

The Contemporary Context of HIV Infection in Victoria, Australia

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Report for the Department of Human Services, Victoria

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Australian Research Centre in Sex, Health & Society

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Introduction

Cultures of safe sex among Australian gay men have changed significantly since the mid 1990s. At that time researchers began documenting increasing proportions of gay men engaging in unprotected anal intercourse in situations of potential risk, such as when one or both sexual partners do not know their own status or that of the other (Prestage et al., 2000; NCHSR, 2005; Van de Ven et al., 2002b). More recently evidence has arisen that some of these men have been using particular strategies in order to engage in unprotected sex but also reduce the risk of HIV infection. Such strategies may include HIV negative men adopting the insertive position during anal intercourse without condoms and HIV positive adopting the receptive position (Van de Ven et al., 2002a). Other strategies include withdrawal before ejaculation and the monitoring of HIV viral load levels in order to glean an indication of infectiousness. Lower or undetectable levels of viral load, it is reasoned, make it difficult to transmit the virus (Davis et al., 2002; Richters et al., 2000; Slavin et al., 2004).

In Victoria there has been increasing concern about the upwards trend of reported HIV infections. The lowest figure recorded in Victoria was 132 in 1999. Since then the HIV figures have risen to 185 in 2000, 202 in 2001, 214 in 2002, 200 in 2003 and 211 in 2004. There has been insufficient data to understand fully the reasons behind these rises. They are, however, similar to rises in other Australian capitals and in other cities throughout the world (NCHECR, 2005).

In this context it was seen as vital that detailed information be gathered about those people who had recently been diagnosed as HIV-positive.

Methodology

The Study of Risk Factors for HIV Infection is an ongoing case series study that began in 2003 in Melbourne. Its methodology is similar to that of a study of the same name based in Sydney that was originally developed in 1993 by researchers at the National Centre in HIV Epidemiology and Clinical Research (NCHECR) and the National Centre in HIV Social Research (NCHSR) (See Kippax et al., 2003). It consists of semi-structured, tape-recorded interviews conducted with people recently diagnosed with HIV infection; “recently” could mean from as little as a few weeks up to a year. For some, diagnosis occurred around the time of seroconversion and for others it occurred much later. All interviews were subsequently transcribed and de-identified.

Participants were recruited either via referral from general practitioners and specialist medical practitioners with high HIV caseloads or from the NCHECR’s PHAEDRA project, a study of the health of individuals newly infected with HIV. All men in our sample were gay men who were infected through homosexual contact. Criteria for enrolment were that they had been diagnosed in the past 12 months. The 11 interviews analysed here were completed between June 2003 and March 2005.

The long period of recruitment reflects the practical and ethical difficulties of recruiting sometimes emotionally traumatised people into a study that specifically asks participants to recount the issue associated with their distress. It also reflects reluctance or difficulty on the part of some HIV clinicians to provide referrals. Needless to say interviews were conducted with sensitivity to the emotional state of participants and the study was approved by the La Trobe University Human Ethics Committee.

In order to examine the meanings of risk for men recently infected with HIV, participants were asked to recall the occasion on which they believed they had become infected. All men could, in the end, isolate one occasion that seemed to be the likely source of

infection, to the satisfaction of both them and interviewer. They were then asked for a detailed description of those events. These accounts are reconstructions of risk encounters that attempt to make sense of the experience. If the explanation seemed implausible to the interviewer, s/he would probe further and negotiate with the participant until a more likely event was identified. Agreement was reached in the vast majority of cases. In many of the interviews this process of negotiation reveals much about the different meanings of HIV risk as well as the value that participants attached to certain narratives over others. Even the implausible explanations are rich in this regard. Thus the accounts are important both for what they reveal about the meanings and understandings of risk for participants and for what they reveal about the actual ways they contracted HIV. On average interviews lasted 1 ½ hours, generating transcripts of up to 80 pages.

Transcribed data were analysed using an interpretive thematic approach (Ritchie & Lewis 2003). Transcripts were each read at least twice and initial themes were identified that arose from the narratives. Transcripts were then coded using the NVIVO software package and further themes were identified, compared across interviews and refined. This report discusses the major themes that arose in the interviews. These are not necessarily representative of the entire sample and may have only arisen in some interviews. They are discussed here because they are salient in relation to gay men's sexual practice and HIV more broadly.

Findings

The average age of participants at the time of interview was 36 years. This is broadly consistent with epidemiological data that suggests the average age of gay men at time of HIV infection is 37 (NCHECR, 2005). The youngest participant was 24 years old and the oldest 54 years old. Eight participants were from Anglo-Australian backgrounds and three were from

Mediterranean backgrounds. All identified as gay men. Their levels of education, income and occupations varied considerably. Some men held postgraduate qualifications and two had completed year 10. One man was receiving the disability support pension (around \$12,000 p.a.) while another earned over \$100,000 per annum. The average income was \$30,000 to \$40,000. Occupations were diverse and included professionals, tradespersons, one sex worker and one artist.

Unsurprisingly in this group, all participants were likely to have been infected with HIV via an event of unprotected anal intercourse. Of the 11 men, 10 were receptive in this event and one was insertive. Seven men said this event occurred with a partner they did not previously know and three knew their partners. Six said it happened at a sex-on-premises (SOPV) venue, four in either their or their partners' homes, and one at a beat (outdoor sex location). One man said he was sexually assaulted at a SOPV after being taken there by a man he met at a bar. These results should be treated as a description of this sample only and not a general indication of how or where other infections have occurred in Victoria.

The following discussion is organised thematically rather than as a diverse series of case studies. We begin with the more practical themes and move to the more theoretical.

PEP

Post exposure prophylaxis against HIV (PEP) involves the administration of anti-retroviral drugs within 72 hours of exposure for 28 days. National guidelines exist for the provision of PEP that include a risk assessment schedule and recommendations that patients be followed-up for HIV antibody tests and behavioural counselling to reinforce the importance of safe sex (ANCAHRD, 2001).

At the time the interviews were conducted, availability of PEP in Victoria was limited to the Alfred hospital in Prahran. A review of this arrangement recommended an expansion of the program which began to take effect in the second half of 2005.

None of the men in this study received PEP for the risk exposure they believed led to their infection. Some were ignorant of the treatment and/or its availability while three encountered barriers when they sought PEP.

After a high risk sexual encounter with a known HIV positive partner, one participant attended the Alfred's emergency department. He said:

I actually went to the hospital and told them and tried to get on to PEP, and I had to wait three or four hours. I was told I had a one in ten chance of becoming positive, and they won't do an HIV test, that they were too busy. But then I thought I could see my doctor on Monday and I thought one in ten chance, fuck it. That was a bad experience. And I was told by that particular doctor that it costs the state government \$10,000 to put me on PEP, 'Don't waste their money'. (10)

This man did not subsequently attend his general practitioner for PEP. In the weeks that followed, he seroconverted. This account reveals the difficulty of triage in a busy emergency department in relation to HIV exposure and raises the question of whether emergency departments are the most appropriate contexts to assess patients and administer PEP. Such busy, stressful environments are also unlikely to be ideal for doctor and patient to discuss sensitive issues of sexual practice, or to make complex calculations about relative risk. In this instance, the risk, according to the PEP guidelines, was very high and PEP was indicated. The patient instead considered the odds to be favourable.

Presenting for PEP in the context of a normative safe sex culture carried a degree of stigma and shame for the following man:

I had heard about it and I've read the signs at the saunas and things, but I kind of felt that it was such a big and dramatic thing -- at the time it just seemed really quite inaccessible. A lot of shame involved in saying 'oh, look, I've had unsafe sex and can you help me out here,' 'cause there's all that promo saying, you know 'it's not a safety net, it's not an excuse to go and have unsafe sex,' so I kind of felt like it was a bit too big a deal and something you'd have to go in shamefully and say, 'look this is what's happened', and go through a punishment almost to get it. (7)

Here the seriousness of the situation was correctly identified but shame prevented him from seeking help. While this confirms the continuing norm of safe sex, other evidence indicates that for a significant minority of gay men some unsafe sex is relatively commonplace (NCHSR 2004). It may be that this combination of some regular unsafe sex in the context of a strong cultural norm of safe sex may inhibit discussion of HIV risk incidents and act as a barrier to seeking PEP.

It has become widely accepted among clinicians and health promoters that the provision of PEP is an opportunity for patients to reflect on risk behaviours. The national guidelines recommend cognitive behavioural interventions. Sometimes the potential side effects and uncertain efficacy of PEP are emphasised creating the feeling for some men that the treatment itself is a form of punishment. There is a fine balance to be struck. Given that occasional unsafe sex is now common for some gay men, it is unlikely that stressing behavioural failure will support ongoing safe sex practices. Instead, seeking PEP should be regarded as evidence of success in preventing HIV infection, by identifying risk, overcoming shame and seeking medical help. This may entail the supply of PEP on multiple occasions to some patients with recurring risk incidents in order to avoid the following situation.

I: Did it occur to you to seek PEP this time?

R: Ah, it did. But the stigma that's put on PEP, in all the literature they publish and that sort of thing, I had this corrected while I was actually up in Queensland and I was having a discussion with them, they said, 'well if you're negative you really should be using PEP more often'. 'Using PEP more often' is an expression I hadn't heard in Victoria. The spin put on here is that it's a one lifeline kind of thing, and that I was under the impression that if you turned up asking for it a second time, they'll be very reluctant to hand it out again. It's for the freak occurrence and it's not for regular bad habits.

Victoria's program of PEP delivery is currently being expanded to make the drugs available through all doctors eligible to prescribe anti-retrovirals. This should remove many of the barriers outlined here. However, PEP prescribers should think carefully about the style of behavioural interventions given at the time of risk assessment. Patients should not be given the impression that provision of PEP is dependent on their showing remorse or upon their future behaviour.

Condoms

Condoms were discussed by participants in a variety of ways. Some men found that a condom made it difficult to maintain an erection. For the following man the effect of his erection difficulties was that he took the receptive position in anal sex throughout his life.

R: As an active partner I find it very difficult and always have, to maintain an erection with one on, that's the main reason I've been a passive partner for the majority of my sexual life.

I: So you're generally a bottom?

R: More often than not, although with the use of drugs these days. God I wish I'd found them years ago, like Viagra and the other new one that's out. I've just lived with that all my life. I've had a couple of sessions with a hypnotherapist. It didn't really do much for me, so I just live with it.

I: What kind of experience do you have using those drugs?

R: They're very effective, but they're also a bit synthetic, it tends to give a loss of sensation. But because I've not been able to do it very often, it's 'oh, triumph', I can actually do this. They're not cheap either. Initially you go on a bit of a splurge and then you think, 'well shit, this is a bit expensive'. You can go through four hundred dollars worth of this drug fairly quickly and you think 'this is ridiculous.' (1)

While this participant tried to accommodate his erection difficulties within a framework of safe sex, two other men in the study said that erection difficulties were a factor in their decision not to use condoms in some circumstances that had placed them at risk of HIV. An additional two participants said they found condoms uncomfortable while they took the receptive role in sex. Both explained symptoms consistent with an allergic reaction to either the latex or the lubricant used in condoms.

There was agreement among all the men that sex without condoms feels better than sex with condoms, regardless of their sexual position. This was both a physical and a psychological issue.

The experience of erection problems with condoms is, anecdotally, not uncommon among gay men. Some GPs report that they prescribe erectile dysfunction drugs such as sildenafil citrate (Viagra) to assist men with safe sex practices. These drugs, however, are not subsidised by the Pharmaceutical Benefits Scheme and are expensive. Viagra costs around \$70 per script of four tablets.

Allergic discomfort with standard latex condoms affects a small number of men. An alternative to latex are polyurethane condoms, which are now available in Australia. Awareness of this alternative remains seemingly low among gay men. Further, the retail price of polyurethane condoms is over five times that of latex condoms.

Condoms remain a serious impediment to sexual satisfaction for some gay men. This resulted in HIV infection for some of the men in this study. Renewed attention should be given to the role of condoms in safe sex practice. An aspect of this should be the availability

and awareness of polyurethane condoms and condoms of different sizes. Discussion may also be worthwhile about the role and affordability of drugs for erectile dysfunction and their possible part in helping sustain safe sex practice among some gay men.

Communication

In one form or another, failure of communication was implicated in HIV infection for all of the men in this study. Many of them had unprotected sex on the basis of some discussion about HIV status or health. However, in many instances interlocutors were speaking at odds. Sometimes this resulted from misunderstandings and sometimes from incorrect assumptions. The following man elicited a response to a question that he did not ask:

R: It was at a sauna and I was quite drunk, off my dial and we started doing whatever and we sort of discussed having sex and, I said ‘are you okay?’, which was in terms of HIV and he said ‘yeah, yeah, I’m fine, I’m fine.’

I: Do you think he might have misunderstood you?

R: How do you mean?

I: When you asked him if he was okay, do you think maybe he could’ve thought you meant something else?

R: Oh. Oh, he could have. Because I didn’t actually come out and ask, ‘are you HIV positive?’ (8)

This man’s question may seem naïve but it also reveals the limits of communication conducted in settings such as SOPVs. It is not normal in such venues to ask a person’s HIV status directly and thus the query was put obliquely, leaving room for misunderstandings. From the perspective of HIV positive men, receiving such a direct question may feel confronting or stigmatising. The following man tried to negotiate unprotected sex in a similar manner:

R: I asked him if he preferred to use condoms or not. And he said to me ‘well what do you prefer?’ and I said ‘well not’. And at that stage in my head I felt that I’d negotiated it, obviously I hadn’t.

I: So you felt by talking about condoms, if he had been positive he would have said ‘no let’s use condoms?’

R: Yeah. (2)

There is a miscommunication here and an expectation that the sexual partner would declare his status if he were positive. This belief implies that HIV positive people do, or should, take responsibility for HIV prevention. This was a common assumption among participants.

Interestingly it was a belief that many continued to hold after they became infected. The same man related the following:

R: I was at a sex on premise venue where a man was going to have insertive anal sex with me and I stopped him and said ‘you’ll need to put on a condom’, and he said ‘no, no, it’s okay, I’m clean’ [laughs] and I went ‘oh, here we go’, [laughs] I said ‘this is going to be good’ I said ‘no, I’m telling you that I’m positive’ and that was the end of that [laughs]. (2)

This experience took place a few months after diagnosis. Whether or not it is possible or desirable to maintain this degree of openness over time is doubtful. It certainly seems unreasonable to expect that HIV positive men reveal their status in all sexual contexts as a matter of course.

One of the key assumptions made by participants was in regard to their own or others’ HIV negative status. Purported HIV negative status was frequently used by these men as a way of negotiating unprotected sex. It is difficult, however, to be entirely confident of this status due to the fact that HIV antibodies may not develop for up to three months after infection. Some men repeatedly engaged in unprotected sex based on the belief that they were

HIV negative, but they may in fact have seroconverted as a result of an earlier sexual interaction.

R: From the first time we had sex, we had unprotected sex and I asked him after that first time if he was positive or negative and he said that he was negative, so we continued having unprotected sex until I tested and found out I was positive.

I: How did you make the decision to have unprotected sex with him?

R: Normally I would use condoms and then after I've had sex with someone a few times, then we would maybe stop and or we'd talk about it. I believed him when he said he was negative.

I: Do you think he was lying to you?

R: My feeling is that he probably didn't want to get tested. There was some assumed knowledge, which I've since found out is useless, but there was some assumed knowledge that he was negative and it was safe. (7)

Drugs and alcohol

Drugs and/or alcohol featured in the risk incidents for most men in the sample. As with the following man, this is not so much a causal factor in relation to unsafe sex but a contextual feature which enables sex to occur in the first place.

At that stage I went out probably four out of seven nights and throw down the alcohol and get quite pissed and to be bluntly honest with you, a couple of us would go to the sauna to get sex. I'm thinking that's maybe where I picked it up. (8)

Alcohol, in particular, is commonly associated with socialising in Australian culture and can be used to ameliorate unhappiness. The men in this study are not exceptional in this regard. Nor is gay sexual culture unusual in relying heavily on alcohol as a way of easing interactions and heightening confidence. That it may also affect people's judgements about safe sex or their capacity to make decisions is not surprising, as articulated by the following man:

R: I guess it was a lot of alcohol was involved, a great deal, at the time that I seroconverted. I remember drinking quite a bit at that stage, because I wasn't happy with my job, wasn't happy with my lifestyle.

I: So when there was a lot of drinking involved, condoms didn't factor in much on those occasions?

R: Probably. I'd say I'd agree with that. Probably the alcohol took away any concerns that I had. Drugs are a different matter. Condoms are not a concern, it's a bit of a free for all. (2)

This participant claims that drugs are part of a different context with regard to safe sex.

Whether this is a feature of particular drugs or the micro-cultures in which drugs are used, varies between men. There is general agreement nonetheless that drugs do play a role in some incidents of unsafe sex. The following man exemplifies this:

I: You said you thought that unsafe event was a calculation.

R: Yeah, but I didn't think of it as a calculation. That's rationalising it afterwards. It really was just heat of the moment, I was drug fucked, it seemed like a good idea. I mean I really didn't think about it any further than that. (5)

Drugs play a key role in producing sexual pleasure for some of these men. One described the two as going "hand in hand", referring to the pleasure of sex when on drugs and the fact that illicit drugs are normal within the gay scene, notably nightclubs and dance parties. Drugs carried certain associations and meanings, for example, they were frequently part of celebratory events. The following participant alludes to the illicit nature of the practices surrounding drugs and the effect this had on the experience and its meaning:

I'm less likely to ask for a condom when I'm out partying or on pills. Definitely less likely to ask and more likely to just go with it and be fucked up. (7)

Being “fucked up” or, more commonly, “out of it” does not necessarily have a negative connotation in gay culture; it can describe the experience of good quality drugs that transport the user out of the everyday with their psychotropic effects.

Several participants identified crystal methamphetamine as exerting a powerful effect on judgement and decisions around safe sex. Three men commented on what they perceived to be the strength of this drug to increase the desire for receptive anal sex and to increase the time spent engaging in sex. The following participant is typical of this sub-group:

R: I take drugs probably twice a week, maybe on a Friday and a Saturday night. Most weekends.

I: Ecstasy?

R: Yeah, mostly but lots. Four or five in a night. Now the drug of choice now is crystal, and has been for about a year. A couple of times a month.

I: So how do you use crystal?

R: Mainly for sex. For going out dancing I’ll have crystal combined with G [GHB]. Smoke it generally. Sometimes blast [inject]. The effect of blasting is fantastic.

I: And tell me about your experiences with crystal and sex?

R: Well everything that they say is true [laughs]. I love going out and playing at the saunas. I could be fucked as many times as I liked and it’s fantastic and crystal just seems to make that ten times more.

I: The experience or the desire?

R: I think it’s the desire. If that’s what I want, that’s all that I want, and I just keep going.

I: And do you use crystal with your partner?

R: Yes. But he turns into a bit of a bottom, I don’t like that. (3)

The following man believed he became infected in the context of group sex at a SOPV which involved the injection of crystal. He was diagnosed with hepatitis C at the same time as HIV:

I: Who did the injecting that night?

R: Well he did. I developed a bit of a fetish for being injected. I say almost involuntarily because with kink overtones the whole concept of consent gets a bit blurry.

I: And can you inject yourself?

R: Not easily. It only ever happens in the context of group play. I never use by myself. I like to enhance the play. So, pretty much always someone helps me. I think in those circumstances it's very difficult, sometimes, to keep track or insist on people washing their hands between every injection. (9)

This participant identifies the context of the sex as “kink”, or s/m. These practices are not in themselves risky for HIV but in this instance, when combined with crystal injection and the blurring of lines around consent, which is an aspect of s/m eroticism, multiple unsafe sexual acts occurred among a group of both HIV positive and negative men. It is unlikely that crystal meth alone has the power to cause unsafe sex. However, when it features in a scene that already engages in unprotected sex it is undoubtedly difficult for participants to consistently adjust sexual practice according to the serostatus of partners.

Furthermore, crystal meth was frequently injected. Gay men in this study who had injected crystal knew little about hepatitis C prevention and how this varies from HIV prevention.

Meanings of risk

The concept of risk is ubiquitous in western societies and refers to the likelihood of an adverse event occurring in a given context. In relation to HIV, risk has been discussed by educators, policy makers, epidemiologists and gay men in various ways with vastly different meanings depending on the context of these discussions.

For the purpose of this discussion we distinguish between two broad meanings of risk, a statistical meaning and a cultural meaning. The statistical meaning of HIV risk derives from epidemiology and pervades public health and sometimes everyday discourses. It is often regarded as the legitimate and scientific meaning and is represented as the odds of becoming infected with HIV under certain circumstances including specific sexual practices. The cultural meaning of risk refers to the ways in which individuals make sense of HIV risk in the context of their lives. Sometimes these men borrowed statistical terms or ways of thinking, such as odds ratios, but other times they derived meaning from other beliefs entirely. All the men in this study used both meanings of risk to make decisions around their sexual practice and make sense of their own infection. The following quote gives a picture of the complexity of this thinking.

R: We were gradually escalating the risk, initially we were using everything, even gloves for fisting. Then I had my risk re-evaluation. I think a lot of people have it in their early twenties. As a teenager I was really a safe sex fundamentalist. I redrew my risk profile a bit and started taking more mid level risks, which were fine by themselves. They probably wouldn't have caused me to convert. Then I started to top bareback. There was the thing, "oh well, he's negative", so there's no issue there. But you can't really rely on that. That started happening with people who were probably negative, people that we know. I mean despite my bad habits, there weren't too many exposures. There were plenty of low to mid level risks, because I did decide some time ago that I was only prepared to curb my habits to stay negative up to a certain point.
(9)

This participant seeks to portray his thinking around risk as reasonable and rational. He compares such reasoning to an earlier period that he described as "fundamentalist", implying it was less rational. His "risk re-evaluation" was not a singular event or decision. It resulted from a sustained pattern of taking some risks and repeatedly testing for HIV and discovering that he had not become infected with HIV. This pattern occurred for other men in the study who describe fear as an early motivator for maintaining strict safe sex practice, which was

then ameliorated for various reasons, including the advent of anti-retroviral therapy. It also seems likely that as men become older and more sexually confident, earlier fears of HIV may become diminished.

This man is ambivalent about the question of responsibility. On the one hand he blamed his HIV positive partner for encouraging him to have unsafe sex but in the end he probably became infected by someone else. He also emphasises his own agency with regard to decisions about risk. In reality all these factors were at play.

I mean, in the end, I'm a big boy, I took the risk. My choices were my own. But he encouraged me. There wasn't actually a time when the wall caved in. (9)

Towards the end of the interview this participant engaged in a complex critique of what he calls "older style safe sex messages" that promoted the view that there is clear distinction between what is safe and unsafe.

That's actually one of the problems with safe sex messages, at least the old sort where everything's either safe or it's unsafe and there's a very clear line between them and you have to stay on one side -- well why? If you don't stay on that side, you can get AIDS and you'll die. But it's never really worked that way. There's always a continuum of risk, any sexual encounter with anyone involves some level of risk. It might be a very small risk. It might be a somewhat bigger risk, or to take a positive bloke in the arse which is the maximum. (9)

Relative risk and risk reduction practices are conceptually linked with statistical projections of risk, which with many caveats provide figures for the likelihood of infection in everyday sexual situations. When such projections are translated into lived experience their original meaning is distorted and the caveats are often forgotten. Odds ratios do not accurately predict the likelihood of exposure for individuals but rather populations. In everyday life people tend to believe that it is possible to have unprotected sex a certain number of times before infection rather than the possibility of infection being present at each risk incident. While risk

may be seen as proportional in this way, infection is obviously absolute. To paraphrase the old warning about pregnancy, one cannot be ‘a little bit infected’.

An extension of this thinking is when qualitatively different risks are compared, with the consequence that they appear relative, despite the fact they imply starkly different adverse outcomes and arise in different contexts. Consider the following quote where the participant attempts to compare the risk of death in a motor vehicle accident with the risk of HIV infection.

I: I’m trying to get a sense of why you didn’t think there were any risk encounters?

R: Because I don’t think anyone fucked me without a condom and I didn’t see anyone coming in my mouth as a risk, which I still don’t for some reason. I mean I know there must be some risk involved but my perception is that you’ve got more risk of getting in a car and getting killed in a car accident. So I didn’t see any of that as putting me at risk, and also the risk of being an active partner in unprotected sex, there’s much less risk of contracting it. (4)

The notion that there is greater risk associated with being the receptive partner in unprotected anal intercourse than being the insertive partner is suggested by epidemiological studies and seems biologically plausible. However, it is more fruitful, at the level of everyday social interactions, to examine this belief as cultural. Many of the participants in this study held beliefs that seemed to suggest they thought about HIV as subject to gravity. The following participant exemplifies this:

R: I ended up having insertive anal sex unprotected on different occasions. Five people over a period of a few months.

I: And why were you being the insertive partner?

R: I’ve always believed that’s less of a risk factor.

I: So you factored that into your decision making?

R: Yeah, in my very alcohol affected decision making, yeah, but that would’ve been there, very much so. If it had been me as the receptive partner I would’ve refused unless a condom was used so it’s definitely there. Even though I know the

information is out there that says that that is risky, it's still in my head that to be the top is less risky than being the bottom. (3)

When asked what he considered to be high risk he replied:

R: I guess receiving anal sex and the person actually coming. I would've thought receiving anal sex and the person not coming as being medium, and then actually giving anal sex I would've considered quite low without a condom.

I: Where did you develop those ideas do you think?

R: I guess a lot of it through advertising; also my best friend is positive, so a bit of education from him too. He became very active in talking about it and letting people know about this stuff. (3)

This participant went on to describe how he and his uninfected partner continued to have unprotected sex after his own infection, attempting to reduce the risk based on the gravitational theory of HIV transmission. This idea also took on gendered characteristics for some participants, where receptive was regarded as feminine and insertive as masculine. One participant said: "I think with me being a bottom it's the effeminate side of me or something. These are the parts where I haven't quite understood it yet." (10)

The following participant illustrates one of the problems with risk as a way of thinking about HIV transmission. Risk is a theory about probability and does not describe exactly where or when an event will transpire. To borrow from Mary Douglas (1992) risk is like an invisible glass wall, you do not know where it is until you crash through it. Repeated risk taking can lend the illusion that there is no risk at all or it is much more remote than is actually the case. The following participant illustrates this form of incredulity.

R: I thought 'am I actually immune?' because I know that I'd had some risky behaviour, I'd known that I've had an HIV positive partner, a couple of HIV positive boyfriends, and I've come out still negative. So that was in my head as well, and I think the more I got away with it the more confident I became that I wouldn't become positive. If it hadn't happened, I'd probably still be out there doing it. (2)

This quote also shows the distortion that can occur when experience and official knowledge are thought to be at odds. There is both scepticism of that knowledge and an attempt to interpret it through a theory of immunity that, while perhaps not plausible, is at least consistent with bio-medical interpretations of infection.

The following participant is an example of someone for whom remaining HIV negative induced stress and anxiety.

R: I feel that I've been positive for quite a while, and it's never shown up in testing. I've been tested regularly. That's why I had so many tests. Before I popped positive on the last test I had six HIV tests in a row. I mean some twice a week, some once every two weeks because I had some feeling. My doctor started getting mad, he said 'you know, the government is going to get mad, you can't keep testing like this'. (10)

It is striking that it was so important for this participant to know when he seroconverted suggesting that medical confirmation would provide a level of certainty that he had not derived from his HIV negative status, or from safe sex.

Relationships, intimacy and trust

Unprotected sex signified intimacy for many of the participants. There was broadly held belief that condoms are a "barrier to intimacy". The following participant discusses this belief in light of his recent HIV infection.

I'm dating someone at the moment and it looks like it is heading towards a long term relationship. It's sad, almost numbing to think 'well we're never going to be able to have unsafe sex, never'. That's a beautiful thing to be able to do with a partner. (7)

Unprotected sex, in addition to being a symbol of intimacy, was a sign of commitment, particularly at the start of relationships. A number of men believed they were engaging in

negotiated safety agreements with new sexual partners, but were in fact using unprotected sex as a way to build trust and intimacy. For a number this led to their infections:

I'd just started seeing somebody. It was looking like a full on thing, it was time to be tested, seeing somebody, and we were having unsafe sex. So I went and got tested, it came out a positive result. (2)

Romance played a significant role at the start of relationships and influenced sexual behaviour in various ways. The following participant talks of how romance was mixed with the excitement of a new relationship, and the different expectations he and his partner held:

R: It was basically a sexual relationship. We weren't serious boyfriends who were going to stay together for ten years and get married and buy a house. We were just having lots of fun and doing lots of drugs and partying lots.

I: Tell me a bit about him.

R: Oh, he's a lovely man, he's beautiful. He's very genuine and he's caring and he's a slut. He's lovely. He's one of the nicest people I know. He's really attractive. We were fuck buddies more than anything, it wasn't like an 'I love you' relationship.

I: So it wasn't a conventional relationship, you weren't wanting to settle down as boyfriends?

R: Well he wasn't.

I: And you were?

R: Yeah, I would've settled down, but he didn't want to.

I: And why not?

R: I guess I wasn't the one. That's what it all comes down to, they tell you things like 'I've got plans to do this and that', but it's all bullshit. I just wasn't the one.

I: Was he the one for you?

R: At the time, yes.

I: So it sounds like you were a little bit in love with him?

R: Yeah, I was in love with him. (6)

This quote demonstrates well the shades of ambivalence and ambiguity that affect how people feel about those they desire or fall in love with. On one level this participant is almost

dismissive of the possibility of romantic love with his former partner but at another he seems to regret its loss. Such ambivalence will inevitably generate some confusion over the meaning of sex within the relationship.

Shame

A striking theme among participants was an acute sense of shame associated with getting HIV. For some this manifested as “feeling that I’m dirty and diseased”. For several other men shame was expressed in relation to their feeling foolish for becoming infected.

When I was diagnosed as being positive, one of my major emotional responses was that I was embarrassed, that it was actually 2002 and that I’d been diagnosed as HIV positive, so even though I’d sort of had that immune thing going, in my head about being on top was less risky, yeah, I was absolutely embarrassed, probably mortified and embarrassed about telling my close friends as well. (2)

“The immune thing” referred to here was not a sophisticated theory about immunity to infection as some participants discussed, rather a feeling of invincibility based on nothing more than the fact that infection had not already occurred despite many previous years of sexual activity. This signifies the fact that for some gay men, homosexual sex is still felt to be marginal. The close symbolic relationship between homosexual sex and HIV implies that HIV can be viewed as a moral as well as a material consequence.

The following man epitomises the individualising effects of risk as in his mind he is responsible for HIV, as though it were a punishment meted out for bad behaviour:

Why did I have unprotected sex when I should’ve known better? I definitely should have known better. I have had mates who died. Yet I went out and had unprotected sex, really for self gratification. So yes, I should’ve known better, but I didn’t. You do the crime, you do the time. (5)

In this quote a number of themes come together from across the sample. This participant believes that he was responsible for getting HIV because he took risks. He believes those risks arose as a consequence of choice and that choice was a decision or set of decisions made rationally with full knowledge of the mechanisms of infection and its consequences. Given all of this he believes himself to be morally culpable, the consequence of which is HIV itself. Needless to say, none of these beliefs helped prevent infection in this man in the first place, a point worth remembering for HIV prevention education.

Conclusion

For the men in this study sex carried manifold meanings. Michel Foucault (1990) contends that sex and sexuality are regarded in the West to stand at the core of individual subjectivity and identity. Sexual expression is thus regarded as self expression *par excellence*. That sex is culturally regarded as secretive in nature does not prevent it from being the focus of considerable cultural attention, in fact the secrecy surrounding it often serves to heighten this attention. Such focus allows or even compels individuals to seek all kinds of meaning through sex. For Foucault, sex in the West is “more important than our soul, more important almost than our life”. He goes further, arguing that the socio-cultural deployment of sexuality amounts to a Faustian pact, which tempts us to: “exchange life in its entirety for sex itself, for the truth and sovereignty of sex. Sex is worth dying for.” (p.156)

This argument is particularly salient for the gay men in this study who experienced the significance of sex in various ways. Some previous research on the contexts of HIV infection have highlighted such factors as alcohol and drugs, and their effects on judgement; the number of sexual partners; or the locations of sex such as sex clubs. While the findings in this study also reveal such factors to be significant at times, they also provide a challenge to consider the meanings that gay men attach to sex.

For all of the men interviewed, any kind of sex was potentially significant and meaningful. This may have been expressed through desire, practices of intimacy, or negatively through shame. The widely held view among professionals from various disciplines working in HIV prevention that gay men's sex can or should be split between casual contexts and relationships (where the former is banal or habitual while the latter is meaningful and significant) did not pertain to these men.

Nonetheless they evince a sense of contradiction over this division, which is after all widespread in this culture. These men did occasionally go looking for intimacy in back rooms (and often found it) and sometimes wound up in alienated relationships based on deceptions that put them at risk of HIV. These are normal human problems with an unusual and unfortunate outcome in the form of HIV infection. To labour the point, HIV is the pathology, not gay male sex. These men are much like other Australian men who have ups and downs, sometimes drink too much and sometimes take risks they may regret later. Such periods are normal, if not healthy in their outcomes.

The complement to this observation is a question that is yet to be seriously pondered or adequately answered: why is the average gay man in Australia who becomes infected with HIV at the current time in his late thirties and highly aware of HIV and the means to prevent it? Conventional public health responses to HIV infection have assumed a deficit in individual characteristics: knowledge, self efficacy, self esteem etc. The epidemiological reality presents a challenge to this assumption as we are not typically dealing with gay men who obviously suffer deficits of any of these things, at least not as individuals. This suggests that the question should be posed at a collective or social level.

Many of the participants in this study pursued sex as a form of meaningful social and inter-personal connection. This stands in contrast to the highly individualising tendencies of risk discourses that encourage gay men to see themselves as rational actors who make

informed choices about the dangers of HIV. Such tendencies are easily observable in participants' feelings of individual responsibility for their infections. There has developed for some men in this sample a powerful tension between social desire and the individual experience of sexual responsibility and shame. It seems doubtless that sex and human intimacy are more fulfilling when undertaken as social activities not individual. It is therefore unsurprising that social and emotional engagement may be prioritised by some men over strategies to avoid HIV. This begs the difficult question of whether individualised sexual experience, in which the risk of disease is a salient feature, is so alienated and unsatisfactory for some men that the possibility of infection is perceived as a price worth paying for more intimate relations.

It is worth examining, in the context of future research, features of gay men's lives in their late thirties and early forties. What is it about this life stage and the associated sexual and drug use practices of some gay men that place them at increased likelihood of getting HIV? What do these practices and contexts tell us about gay culture more broadly and the social and sexual possibilities available to men approaching middle age? Are there ways in which those interested in reducing HIV transmission may engage with gay culture to improve the social and sexual possibilities available to these men and thereby achieve better public health outcomes? Are there ways in which the broader socio-cultural, legal and political contexts conspire to produce in these men a diminishment of meaning, which they aim to offset through sexual expression that may be risky for HIV? More simply, it is conceivable that these men find themselves in a context of diminished social and sexual value in relation to gay culture and anomalous with regard to mainstream social institutions such as kinship. This is not an issue that can or should be rectified at the level of particular individuals. Rather it presents challenges to the gay community including the commercial sector, to imagine and produce social and sexual contexts for men who do not fit the ideal of youth and beauty *and* it

presents challenges to society more broadly to question and oppose ongoing homophobia that regards gay relationships as inferior to heterosexual ones. Under such circumstances gay men of a certain age will begin to have real sexual and emotional choices, not false ones about relative levels of sexual risk.

References

- ANCAHRD (2001) Guidelines for the management and post-exposure prophylaxis of individuals who sustain non-occupational exposure to HIV. ANCAHRD Bulletin no. 28. Commonwealth Department of Health and Ageing, Canberra.
- Davis, M. et al. (2002) 'HIV is HIV to me': the meanings of treatment, viral load and reinfection for gay men living with HIV. Health, Risk and Society 4(1): 31-43.
- Douglas, M. (1992) Risk and Blame: essays in cultural theory. London: Routledge.
- Foucault, M. (1990) The History of Sexuality, vol. 1: an introduction. London, Penguin.
- Kippax, S. et al. (2003) Seroconversion in context. AIDS Care 15(6): 839-852.
- NCHECR (2005) HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Surveillance Report 2005. Sydney: University of New South Wales.
- NCHSR (2005) HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Report of Behaviour 2005. Sydney: University of New South Wales.
- Prestage, G. et al. (2000) The Sydney Gay Community Periodic Survey: changes over time. Sydney, National Centre in HIV Social Research.
- Richters, J. et al. (2000) Condom use and 'withdrawal': exploring gay men's practice of anal intercourse. International Journal of STDs & AIDS 11(2): 96-104.
- Ritchie, Jane, and Jane Lewis, eds. (2003) Qualitative Research Practice: a guide for social science students and researchers. London: Sage.
- Slavin, S. et al. (2004) Understandings of risk among HIV seroconverters in Sydney. Health Risk & Society 6(1): 39-52.
- Van de Ven, P. et al. (2002a) In a minority of gay men, sexual risk practices indicates strategic positioning for perceived risk reduction rather than unbridled sex. AIDS Care 14(4).
- Van de Ven, P. et al. (2002b). Increasing proportions of Australian gay and homosexually active men engage in unprotected anal intercourse with regular and with casual partners. AIDS Care 14(3): 335-341.