms in this relationship, relying instead on taking the “top” role in sex.

We used a condom on the first night, or the first few times we dated, two and a half years ago. Then we just, I think we didn’t have one, one time and then we just decided that we would go ahead and do it and ever since, we haven’t used condoms. I’m HIV [positive]. His former partner was HIV, and they used to have sex so, he was not concerned for his risk factor being that he was the giver. I was head over heels in love and felt that it was a forever thing. and... so, I wasn’t too worried about it.

(30s, Canadian, HIV+, 2^{1/2} years)

Several study participants sero-converted during the early stages of relationship development.

I had a relationship with a guy who was a flight attendant and I fell in love with him so much. Well he told me that he was okay, he was healthy. So I don’t know how it happened, but it happened and we had sex without condom and all the relationship was without condom, without condom, without condom and then I found out I was HIV positive. So when I find out that, I didn’t say “Oh, he’s a guilty,” because no [one’s] guilty. So it was my fault, you know. ...It happened. So I have to face it.

(30s, Latin American, HIV+)

Protection against risk is intuitively easier when a partner is not well known or a stranger; romantic engagement and the promise of intimacy is harder to reconcile with the perception of a partner as posing some kind of risk (Joffe 1997).

MONOGAMY DECISION-MAKING

Sexual exclusivity may become a fundamental part of a relationship. Though its implications for HIV prevention usually play only a small part in the decision to adopt monogamy, it is perhaps the best known way, apart from abstinence, to limit HIV transmission. Two men participating in the couples study state their views this way:

We don't have sex outside the relationship....We both sort of share the same value system.

(20s, Irish, HIV-, 1 year)

We don't have it [sex outside of the relationship]. That's our understanding. If there was any cheating, it's over.

(30s, German, HIV+, 3 years)

About a quarter (18 of 70) of the men interviewed in the couples study reported having a sexually exclusive relationship. In other words, sexual exclusivity is not an organizing principle for a large majority of men in relationships. Monogamy often shows itself in the speech of study participants as an accomplishment, rather than a presumption, and as a provisional rule-of-thumb subject to revisiting. Monogamy is often counterposed to an active consideration of alternatives in the narratives of men in relationships. Referring to a past relationship at a time when he was HIV-negative, this study participant remarks,

Initially we always had protected sex and then at some point we discussed monogamy and we both felt confident in the other person, that we could trust the other person, that if ...we both tested, we both were negative and we both trusted each other that we could have unsafe sex until such time as something happened, an extramarital affair or something like that, or extra-relational affair, and in which case we would have to renegotiate things.

(British, 20s, HIV+ at time of interview)

Among the men in this study, monogamy scripts appeared most commonly among younger men, men new to gay relationships, and among men whose formative years have been in cultures with limited or absent autonomous gay worlds. A policy of sexual exclusivity prevailed especially among men in the "honeymoon" phase of their relationship, that is in the first two years. Sexual exclusivity provided a context for foundation-building in relationships, and time for the development of mutual trust. Some couples found monogamy worked for them over the long term, but it was contested in many others who treated it as a passing phase, developed "exemptions," or struggled to arrive at new accommodations.

Monogamy may work, then, as a safeguard for some couples against HIV transmission, but it can also act as a semiotic snare (Adam, Sears and Schellenberg 2000), setting up the conditions whereby vulnerability to HIV may be increased. This man explains:

I think my partner assumes like, monogamy, which I also do. I know that the reason why, say, we're having unprotected sex is because he guarantees to me that...we're in a monogamous relationship...I hate to see all that trust that he put on me. It's like, but if I fool around with someone else, you know, I'm obviously not going to say anything.
(20s, southeast Asian, HIV-, 2 years)

A semiotic snare refers to a message where a well-understood but unspoken subtext undermines the overt thrust of the message, and includes: self-negating propositions in AIDS education messages, unintended meanings that contradict overt messages, and safety messages that promote self-exemption, thereby creating more unsafe practices. Monogamy discourses can have a self-negating outcome, as an ostensibly safe strategy nevertheless leads to the abandonment of condom use.

If it was my choice, I would prefer to use condoms...but when I bring up the subject about wearing condoms, he come up with, "Okay, why? Are you doing something with someone?" So the fact that I want to use condoms, for him, means that I'm doing something with someone....It's really stupid, though.
(30s, other European, HIV-)

The monogamy presumption, then, makes it more difficult to introduce condom use inside a relationship, thereby heightening the risk to both members of the couple should an unsafe encounter occur outside the relationship.

RISK MANAGEMENT IN COUPLES

The seventy men interviewed for the couples study (along with several more men in the high-risk study who were in fact in long-term relationships) show a wide spectrum of approaches to HIV risk. This section reviews two broad categories of risk management in couples: (1) couples who do not practise anal sex and couples who employ condoms for sex both inside and outside the relationship, (2) varieties of negotiated safety, and then notes some of the difficulties experienced by couples of mixed sero-status.

With a large majority of this sample of men in couples not organizing their relationships around sexual exclusivity, risk management remains a salient consideration. More of the couples in this sample had experience with three-way encounters than with sexually exclusive monogamy, but the range of relationship arrangements is highly diverse (Adam 2003). Some couples had sex with other men as couples, others as individuals apart from their primary partner. Some couples practised "full disclosure" of all their sexual activity, others had little disclosure. Many couples had explicit or tacit "understandings" about when and where sex outside the primary relationship could occur.

LOW RISK STRATEGIES

Ten of the seventy men in the couples study mention that they have never had anal sex with their partners, or had tried anal sex but were no longer

doing it. Another twelve report using condoms inside and outside the relationship. Consistent condom use with both the primary and casual partners appears to be most common among men in relatively new relationships, in relationships of mixed sero-status, and among HIV-positive men who wish to avoid the risk of “super-infection” through unprotected sex with a sero-positive partner.

NEGOTIATED SAFETY

About 15 of the 70 men in couples in this study followed the general prescriptions of “negotiating safety.” This story is typical:

We haven’t used condoms. We were both tested fairly early in the relationship and he’s never been with a man before, so ...we both got tested and since then basically we’ve had unprotected sex.

(30s, French, HIV-, 1 1/2 years)

Some couples “do it by the book” ascertaining and building in safeguards before dropping condoms.

About four or five months after we started our relationship, it was something that we both considered and...we had established that we were in a monogamous relationship and it was something that we were both interested in—having sex without a condom—and so we both went to get tested for HIV and the results were negative, and so after some discussion on not having any sexual relationships outside—that it would be just the two of us, and if anything did happen, that we would talk about it—then we started to have sex without a condom.

(20s, Latin American, HIV-, 1 1/2 years)

In these instances, the couples are monogamous. In others, negotiating safety means permitting unprotected sex within the relationship but maintaining a cordon sanitaire around it by applying protective measures outside of it.

When I said to you that I never have sex without a condom, this is if I do it outside of my relationship with my partner, but with my partner I do not use a condom.

(40s, Latin American, HIV-, 4 years)

Almost as common is a move away from condom use that flows from familiarity, trust, or a partial “negotiation.” Men encountered in the high-risk study who drop condom use, or never used a condom, in anticipating a relationship, we find in the couples study, somewhat farther along their relationships. It appears that while movement away from condom use is a frequent occurrence as relationships progress, the introduction of condom use later in a relationship hardly ever happens. In other words, those who begin their relationship without condoms nearly always continue without them.

ASYMMETRIC RELATIONSHIPS

Men with partners with a sero-status different than their own are not

immune to the influences experienced by sero-concordant couples. Many, of course, take measures to prevent HIV transmission.

I never do anything where there would be a chance of body fluids. My partner is not positive. We have never had sexual intercourse without a condom. I have never come in his mouth. If I have a cut or a bruise in the finger or what not, I would never put my fingers inside him. But I've been with him five years and he has managed to stay negative.
(36, Latin American, HIV+, 5 years)

Barry Adam and Alan Sears (1996:87-88) remark in an earlier study of people living with HIV disease:

The asymmetric test result violates a fundamental property of couples by rupturing their sense of a shared fate in its designation of one partner as marked by a life-threatening disease and as a potential threat to the other. In some sense, the HIV-negative partner may seek to abstain from confirming this script by refusing to comply with this stigmatization of his or her partner through failing to protect him- or herself from the imputed threat of infection.

Several men in these studies report sero-converting while in a relationship, and several more report sometimes occasional, sometimes frequent, instances of unsafe sex with a sero-discordant partner. There is a wide range of circumstances in which unprotected sex occurs; in many instances men in couples comment on issues similar to those who are single. Two HIV-negative men accede to unprotected sex with positive partners with erectile difficulties. Two HIV-positive men find their negative partners reluctant to use condoms, having acquired a sense of invulnerability from not sero-converting in a previous asymmetric relationship. Another believed he had “negotiated safety” with his partner but later found his partner sero-converted while sojourning in another country. Yet another couple relied on reducing risk by having the negative partner stay with the top role, but:

the last time was about eight months ago, and I told him, “No more. We can't do that. We know that it's lower risk because it's you doing me and not me doing you but I just don't like taking the risk.” I don't like holding my breath when he goes every three months for his test 'cause he does go every three months and get tested and knock on wood, it's been negative so far.
(30s, Aboriginal, HIV+)

In a handful of cases, inconsistent or infrequent condom use inside the couple appears to carry over in practices with additional partners.

“BAREBACKING”: DEVELOPMENT OF A MICROCULTURE OF UNPROTECTED SEX

Unplanned unsafe sex, then, arises in a variety of circumstances: as a resolution to condoms and erectile difficulties, through momentary lapses and trade-offs, out of personal turmoil and depression, and as a byproduct of strategies of disclosure and intuiting safety. But much more evident today than in the mid-1990s are those who have stopped safe sex altogether. Scott O'Hara (1997), who may have been the first to write about “barebacking” in his book, *Autopornography*, talked of a recaptured sense of freedom on becoming HIV-positive in being able to return to a sexuality no longer constrained by the fear of infection. O'Hara was clear in his use of the term ‘barebacking’ as referring to sex among HIV-positive men only; he tattooed “HIV+” on his shoulder to warn all potential non-positive sexual partners of his status. Since that time, barebacking has become a more amorphous word, at times standing in for virtually any kind of unprotected sex, but often still retaining a sense of intentional condomless sex. In this study, it is noteworthy that about a quarter of the 102 men in the high risk sample (and a few of the men in the couples study) invoked the language of barebacking in explaining their own generally consistent lack of condom use. Nearly all of the other men rejected or even resented the possibility that ‘barebacking’ could be thought to typify their practices, questioned the meaningfulness of the term, or stated they had not encountered or did not understand what ‘barebacking’ meant at all.

This section explores some of the characteristics of men who have abandoned safe sex altogether, and examines the moral reasoning around their practices. While barebacking has come to be treated as something of a scandal in both the gay and mainstream presses, those who see themselves as inside the category do construct themselves as responsible citizens and offer accounts of their behaviour that are remarkably consistent with leading strands of moral reasoning circulating in society at large.

All of these men are HIV-positive, and in many cases have been for many years. They have an average age four years older than the age of the high risk group as a whole. They are, then, at the confluence of several factors associated with problematic condom use and with the tendency to “push the boundaries” on safe sex. Age has an association with a lessened ability to maintain an erection in some men, and research evidence suggests an association between HIV disease and diminished sexual function, and between anti-HIV medication and sexual dysfunction (Colson, et al. 2002). Years of unsatisfactory experience with condoms create some of the conditions for abandonment of protected sex in general. In addition, HIV-positivity is not just an individual status. Many of the participants in this study speak of years of participation in support groups, the development of friendship networks with other positive men, seeing other positive men regularly on the street, sometimes living in subsidized housing where most of the tenants are positive, participating in internet websites and chat rooms with other positive men, and frequenting bars and baths where they have become accustomed to recognizing other positive men. Over time, they begin to speak of shared perspectives and tacit understandings that inhere in interactions with other men. In these conditions has emerged a culture of positive sexuality and the foundations for a barebacking microculture.

These men, then, often experience several conditions that lead toward diminished sexual satisfaction and more often express a variety of condom difficulties. These two HIV-positive men talk of defining events in the struggle to resolve the tension between condoms and erections which precipitated unprotected sex:

He tried to use a condom but he couldn't keep a hard-on so he skipped the condom. I remember feeling alarmed and then I thought, well where am I? I'm in a bathhouse in Oakland, California, and do I have an obligation to tell this guy my [HIV+] status?...I don't know if I did the right thing or not, but I do know that I grappled with it.
(30s, Canadian, HIV+, 8 years)

A very similar event is reported by this man:

Does using a condom affect keeping an erection? For me absolutely. I've heard many people express the same problem. I remember one night at the baths, a fellow came in and he was going to use a condom, as soon as he put the condom on he said, "fuck this," and threw the condom away, so obviously he was having a similar type problem and I don't know how universal it is or isn't.
(60s, British, HIV+, 13 years)

HIV disease has had a very real impact on the sexual repertoires of gay and bisexual men over the last two decades. While men who practise safe sex now rarely express an interest in, or say they miss, sexual experiences centred around insemination, some men who have stopped practising safe sex use almost rhapsodic language to describe the discovery, or rediscovery, of eroticism denied by condoms.

[With condoms] you just don't have that energy flowing. It blocks that flow, that energy and it's just not the same no matter how intimate it is and how loving it isIt's on my conscience, you know, if something should happen, if he should become positive then... I...deal with the guilt feelings of it....The way that I felt as well, when I was younger before I was positive that ...when you're dealing with love and that kind of intimacy it's worth the risk....What's life worth living if you're not experiencing that part of life? It's such a special part of who we are and what we are as human beings.
(30s, Canadian, HIV+)

Sexuality, of course, is as much cultural, as it is physiological. The valuation and development of sexual practices occurs in particular social venues and networks over time. While there is clearly no single set of practices or meanings about sex shared by all gay and bisexual men, these networks constitute micro-cultures which nurture and enhance particular visions and discourses about eroticism. The revaluation of insemination is one of the elements that characterize those who now feel free of the fear of becoming HIV infected.

Swallowing during oral sex [is] like a fulfilment, almost like a perfection, you know, where something is done, it's complete; we're two people who shared an incredible passionate moment.
(30s, Middle Eastern, HIV+)

These conflicting discourses about health, pleasure, and sexual communion may collide and require sorting out in different ways according to time and place.

I liked it, not using the condoms 'cause it was a risk, you know, but now I look back on it and it was stupid. It was really dumb...but, I don't know, it's kind of like a rush, you know, knowing that you have somebody else's cum inside of you.

(20s, Aboriginal, HIV+)

Compare these views to the sense of closure, resignation, and loss expressed by this man:

Why would you even want to come up some guy's ass anymore knowing you have no idea what disease, STD, or otherwise is there and again, why would you swallow loads from complete strangers not knowing anything about them and it's just that I guess once the message is pounded into your head a hundred thousand times over twenty years that sex is death and come is death, ...who's ever going to be intimate? I can't see it happening.

(Afro-Caribbean, 30s, HIV+)

HIV education has asked gay men to transition from one erotic mode to the other, and there is a new generation, many of whom have never tried unsafe sex and for whom related sexual practices have never become part of their sexual repertoire. For many, the project of reconstructing an eroticism inclusive of safer sex has been successfully realized, but profound changes of this kind are not necessarily easily made. This respondent throws into relief the transition he has made from one mode to the other.

Before I was positive I found that [insemination] to be very erotic, and a certain closeness from that, but since I found out I was positive,...I prefer...not to have sex without the condom, so it's irrelevant, like it doesn't even factor into my sexual life now.

(30s, Métis, HIV+)

MORAL REASONING AROUND UNSAFE SEX

For this subset of men who have left safe sex behind, "raw" or "bareback" sex is justifiable through a rhetoric of individualism, personal responsibility, consenting adults, and contractual interaction. Used to being part of networks of men who are already HIV-positive, those who employ the language of barebacking typically presume that prospective partners will be "in the know," that is, they will be fully knowledgeable about HIV risk, they will be adult men capable of making informed choices and of consenting after having weighed all relevant risks, and often enough they will be HIV-positive themselves. Few, if any, actually insist on unprotected sex; they are nearly always willing to respect partners who prefer to use protection. But if a condom is not produced by a new partner, there is a ready-made explanation projected into the sexual interaction that allows unsafe sex to occur.

There are, then, a set of qualifications presumed to be in place that give warrant for unsafe sex. One of them is that a partner will be well-informed.

Interviewer: Would you have sex with someone who wasn't educated around HIV? Respondent: No. No. No. Because then that means that if they're saying, "Okay, well, let's have sex without a condom," [then] I don't care. But they can't tell me something about HIV? Well then, no, no.

(20s, British, HIV+)

Age may be read as an indicator of "having been around."

Generally it's [unsafe sex] with older guys,...if they're "uninhibited" quote-unquote like on the web or whatever, that seems to open up a lot or take away a lot of inhibitions.

(30s, Scandinavian, HIV+)

This man avoids any implication that his unprotected sex with an HIV-negative man may be exploitative by explaining that his partner was "older" and informed.

So he knew that I was positive and he was conscious of the situation. So I don't feel guilty about that because he knew. He's older than me and, you know, that's the situation.

(30s, Latin American, HIV+)

And finally willingness to practice unsafe sex may be read as ipso facto evidence that a partner "must be" positive.

If somebody's willing to have unsafe sex without the discussion of protection, I just assume that they're HIV positive.

(30s, French Canadian, HIV+)

Some men rely on sometimes highly subtle clues to impute the seropositivity of a partner, or to communicate to a partner that they are already sero-positive. In one instance, an HIV-negative man recalled encountering an acquaintance in the lobby of a building who asked him where he was going. The narrator said he was visiting his boyfriend, at which point the acquaintance remarked that his boyfriend must be HIV-positive because the building was a well-known place where many people with HIV live. The boyfriend had apparently presumed that his address automatically informed new partners of his seropositivity. In another instance, an HIV-negative man was "reminded" after several weeks by his new partner that the partner had already told him that he was taking a certain medication which he presumed "everyone knew" was a treatment for HIV disease, though the meaning or implication of the medication had escaped the sero-negative man at the time. As well, several men practising bareback sex remark that there are certain venues where it is "well known" that unprotected sex is to be expected, yet none of the men outside of the barebacker group remarked on this or apparently "knew" this to be the case.

In many ways, these accounts for unsafe sex participate in the moral reasoning widely propagated by government and business today that constructs everyone as a self-interested individual who must take responsibility for himself in a marketplace of risks. It is perhaps also a particularly masculine discourse in its evocation of the norms of competitive individualism where neither nurturance nor care for community can be expected of oneself or for oneself.

When you consented to it...if your other partners were willing to participate, it [condomless sex] was just a given. I just assumed that they take responsibility for their actions if they're willing to go along with it.

(30s, French Canadian, HIV+)

Once another man's informed consent has been attained, both his actions and the actions of the self move beyond reproach:

I said, "I'm positive. It's, you know, your ball game then. No problem." And he said, well, his quote was, "I'm a top and I have less risk of catching it." All right. And I said, "Well, that's your choice. It's a high risk. It's always your choice."

(30s, Métis, HIV+)

Legal, contractual discourse is pervasive in our society from the marketplace to marriage to the norms used to determine when research is "ethical." Adam Smith's "invisible hand" governs not only the capitalist market but sexuality in this construction of human nature and human interaction.

In my mind, I got to look out for number one. You got to look out for number one, and while I'm looking out for number one by using a condom in a way I'm sort of helping; I'm sort of protecting you at the same time.

(20s, Northern European, HIV+)

But faith in individual responsibility as a primary value gives equal warrant to unprotected sex. One interviewee neatly summed up several of the premises underlying unprotected encounters in this way:

If there's anything about the individual that I think...they might be misunderstanding something or not knowing the whole score—somebody who's really young...but if I think they're just acting irresponsibly...that they don't realize what they're doing, I'll make a point of, you know, disclosing and, and much earlier on. If there's any kind of language barrier or if I think somebody just doesn't understand, I'll make more of a point. But generally the age group that I'm attracted to...they're all guys over 30...and a lot of the guys who are over 30 who go to the bath houses on a regular basis, who live in downtown Toronto are already positive and if they're not positive, they're smart enough to take care of themselves.

(30s, Canadian, HIV+)

Like the neoliberal rhetoric of which it is a part, this form of moral reasoning has many blindspots and limitations, whether it is circulating in government, business, or civil society. While ostensibly democratic, respectful, nonjudgmental, and non-coercive, it denies the existence of vulnerability, naïveté, or simple human error. It also absolves those "in the know" of any responsibility to be one's "brother's keeper" and in fact shifts "responsibility" foursquare onto the other, often without admitting what is being done. In their own words, the same core logic appears again and again:

I respect whatever the guy wants regardless of whether he's positive or negative. If he wants it wrapped, it's wrapped and if he doesn't, you know, that's fine too...If a guy asks me whether I fuck bare or wrapped

I usually say, “Your call. Whichever way you want is okay with me.” (50s, Canadian, HIV+)

- 2 I was assuming that everyone is HIV positive and, you know, they have to protect themselves and the onus is on them, I would say. (30s, British & Latin American, HIV+)
- 3 I’ve not really ever used condoms for such a long time that I...pretty much consistently bareback....I’m usually pretty up front when I meet people that I prefer to bareback, you know, and if they want me to use a condom I will....Honestly almost exclusively I bareback and the only times that I don’t bareback is if somebody specifically asked me to use a condom....I would say, like nowadays almost all of the sex is raw. (30s, French, HIV+)
- 4 Obviously I’ll respect the wishes of whoever I’m having sex with. If they so desire to have safe sex, we’ll have safe sex. If they don’t, if they’re willing to go there [unsafe sex], I’ll participate in that as well. (30s, French Canadian, HIV+)
- 5 *So the option is up to the other guy?* Basically, yes, that’s very good, I like that -it’s up to the other guy. If the other person wanted to, yeah, it’s okay...I don’t like the feeling [of a condom]. (60s, British, HIV+, 13 years)
- 6 That’s your prerogative, you know, like, if you’re willing to, great. Otherwise, then yeah, we can use safes. (50s, French, HIV+)
- 7 I think everyone has to take...responsibility for their own acts. (30s, Latin American, HIV+)
- 8 We’re very honest about our HIV status and if they don’t want a condom, again, they’re in our house, we’re there to please them you know? If they want a condom we put a condom on, if they don’t, we don’t use one. (20s, American, HIV+, 2 years)

Indeed one of the basic tenets of HIV prevention has been to warn everyone to act as if everyone else is HIV-positive. It is a message that implicitly hails an HIV-negative audience to practise self-protection; but it also circulates back as a justification for precisely the opposite practice, that is, as a warrant for HIV-positives to leave safer sex behind.

I think in the year 2002 everyone should go on the assumption that everybody is positive and if you’re out there playing, you should assume that that person is positive and not negative because the chances are more likely that they’re positive than negative.

(60s, British, HIV+, 13 years)

It must be stressed, against the panic icons of “barebackers” and “bug-chasers” circulating in the press and in popular discourse, that none of these practices nor the moral reasoning associated with them, overtly intend HIV transmission to happen. No one expressed any willingness or acceptance of the idea of knowingly infecting a partner. When the premises of individual responsibility are knowingly absent, many express a strong reluctance to allow unprotected sex.

If they want to bareback right away, I usually ask if they're positive....I usually say I prefer not to if you're negative and I'm positive and they want me to fuck them. And then, you know, sometimes they'll say, "Well, you don't have to come inside me." And I say I just prefer not to. (40s, Canadian, HIV+)

Or again,

If I play with negatives, as I say, safe is mandatory. (60s, British, HIV+)

Some talk of an actual mental or physical block to continuing forward once the justifications for unprotected sex are missing.

I need to know whether you're positive or negative because I don't ever want to infect a negative person. It doesn't mean I don't have sex with negative people, but I take the necessary precautions.... Once the discussion is made, then if I'm free of mind, then I can actually function properly. If I'm not, I'm not comfortable, and then I can't have sex. (20s, Afro-Caribbean, HIV+)

Virtually all HIV-positive men know that coping with HIV disease is onerous, and hardly anything to be wished on someone else.

- 1 I mostly only have sex with, with poz guys now....I don't want to have sex with somebody and infect them especially if they don't know.I'm not gonna go convert some little 19-year-old boy who doesn't know his ass from his elbow because I would feel totally responsible and I can't do that. So I mean, I've actually given lectures to some of these guys on the internet saying, "Listen guy, you got, you better do some thinking before you do this." (50s, German, HIV+)
- 2 I don't want to make somebody seroconvert just for a moment of fun. I mean, I made that mistake in a way. (30s, French, HIV+)
- 3 Of the guys I see and have sex with on a periodic basis, we never have safe sex. Because there's a trust in me that I'm not going to put them in a problem situation. I know what it's like to be living with this problem and I don't want anybody else to have to live with this problem because of me. (50s, Scandinavian, HIV+)
- 4 I don't want to be the one to say that, "yeah, I gave you HIV." Contrary to what a lot of my friends think about me, I do have a conscience, I do have ethics, I do have morals. I don't know how I could live with myself knowing that I infected somebody who's 20 years old, hasn't really lived his life any and then have to live with being HIV positive. (20s, Northern European, HIV+)
- 5 I've even barebacked with negative individuals who know my status but I don't come inside them 'cause that's what they want. (50s, French, HIV+)

But then, there are moments, especially in public and anonymous sites when a few men candidly admit to sheer opportunism beyond the moral reasoning that accounts for the vast majority of sexual interactions.

In all honesty, it was more out of pleasure....When I was younger, there were times when I did it, when like, the guy would, usually in a bathhouse setting but not always, or sometimes even out in public but open in sort of a park or beach where the guy would just like, totally get lost in it, and I felt I could get away with it. And so I would take the condom off him to fuck him.

(30s, French, HIV+)

I came in someone's mouth and for me it was very pleasant but I wasn't thinking about taking care of that person because he was someone I was having anonymous sex with. So you know, probably it sounds strong to say that, but when I have anonymous sex with someone, I'm not taking care of that person. I consider that well, he's here just for pleasure....If it's with someone special, it's different.

(30s, Latin American, HIV+)

The larger question that arises, once a critical mass of men practising unprotected sex comes about, is: What effect might a micro-culture of unsafe sex have on future trends in gay and bisexual communities as a whole? Early prevention educators understood well that the central challenge in the adoption of safer sex practices was the creation and consolidation of community norms that would make safer sex taken-for-granted behaviour without need of communication, negotiation, or justification. Despite the evidence reviewed here, this endeavour has had a great deal of success, and for the most part remains successful among gay and bisexual men in advanced, industrial nations. But now a theme running through interviews with high risk men is how the safe sex norm is in decline, and how the onus is shifting from those who don't use condoms, to those who do, to account for their actions. In this particularly insightful passage, a study participant who is among those who have abandoned safe sex sketches out the cultural shift that has been occurring.

It [barebacking]...was becoming sort of like a subculture within the gay community where a lot of people were doing it....People would also let you know who else likes to bareback and so it sort of became a lot of word-of-mouth-type thing.... There's not the stigma attached to it that there was a few years ago....It surprised me how quickly, it's been embraced in a way....About 10 years ago,...the pressure was on me to actually say to them, "Can I fuck you without a condom?"...I have encountered a few back then that were like, aghast, actually with one guy asking me to leave when I said that. So that felt, I can remember the feeling, and feeling like, well like, almost trampy-trashy. Now I don't see that. The pressure now is on somebody to ask for a condom.

(30s, French, HIV+)

Just how the boundary between safe and unsafe sex practitioners may shift through subtle pressure shows up in this revealing comment.

I say, 75-80 percent just never asked [to use a condom] or if they did...then I would wear it, but then sometimes, it was sort of like, because it was discussed that I prefer not to use the condom, it's like the seed became planted in their mind and when we'd start then, at some point I'd say, "Well, if you want to fuck me without a condom you can. Just don't come inside."...I'm certainly somewhat culpable because I kind of knew...if I planted a seed I had a better chance of being able to not do it. But I generally have always found more men willing not...to use a condom.

(30s, French, HIV+)

Men outside the bareback microculture express considerable puzzlement and sometimes alarm in their stories of encountering men who show no interest in safe sex. It is not clear to these men why they make no move toward safer sex; the common-sense knowledge that everybody knows in the bareback microculture lacks recognition among men working from different presumptions. For example,

I had him on his back and I knew that he was a bottom,...but as I was approaching his mouth, he said, "Fuck me," and I said, "Okay." I can't remember exactly what I said, and as I reached over for a condom, he held my hand like this and said, "No, I want you to bareback me." I said, "I don't think so," so he said, "Okay," and I think he was a little disappointed....The only thing that really surprised is that, you know, twenty years after the disease has hit, there's this person who's, I think he was in his mid to late thirties, an articulate, educated, obviously-been-around-the-block type who is okay with my fucking him without a condom.

(40s, south Asian, HIV-, 1 year)

Some presume that prospective sexual partners who fail to practice protected sex are HIV-positive. It is remarkable, however, how many HIV-negative men practising unsafe sex in this study, when asked, "When you know a partner is HIV-positive, how does that affect your sexual experience?", respond that they have rarely or never knowingly had sex with an HIV-positive man. In other words, they apparently presume that most or all of their partners are negative. Still others employ the language of irresponsibility, deception, and indeed of bug-chasers and barebackers who are understood as motivated by malice. Whether a real behavioural change has happened or not, there is developing a perception that community norms are shifting, and once perceptions change, their consequences may ultimately have real behavioural consequences. Here is a small sample of the conclusions drawn by some men from their experiences in the gay scene:

Now people just don't care from what I'm noticing and they're all younger guys so they're just, "oh, well."

(20s, British, HIV+)

I can't count how many people I've gone home with and they had no desire to use them [condoms]. They just wanted to have sex. They didn't care.

(30s, Aboriginal, HIV+)

I wasn't practising safe sex before I became positive so from what I've read and heard and seen and from what I've viewed in the bath houses when I've been, I haven't seen a lot of condom usage to be perfectly honest. In fact I have seen some group activities where I've been kind of amazed at what the people are doing and...(voice trails off)
(40s, British, HIV+, 5^{1/2} years)

The ineffability of these interactions of men in microcultures with divergent understandings, and of the processes whereby conflicting stories converge and collide is captured in this man who wonders if the presumptions he thought were shared were “just a fantasy.”

You can't take comfort in the fact that you think, “Oh, well, he knew I was [positive], you know—I let him fuck me without a condom. Of course he knew I was positive.” That logic just doesn't exist any more. Where, a year or so ago it did seem to exist, I don't know if it was. Maybe it was just a fantasy we all kind of believed in but it seemed to be, it seemed to be there. Now it doesn't seem to be there in the same way.
(30s, Canadian, HIV+)

For the most part, neoliberal rhetoric of personal responsibility and consent works as a closed system. Since its premises and qualifications are rarely questioned or exposed, they are also rarely subject to disconfirmation. Much of it operates at a tacit level such that neither party comes away fully informed of what was happening.

These interviews nevertheless encounter a few instances of disruption which expose the limits and failings of the rhetoric of responsibility. As this respondent remarks

I think that if you're positive, you should have the balls to say, “I'm positive, so you want to use a condom or do you not?” and not assume because someone is not asking you to use a condom that they're assuming that you're...positive....[Also] the person getting fucked should have the balls to say, “Look, I'm not positive, so if you're positive, put on a condom”...but neither one communicates and because neither one communicates...they're assuming something, which I think is stupid.
(30s, French, HIV-, 1^{1/2} years)

The following especially telling episode is remarkable by its rarity. Here the tacit understanding underlying unprotected sex suddenly saw the light of day.

There was a fellow I called one time—this was less than a year ago—and he was fairly young. He was only 25 or so and we...went home...and I was washing up after having had intercourse and as I was washing up, I said, “So how long have you been positive?” And he said, “I'm not positive.” And I said, “What!?” Because I sometimes understand where tops think—there's this stupid idea that tops don't get the disease, that somehow they're immuneThere is that foolish idea....So anyway, we ended up dashing off to St. Mike's [hospital emergency] and doing, you know, the emergency cocktail thing and all those other sort of stuff.
(30s, Canadian, HIV+)

It is noteworthy that this man who regularly engages in unprotected sex was so alarmed to discover that he might possibly have infected a sex partner that he went to considerable lengths to find his partner post-exposure prophylactic treatment.

It is also remarkable to see that the doctrine of individual responsibility is so strong that when men do sero-convert they nearly always blame themselves for doing so. This may explain why so few cases of HIV transmission in the gay community proceed to court to invoke the *Cuerrier* decision. In the *Cuerrier* decision, the Supreme Court of Canada ruled that HIV-positive people must disclose their sero-status before sex, thereby implicitly placing the onus on them to prevent HIV transmission. The doctrine propounded by the AIDS movement over the years, that everyone is responsible for protecting him- or herself appears to have been taken up as a bedrock presupposition among men having sex with men, even though this idea is not in itself proving sufficient to slow transmission. At the same time, these interviews show that consistent disclosure is an expectation that is not likely to be realized, given the difficulty in making such a declaration, and that disclosure would offer no panacea to the problem of HIV transmission in any case.

SUPPORTING SAFER SEX

At this historical juncture when HIV rates among gay and bisexual men have stopped declining, and in many locations appear to be on the increase, a number of hypotheses have come to the fore to explain the apparent exhaustion of traditional methods of HIV prevention. The AIDS optimism theory has become so pervasive that it has acquired many of the trappings of a public health orthodoxy solidified through repetition in the media. Self-esteem theories and harm reduction approaches appear to have more currency in AIDS service organizations. And finally the construction of barebackers and bug-chasers as a class of men pathologically intent on transmitting HIV finds a place in the press, and in the courts insofar as the tools of criminal justice are brought to bear as an HIV prevention strategy. The thesis advanced here, based on interviews with high risk men and men in couples, is that none of these hypotheses provides sufficient insight into the everyday dilemmas associated with coping with HIV risk to provide reliable guidance for the efficient allocation of public funding in the development of effective HIV programming. Attending closely to the narratives of gay and bisexual men about their own sexuality shows how consistent unsafe sex is with predominant discourses of romantic and erotic communication, and how safer sex decision making is caught up in semiotic snares built into government and corporate neoliberal rhetoric, scientific and public health language, autobiographical narratives, status hierarchies, body image, aging, and the search for intimacy.

A good deal of health research and public policy explicitly relies on the prevailing health-belief (Horne and Weinman 1998) and KAB (knowledge-attitude-behaviour) (Kippax, et al. 1993) models of human behaviour. Both of these models rest squarely on rationalist and individualist foundations, that with proper information, individuals will change their behaviour in order to avoid sickness and live longer. These models no doubt do explain

a lot about why HIV rates have come down through the 1990s, but they are left with few if any theoretical tools to account for the significant amount of transmission that continued to occur even in the late 1990s, and when HIV rates show signs of rise, their adherents are once again cast upon default “common sense” conjecture to explain the change. Into the breach has come the AIDS optimism hypothesis despite such findings as “a large majority of participants (97%) agreed that ‘safer sex is as important now as ever’” (Kelly, et al. 1998), and several other high-powered studies that have succeeded in identifying only very small numbers of men who are willing to support the protease complacency thesis (Remien, et al. 1998; Misovich, Fisher and Fisher 1999; Miller, et al. 2000; Venable, et al. 2000). As Jonathan Elford, Graham Bolding and Lorraine Sher (2001) point out, the mathematics of even the largest estimates of AIDS optimism among gay men are such that the “AIDS optimists” cannot be generating the epidemiological effect reported in major cities. Interviews of gay and bisexual men reported here and in Vancouver reveal how little combination therapies or AIDS optimism in general enters into the thinking of those engaging in safe and unsafe sex (Miller, et al. 2002).

The self-esteem concept is rather too comprehensive an explanation in that men who may have no lack of self-esteem “in general,” at work, at home, and most of the time, may nevertheless be susceptible to stress, episodic depression, or a situational sense of worthlessness that increases HIV vulnerability. While there may indeed be a “grain of truth” in the self-esteem hypothesis, it is salient in only some unsafe encounters. Summing up the mechanism of exposure as the problem of self-esteem, or the problem of homophobia, tends to pose the prevention challenge so abstractly, that inaction is the likely outcome.

The voices of men making practical decisions in everyday life show how often situations of vulnerability to HIV infection are the consequence of following, not deviating from social prescriptions, of attempting to acquit oneself as a good and caring person not a bad or irresponsible one, and of trying to communicate love and commitment not sexual carelessness. Unsafe practices are often less a question of lack of knowledge, attitude, or the disabling of reason, than a complex deployment of signs and interactions that must be addressed if HIV transmission is to be affected. They are embedded in what Michel Foucault (1988) refers to as “practices of the self.” While there is perhaps a “natural” and “common-sensical” quest among human beings to discover “bad” origins for “bad” effects, it is clear that “good” behaviour and “good” people are implicated in exposure to HIV transmission.

Unprotected sex arises in a variety of disparate circumstances: as a resolution to condoms and erectile difficulties, through momentary lapses and trade offs, out of personal turmoil and depression, and as a byproduct of strategies of disclosure and intuiting safety. It is also strongly associated with relationship development and the communication of trust and intimacy. In addition, the development of a culture of unprotected sex among a subset of urban HIV-positive men poses further challenges in crafting adequate HIV prevention programming. There is no “average” gay man nor “average” factor determining unsafe sex. It is doubtful any single social marketing message can cut across these different sites of vulnerability.

After more than two decades of HIV prevention, most gay and bisexual men are highly knowledgeable about HIV disease, and even, in a sense, “over-educated” with prevention messages. The history of prevention messaging is rife with semiotic snares, that is, public statements that overtly convey a rational message exhorting people to behave in a way that conserves or enhances their health but which also communicate important latent content that (presumably unintentionally) undermines the overt message, and indeed sets its readers up for even greater exposure to risk. They are the reverse of self-fulfilling prophecies; rather they are self-negating prescriptions evident in the speech of those who have no desire to “bare back” or “bug chase.”

Here is an example. This fundamental semiotic was evident on billboards in the streets of Geneva during the 12th World AIDS Conference which read (roughly translating from French), “Not faithful in bed—Faithful to condoms.” The message has much to recommend itself. Juxtaposed over the midriff of a man in his underwear, the message is humorous and provocative, and it hails its viewers to practice safe sex. It is also a message with a flip side. It generates a self-negating practice identifying safer sex as a practice of only morally dubious people. It claims that faithfulness—that is being good in a relationship, being loyal, caring, being sexually exclusive—is an adequate recipe for unprotected sex.

If there is a safe generalization supported by HIV prevention research, it is that all studies agree that unsafe sex is much more common with steady partners, than casual partners (Connell, Davis and Dowsett 1993; Thornton and Catalan 1993; Ames, Atchinson and Rose 1995; Remien, Carballo Diéguez and Wagner 1995; Buchanan, Poppen and Reisen 1996; Myers, et al. 1996; Hoff, et al. 1996; Flowers, et al. 1997; Carballo-Diéguez, et al. 1997; Hays, Kegeles and Coates 1997; Elford, et al. 1998; Bleys, Lambrechts and Vincke 1998; Alary, et al. 1998). A lot of studies have sought to measure relationship status but few inquire into what relationships mean, how they are lived, how sexual pluralism is managed, or how safe or unsafe outcomes come to be associated with them.

One of the best studies that does examine the meaning of relationships is Elisa Sobo’s *Choosing Unsafe Sex*. Based on interviews with African American women in Cleveland, Sobo (1995:110-1, 115) found:

Condomlessness was directly described as ‘a sign of trust’ and of ‘honesty’ and ‘commitment.’...The strength of the association between condoms and extraconjugal sex means that condom use denotes failure in a relationship....Women may ‘take the risk’ of condomless sex because condom use would undermine their claims to having chosen partners wisely.

Clearly unprotected sex is associated with good things in relationships; it communicates trust, care, etc. and the prevention message reinforces that binary. The problem is that it is a self-negating message that exposes people in relationships to HIV. The semiotic snare could be resolved only if safer sex were made compatible with the desire to communicate trust in couples.

The degree to which condom use can be equated with the message “I don’t trust you” is the degree to which the abandonment of condoms will be read as a sign of fidelity. This semiotic logic is better dealt with among homosexual couples, as compared to heterosexual, where sexual

monogamy is less often considered an essential sign of love or trustworthiness, but male couples, as well, are susceptible to the monogamy script.

Another example of a semiotic snare is the “know your partner” advice propagated by public health authorities, especially in the early years of the epidemic. It is clearly a significant contributor to unsafe practices by encouraging people to exempt themselves from the need for safe sex through “knowing” their partners by “reading signs” of their partner’s putative “safety” (Ames, Atchinson and Rose 1995:65-66) or by exempting them by giving permission for unprotected sex because the partner has become “known” over a period of weeks or years.

Yet another example of a semiotic snare lies in the prevention message to treat every potential sexual partner as HIV-positive. Grounded on an analogy to the defensive driving message of protecting oneself while treating all other drivers as potentially dangerous, the prevention message presumes an HIV-negative recipient of the message who is to act in a world of putative HIV-positives. Yet interviews with HIV-positive men, who have abandoned safe-sex practices altogether, reveal a discourse where the treat-everyone-as-positive message cycles back as a warrant for unprotected sex because if everyone is positive, then the HIV-positive man has little concern. This discourse receives considerable reinforcement from enviroing messages circulating in the neo-liberal era that postulate the modern citizen as a consenting individual engaging in a contract with another consenting individual in a fundamentally self-interested, anti-solidary, and voluntarist way.

Today with “harm reduction” theories becoming ascendant in community-based organizations, the risk of communicating new “boomerang” messages arises yet again. Perceiving a “slippage” away from safe sex practice and wishing to provide “the facts” with which community members are to make their own choices around risk, there is a trend to craft “risk reduction” messages that ultimately affirm the “boundary pushing” practices of some men, and indeed may help consolidate such practices as viable forms of risk reduction. Given the association between episodic or delayed condom use and sero-conversion (Calzavara, et al. 2003), this approach raises the question of when “harm reduction” simply functions as a cover for harm increase.

ETHNOCULTURAL ISSUES

In addition to situational and personal considerations, and shared understandings of sexual and friendship networks that cohere into microcultures of sexuality, are social and community connections defined by ethnicity. Ethnocultural identities can influence HIV vulnerability in at least two ways: in terms of cultural transitions experienced through immigration, and in terms of social hierarchies of desirability experienced in Canada. Several men drew comparisons between their experiences in their countries of origin and Canada. A study participant from China, for example, remarked on the limited opportunities for sexual connection with men in China, and on a general lack of condom use when encounters did occur. While employing condoms at times in Canada, he continued

generally not to use them while on return trips to China. Several men from Latin America and Asia remarked on a stronger expectation of romance and monogamy in relationships with men in their home countries. They found sex more available in Toronto but were sometimes surprised and dismayed that Canadians seemed less inclined to pursue relationships. They continued to be particularly susceptible to dropping condom use in anticipating relationships, or to expect their partner in a couple relationship to practise monogamy despite suspicion that practice did not always meet ideal. Men of colour who grew up in Canada, or who came out in Canada, on the other hand, were not easily distinguishable from other Canadian men in their expectations concerning sexuality and relationships.

People who feel disadvantaged by their age, race, (lack of) attractiveness, gender, neediness, etc. appear to be vulnerable to “trading off” safety for intimacy with a valued partner. Social hierarchies that prescribe who is more desirable and valuable in courting and sexual relationships create vulnerability. Interviews with middle-aged Québécoises women (Dedobbeleer and Morissette 1998), aboriginal men in Australia (Bartos, McLeod and Nott 1993), older gay men (Murray and Adam 2001), Asian Americans (Choi, et al. 1999), those who feel particularly dependent inside their relationships (Appleby, Miller and Rothspan 1999:89), and young gay men who feel less attractive than a prospective partner (Seal, et al. 2000:11) all report a common theme of feeling unable to assert safe sex lest a prospective or current partner be offended and lost. These social hierarchies of desirability are evident in these interviews as well. While the majority of the participants in this study, whether white or men of colour, state that they do not have racial or ethnic preferences in their attractions to men, some men of colour nevertheless do report rejection or exoticization in their interactions with white men. In some instances, this is considered a relatively benign process:

I can't call it racism. It's just that people don't want to have relationship or boy-friendship with people of other community because they don't feel comfortable with it. So and I don't blame them ...I have never found a person like me, who only feels comfortable with people of other communities because I don't feel comfortable with my own people from my own community.

(30s, Asian, HIV-)

In others, it creates the conditions for “trading off” safety (example of an aboriginal man above), or for treatment complicated by the respondent's relationship to his own pattern of desire.

Interviewer: *Do you find that men fetishize you in any way or exoticize you?*
Respondent: Sure...all the time, they always say, you're so exotic looking and I'm going, well, [it's like] an animal in a cage....I usually will go after white men, although the only reason why I'll avoid Middle Eastern men...[is] that we don't sleep with brothers....I will never sleep with a Muslim.

(30s, Middle Eastern, HIV+)

And

I do like white guys. I hardly ever have any sex with anyone of my own race, like aboriginal (yawning).

(20s, Aboriginal, HIV+)

RENEWING HIV PREVENTION

Though a good deal of research is devoted to the question of what is wrong with condom use, in these interviews we also asked interviewees what they liked about condoms. These responses fell into three general types: safety, hygiene, and a guard against potential re-infection.

The power of the safe sex message is such that many men speak of condoms as facilitating pleasurable sex; that they are too anxious about the possibility of HIV transmission to enjoy sex if a condom were absent. While the “rational” use of condoms for HIV prevention is perhaps obvious, less often noted is the emotional underpinning that many men feel as an incentive to maintain condom use.

When I wear a condom, or the other person is wearing a condom, it enhances the pleasure for me because I'm relaxed, so I'm more able to enjoy the things that we do without having to think about, well you know, he's unprotected, I'm unprotected, what if? So it definitely enhances it [sexual satisfaction].

(40s, Latin American, HIV-, 4 years)

In a few instances, men report a positive association between condoms and sexual pleasure in that the appearance of a condom in a partner's hand signifies to them a pleasure to come thereby enhancing their own sexual anticipation.

A large proportion of men also remark favourably on the cleanliness of condoms for anal sex. While many describe their and their partners' efforts to assure the highest degree of cleanliness in anticipation of sex, they particularly enjoy the guarantee of hygiene offered by condom use. In addition, a few individuals noted additional reasons for liking condoms because the tightness of a condom can enhance an erection, or condoms provide protection against abrasion.

Finally, among HIV-positive men, there is a good deal of rumination around the question of “re-infection” with another strain of HIV. The scientific literature is currently not definitive on the nature of risk posed by re-infection and relies on anecdotal or small-sample studies (Jost, et al. 2002). The result is that some men come down on the side of caution while others do not consider the evidence sufficient to take up condom use again. Those who are concerned about re-infection often refer to additional factors such as their potential vulnerability to any kind of infection due to a weakened immune system as cause for condom use even with other sero-positive partners.

I suppose it's equally important to continue to use condoms, really...If not acquiring HIV resistant strains, higher incidence of the STDs. So I think it's something that people have to be more aware of.

(40s, Canadian, HIV+)

While aware of the re-infection argument, others nevertheless find on balance that the risk of re-infection does not outweigh other considerations.

I know that there is a chance of cross-infection in terms of HIV and there's a possibility of taking up other types of STDs as well. And I'm well aware of the health and safety implications, and so are the men that I play with, but we have agreed tacitly-or verbally, that the quality of our sex is of such importance that we choose to take that risk.
(50s, Canadian, HIV+)

The salience and intensity of the reinfection discussion is evident in this narrative.

A couple of times during sex we were having this discussion, you know, while having sex. Okay, "Mmmm, you know, are you willing to have me give you, you know, a different strain of the virus?" "Well, not really but, you know, I, I want to feel you in me. I want to feel the connection. You know, I want to feel skin on skin." I'm like, "OK." This is ironic that, you know, we're in the middle of sex and we're actually discussing the fact that I could be giving you a different strain of the virus.
(40s, British, HIV+)

In another instance, safe sex is motivated not by reinfection but by a concern about possibly passing on a resistant strain.

Because I was given a resistant strain and I don't want to give ...a stronger virus to someone else because ...what options would that person have? I'd basically be killing someone and it's freaking me out....So I have a lot of pressure to protect others from me, not themselves, because sometimes guys are so fucking careless, willing to take so many risks with me and these guys don't have a clue as to what I have and I play the role where I make it seem like I'm protecting myself from the other person when in actual fact, I'm protecting the other person from me.
(20s, Aboriginal, HIV+)

But in the end, certainly among sero-positive men connected through barebacking, the balance of risks is seen as permitting unprotected sex.

I think both of us should be protected because there's many different strains and we could easily share and, and go or pass on a mutated strain. In reality I sort of embrace it as if there's somebody else who's positive we don't need to use condoms. We can fuck as much as we want and come inside each other as much as we want with less limits. It's almost like ...the boundaries get thrown away. So that's practice versus what I know I should do.
(30s, French, HIV+)

Should the scientific information on re-infection become more definitive, clearly there is an audience ready to take account of new findings.

ADDRESSING BAREBACKING

Barebacking is a phenomenon that has come about in major cities where a critical mass of HIV-positive men have lived in close proximity over years, have formed social networks, and have developed a micro-culture of ideas and expectations that make sense in this particular context. It is also a micro-culture that is linked across the major cities of North America,

western Europe, and Australia, but little represented in smaller cities where the sense of living in a “poz” world cannot be sustained. It also borrows, adapts, and reproduces some the major planks of neoliberal ideology circulating in government, business, and the media in these metropolises. As such, it combines together notions of informed consent, contractual interaction, free market choice, and responsibility that create a platform for constructing unprotected sex as a “responsible” choice among adult men. It is especially noteworthy that virtually none of the men endorsing bareback ideology think of themselves as opposed to the message of AIDS service organizations but rather repeat basic propositions of the safe sex message as the warrant for their own practices, for example, that the responsibility for preventing HIV infection is a question of protecting oneself, or that one should treat every new sexual partner as HIV-positive. Indeed, many of these men are not much different from the many other people who have dropped safe sex: they view safe sex as a good thing but believe they have found an exemption from its prescriptions for themselves. In fact it is clear that when the presumptions that uphold bareback ideology are shown to be demonstrably absent (with the young, the uninformed, etc.), they were often quick to revert to safe-sex mode.

The fundamental flaw in the moral reasoning of barebackers is the same flaw inherent in neoliberal reasoning in the larger society. The neoliberal view constructs human actors as rational, adult, contract-making individuals in a free market of options. It turns a blind eye toward to the much more complex motivators and vulnerabilities that characterize real human interaction. It denies the vulnerabilities, emotions, and tough dilemmas faced by people in their everyday lives, and it denies any obligation to care for other people or care for community. In terms of this study, the rationale advanced for unprotected sex by barebackers denies all the circumstances and dilemmas that go into unprotected sex such as erectile difficulties, momentary lapses and trade offs, personal turmoil and depression, disclosure and intuiting safety, and indeed love.

Yet at the same time, these interviews are filled with evidence that gay and bisexual men, whether single or in couples, high or low risk, do also know and show allegiance to care and community when circumstances permit. Gay men are fully capable of acting, like other citizens of this society, according to the neoliberal norms of hyper-rational, masculine, competitive individualism, and are especially likely to do so in situations where sexual interaction is brief, anonymous, and governed by the presumptions of the public sphere. But at the same time, homosexuality has perhaps a unique potential, lacking in the heterosexual majority, to subvert these presumptions by creating a capacity to love and care about (an)other man (or men) and be loved and cared about by them. This raises the question of whether appealing to gay men to take care of other men (instead of simply defending themselves against other men) could prove effective in attracting their attention and building community norms. It would be an appeal that would run against leading ideologies in circulation in our society today but one that would likely have considerable resonance among men whose sexual pursuits are often linked with the desire to love and be loved by other men.

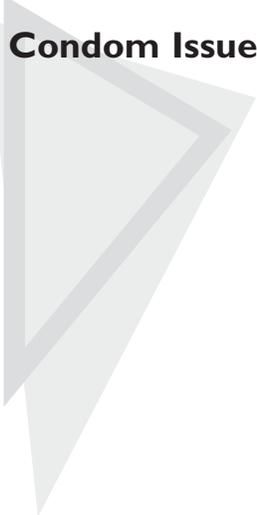
A NOTE ON DRUG USE

As Aguinaldo, et al. (2002) found in a study of drug use among gay and bisexual men in Toronto, these interviews show that drug use is a widespread part of much of the gay and lesbian scene, yet clearly a great many people are able to combine drug taking with safe sex. Still, intoxication is a problem for some but often less a first cause unto itself, than an “alibi” permitting desired behaviour (Odets 1995:220). In a perceptive comment, Gilbert, et al. (2000:51) report that 56% of the seroconverters they studied mentioned drugs or alcohol in association with unsafe sex but that “in only three [of 22] cases was this stated in isolation, the rest feel that emotional issues had resulted in the use of drugs/alcohol as a means of release/escapism,” suggesting that drug use may be not so much a “determinant” as a symptom or coping strategy for other issues. This finding is in accord with the interviews reported here and in earlier interviews of men in Ontario where substance use often arose as a coping strategy or mediating effect between sexual expression and other problems in men’s lives (Adam, Sears and Schellenberg 2000) and is emerging again in a study of the drug scene currently being conducted by the AIDS Committee of Toronto in collaboration with several other Toronto-area ASOs.

Survey-based studies that have attempted to demonstrate a connection between drug use and unsafe sex have frequently produced ambiguous and non-replicable results. Progress in understanding this linkage will require: (1) better understanding of why individuals take drugs since these underlying reasons appear to explain more about the effect of drugs on sex than drug use itself, and (2) ethnographic study of the so-called “party and play” or “PNP” microculture emerging in major metropolitan areas where drug use, along with sexual interaction, is taken up as part of a culture of pleasure and recreation.

A sizeable portion of the study also experimented with Viagra, either through prescription or through the informal economy, with several men remarking that they found it so effective that they preferred to reduce the dosage to half or quarter pills before taking it. This points toward the need for a prospective study of Viagra among men whose episodic use of condoms follows from erectile difficulties to see if Viagra can act as a remedy for inconsistent condom use. It should not be the occasion for a broad-based epidemiological survey, so often favoured by health funding authorities, as an attempt to discover a statistical association between Viagra use and un/safe sex is to sure to produce an uninterpretable result. Clearly there is no reason to believe that there would be any benefit to prescribing Viagra to men whose unsafe practices are not related to erectile difficulties, or who have given up on condoms altogether.

Condom Issues



The one-size-fits-all approach to condom distribution may have led some men to drop condom use prematurely. Some men appear to have abandoned condom use because of size or feel without having fully explored larger or smaller condoms, or thinner condoms.

Condom manufacturers and marketers, ASOs, and bathhouses should consider more effective distribution of, and encourage experimentation with, the full range of condom types, rather than relying on a single “generic” condom.

Bathhouses, in particular, should increase the visibility of condoms and support the maintenance of a community norm of condom use by providing condoms in “hot spot” areas. Simply handing out condoms at the door to men who are about to change into towels is insufficient.

The promotion of erection-enhancing techniques could make consistent condom use more attractive to high risk men. Some report the use of cock rings and elastics as effective ways of sustaining an erection.

A prospective study of Viagra among men whose episodic use of condoms follows from erectile difficulties is warranted.

The things men like about condoms deserve a higher profile, such as cleanliness and protection from diseases other than HIV.

The development of alternatives to condoms, such as microbicides and vaccines, could benefit gay and bisexual men who experience difficulties with condoms. Microbicide research has been developed almost entirely as an HIV prevention tool for women; gay men should not be excluded from research samples.

Men who are considering penile piercing should be warned of the heightened risk associated with no longer being able to use condoms.

Barebacking



ASOs and the gay press should increase awareness of the mismatch of presumptions where some HIV-positive men presume that willingness to have unprotected sex means their partner is sero-positive, while some HIV-negative men presume the opposite.

Prevention messages should not rely exclusively on the premise of self-preservation as an incentive for safe sex but should also appeal to gay men to look out for, and take care of, other men.

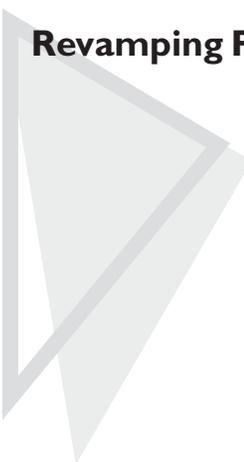
ASOs should consider developing a campaign, in association with organizations of people living with HIV, directed toward HIV prevention among HIV-positive people.

HIV prevention for sero-positive people needs also to consider if there are ways in which disclosure of sero-status to prospective sexual partners might be made easier.



Reinfection

Should the research evidence on the danger of re-infection become substantially more definitive, significant number of HIV-positive men will likely shift back toward more consistent condom use. A campaign that over-reaches available evidence, however, would likely risk discrediting itself since many men are well-informed concerning the current state of the scientific evidence.



Revamping Prevention

There is general agreement among high-risk men that the traditional message of ASOs concerning the facts of HIV transmission still needs to be communicated, especially to newcomers to the gay community.

Effective HIV prevention requires engaging the uneven communication processes of gay and bisexual men by creating public spaces and involving the gay press, websites, and other media in which to develop public understandings around sexual interaction. In this sense, HIV prevention entails community development to be effective.

While social marketing approaches have the advantage of reaching a wide range of people, they are limited by being able to telegraph little more than “sound bite” messages. What also needs to be done is to engage a community dialogue through open forums, group discussions, web chats, even one-on-one counselling over time.

Interest in how relationships happen and managing non/monogamy provides an opportunity to hold public forums in which ways of negotiating safety should be promoted both for members of couples and for couples with additional partners.

Improved availability of gay-positive therapy for depression could impact on HIV transmission.

There needs to be a public discussion, especially involving the gay media, about the continual reproduction of the usual images of desirability especially in advertising. The depiction of attractive men drawn from a greater diversity of ages and ethnocultural backgrounds could help diminish the power of beauty hierarchies that influence men to “trade off” safe sex.

It is important to support prevention programming for men moving to Canada from different cultures, especially from cultures in which homosexual relations are not organized around gay identity and HIV prevention has not included homosexual men.

Caution needs to be exercised in presenting claims that taking the top role in sex is “lower risk” or that HIV transmission occurs due to “tears” in the rectum, as significant numbers of men are reading these messages as sufficient for HIV prevention, at the same time as epidemiological evidence finds them to be significant routes of HIV transmission.

Public health authorities, researchers, and ASOs should examine their own messages to see how they may be facilitating HIV transmission through semiotic snares and promotion of neoliberal reasoning.

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