

CULTURES OF CARE AND SAFE SEX AMONGST HIV POSITIVE AUSTRALIANS

**Papers from the HIV Futures I and II surveys and
interviews**

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**The Living with HIV Program
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Preamble

Michael Hurley

The notion of 'cultures of care' was developed initially as part of the Researchers in Residence program which was a collaboration between the Australian Research Centre in Sex, Health & Society and the Australian Federation of AIDS Organisations, 1999-2000. I was researching the relationship between *Positive Living* and its readerships nationally and at the same time investigating how treatments information circulated amongst HIV positive people in Queensland. The research was highly informed both by people living with HIV and the work of several other social researchers. As I surveyed and interviewed people with HIV it became clear from what they were saying that we needed to conceptualise how treatments information, treatments media and mass media are linked to social networks amongst people with HIV, and to practices of self-care and care for others. These social networks are themselves partly constituted by the treatments media's relaying of practices of self-care. Publicising these practices was an act of sharing and an active mobilisation of sharing. The practices themselves were highly sophisticated, densely informed, creative resources in the everyday life of people with HIV.

Developing the notion of 'cultures of care' was a way of conceptualising the relations between health service providers, the people taking treatments, their social and support networks, international media relays, community-based treatments media and the development of practices of self care amongst people living with HIV/AIDS.

Being able to link all these elements gave the concept of a 'culture of care' considerable analytic force. Just as importantly, it resonated amongst people living with HIV because it both encapsulated significant parts of their experience and allowed critical reflection on it. The concept is flexible and dynamic. It incorporates some of the tensions in everyday life such as how to position available treatments in the intricacies of the clinic/patient/person living with HIV matrix. It is also able to incorporate shared histories, including the knowledge that these tensions long predate HAART, even as they are reconfigured to take into account its effects and successes. There is considerable descriptive force in being able to identify that cultures of care broker the relations between living with uncertainty as a form of knowledge, treatments information and practices of self-care, including safe sex.

Jon Willis has since taken the concept further. He used the concept to link uptake of antiretroviral therapies as an act of self-care and the HIV status of sexual partners. On this basis he was able to establish care of the self and care for others as predictive of safe sex.

The cultures of care that have grown up around HIV positive men and their interactions with both clinic and community need to be understood as systems of meaning, as systems of shared history and values that extend beyond the clinical sphere, beyond the intensely permeable boundaries of the HIV positive gay community, out into the wider gay community, and its spaces and practices (John Willis).

What follows is a collection of papers prepared over the years by ARCSHS researchers. It is hoped that the perspectives offered in these papers will help to inform and stimulate further debate and discussion on these issues.

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Acknowledgements

The conference papers and posters reproduced here are derived primarily from the HIV Futures I and II Studies, 1997-1999. These studies are major research projects and have involved a number of researchers in gathering and analysing quantitative and qualitative data. Readers will be aware of the quantitative arm of the studies which has produced a number of major reports since 1998. At the time of writing these quantitative reports included the two HIV Futures Reports on people living with HIV in Australia, reports on women and HIV in Australia, state-based reports, and reports on Aboriginal and Torres Strait Islander people living with HIV, on heterosexual men and HIV and on people with haemophilia and HIV infection.

These quantitative reports are now accompanied by three qualitative reports that include analysis based on both the HIV Futures I and II surveys and a set of associated interviews carried out between 1997 and 2001. These reports include analyses of antiretroviral treatments and similarities and difference between women and men (McDonald and Hurley 2002a), of motherhood and being HIV positive (McDonald and Hurley 2002b) and the present volume on cultures of care and safe sex.

Research projects of this size that are carried out over a number of years involve many researchers and many more research respondents. The first two HIV Futures surveys were completed in 1997 (n=924) and 1999 (n=925). This research is continuing. The HIV Futures 3 survey was carried out in Australia in 2001-2002 at about the same time as the survey was administered for the first time in New Zealand. Reports from these surveys appeared in 2002. The Australian HIV Futures 3 survey will again be accompanied by a set of interviews which will in turn receive qualitative analysis.

All this research has been made possible through a Collaborating Centre grant from the Department of Health and Ageing.

We gratefully acknowledge the participation of all the survey respondents and interviewees 1997-2001. These respondents constitute a representative sample of

all people living with HIV in Australia. The survey is large and demanding to complete. Its representativeness relies totally on the generosity and willingness of respondents and the efforts made by supportive organisations and individuals to reach as many people living with HIV as possible.

We acknowledge the role of many organisations in assisting with the gathering of this data, including state and territory based AIDS councils and PLWHA organisations, the National Association of People Living with HIV/AIDS, the Haemophilia Foundation of Australia and its state affiliates. Each of the major HIV Futures reports carries a full list of participating organisations and individuals.

The HIV Futures and Futures II Studies each had their own reference group. The Studies are part of the Living with HIV Program which now has a Living with HIV Reference Group whom we also gratefully acknowledge.

The following researchers worked on the HIV Futures I and II Studies.

HIV Futures: Douglas Ezzy, Michael Bartos, Richard de Visser, Karalyn McDonald, Darryl O'Donnell and Doreen Rosenthal.

HIV Futures II: Jeffrey Grierson, Michael Bartos, Richard de Visser, Karalyn McDonald and Sebastian Misson.

INTRODUCTION

Michael Hurley

The focus of health promotion and HIV prevention efforts under the fourth National AIDS Strategy will be on maintaining and reinforcing the safe sex culture of gay and other homosexually active men through education, social mobilisation and advocacy. In this, consideration must be given to the needs of HIV-positive and HIV-negative men as well as their male and female sex partners. (Commonwealth Department of Health and Aged Care 2000: 15)

HIV is an extremely sophisticated, cunning, ever evolving, totally heartless bastard. You wanna work in HIV? Then get used to living with uncertainty. (Bill O'Loughlin 2001)

Cultures of care and safe sex amongst HIV positive Australians is a collection of selected conference papers and posters primarily based on the HIV Futures I and II Studies. The papers are ordered sequentially from those presented more recently to those presented earlier. They have been edited, and in the case of 'Taking care of me, taking care of others' turned from a powerpoint presentation into a written paper involving substantial new analysis (Willis *et al*, this volume).

The HIV Futures I and II Studies include quantitative data from the large scale HIV Futures surveys conducted in 1997 (n=925) and 1999 (n=924), as well as qualitative data from over 100 associated interviews carried out between 1997-2000. The papers collected here have been delivered at conferences over the past five years and care should be taken not to read the papers that refer only to HIV Futures I survey data and associated interviews as definitive of the current situation. This is especially so as survey data from HIV Futures 3 have been released throughout 2002. I anticipate that these data will introduce new findings into the general discussion, requiring it be further refined.

This introduction positions the sexual practices of people living with HIV in Australia within a context of self-care. A self-care practice is any technique used to better a person's quality of life (Hurley 2001a). Self-care practices involve, but are not restricted to, medical technologies such as drugs and tests used for diagnosis and medical management. Self-care is identified as central to discussions of both HIV-positive sex sub-cultures and to the relations between those specific sub-cultures, wider safe sex cultures, health and HIV prevention.

The HIV Futures I and II Studies clearly demonstrate that people living with HIV maintain a major commitment to safe sex. People living with HIV are often in regular relationships (48%), are highly sexually responsible in regular sero-discordant relationships as well as in casual sex, and frequently fear infecting other people (70%) (Grierson *et al*. 2000: 71-76).

The HIV Futures I and II Studies further demonstrate that *the commitment of people living with HIV to self-care practices is a major form of HIV prevention:*

Evidence of self-care, particularly uptake of antiretroviral therapies and consequent reduction of viral load, is a significant predictor of care-of-others in sexual situations. (Willis *et al.* 2002, this volume)

Earlier, important analysis by Michael Bartos, using HIV Futures I data produced from ARCSHS to complement extensive data from research projects undertaken at the National Centre in HIV Social Research, indicated 'a continuing proliferation of HIV risk assessment and minimisation strategies' on the part of those most directly affected (Bartos 1998, in this volume).

This result confirmed yet again the dynamism of safe sex cultures (Ariss *et al.* 1995; Kippax *et al.* 1993a; Vadasz and Lipp 1990) and the need to continue to take this dynamism into account in HIV prevention. Even though Positive Education has had a chequered history (Duffin 1990; AFAO/NAPWA 1997; Hurley 2000a), best practice in HIV education has long been informed by an understanding of this dynamism in gay and safe sex cultures. It was central to shifts in educational practice in the later 1990s (AFAO 1995, 1996; Duffin 1996; Parnell, 1997; Murphy *et al.* 2000). It was informed by the knowledge that gay men were in the process of re-positioning HIV in relation to gayness, rather than gayness in relation to HIV (Dowsett 1996a; Dowsett and McInnes 1996; Honnor 2000). HIV-positive gay men were often integral to these shifts in lived cultures and in discussions of their educational implications. Duffin argued in 1996 that 'gay men have adopted a set of strategies to minimise HIV transmission rather than eliminate it' and went on to say: 'we've also tried to grapple with a risk assessment or risk minimisation framework for safe sex guidelines' (Duffin 1996: 7).

Subsequent analysis of data from the HIV Futures II survey indicated that:

The most conclusive impact of Highly Active Antiretroviral Therapy (HAART) is to make it increasingly difficult to talk in unitary terms about a single HIV-positive population. (Bartos *et al.* 2000b)

Overall, the research indicates that *HIV prevention and our understanding of safe sex cultures amongst gay men generally, and people living with HIV specifically, are challenged by the adaptations made in everyday life by those most affected by HIV.* The fourth National AIDS Strategy has a built-in understanding of these issues. It names the 'changing epidemic and changing perceptions of the risk of HIV transmission' as challenges for the maintenance of safe sex cultures (Commonwealth Department of Health and Aged Care 2000: 15).

The research also makes it clear *that these adaptations are not in themselves a threat to safe sex cultures.* Rather, they indicate that safe sex cultures evolve and that 'maintenance' has to take this into account. The adaptations now require that researchers, policy makers and educators understand the differences between 'unprotected' and 'unsafe' sex and the implications of these differences for educational relevance. Hence we have seen from 1994 onwards the incorporation of research on 'negotiated safety' (Kippax *et al.* 1993b, 1996, 1997) into HIV prevention with sero-discordant partners in regular relationships. More recently we have seen the development in evidence-based HIV education of risk reduction approaches to casual sex ('No Worries' campaign, www.afao.org.au). This

education is underpinned by research involving the notion of 'strategic positioning' in unprotected anal sex in casual contexts (Van de Ven *et al.* 2002). That research rules out 'complacency' amongst gay men as an appropriate explanation of unprotected sex and highlights the 'ever more complex domain of HIV prevention'.

Cultures of care... provides readers with the documents to understand and assess these claims about self-care and HIV prevention and to trace how some of the thinking involved has developed as researchers progressively analyse the data gathered in the HIV Futures Studies. The report amply demonstrates that research of this kind not only has immediate application for care and support services, treatments and social equity advocacy, but also makes important contributions to discussion of HIV prevention policy and practice. Perhaps its major implication is that people living with HIV are often sexually active, sexually responsible human beings and that the subcultures they create are expressive of their humanity, indicative of social citizenship and actively embody sensuality in the face of disease if not death.

On the surface there are some differences between the conclusions in the papers included in this report, especially between the conclusions in Bartos *et al.* 2000a and 2000b and those found in Willis *et al.* (2001). Bartos *et al.* (2000b) conclude that 'Partner serostatus rather than antiretroviral treatments governs the use or non-use of condoms within HIV-positive people's regular partnerships.' In the original oral version of their paper, Willis *et al.* (2001) argued that there is a strong case for understanding use of antiretrovirals as an act of self-care that in turn becomes a predictor of safe sex. However, if we read on we see that Bartos *et al.* (2000b) went on to say: 'those on antiretrovirals also turn out to be more consistent condom users than those not using antiretrovirals'. As it happens, refinements to the analysis of Willis *et al.*, as presented in this volume (2002), led to the following conclusion: 'Partner serostatus has the biggest impact on whether HIV positive men have UAI in both casual and regular relationships ... a person's treatment status is the second most important factor'. The difference is that in the earlier oral version and in Willis *et al.* (2002, this volume), both partner serostatus and use of antiretrovirals are linked under the over-arching concept of 'self-care', and it is the amalgam of these and other factors which becomes the predictor of safe sex. From a 'cultures of care' perspective (Hurley 2002, this volume), both possibilities are suggestive of a strong link between self- and other- regarding care practices and safe sex.

The remainder of this introduction briefly discusses some key issues in how links emerge between a general notion of cultures of care and a generalised account of the sexual practices of people living with HIV, especially HIV positive gay men.

It's no accident that I refer to sexual 'practices' rather than sexual behaviour. 'Practices' is used because it signifies and insists on the social dimension of individual acts (Dowsett 1996b). By and large, people living with HIV are socially linked (not only, but also, with each other) and their sexual acts are charged with meaning. That meaning is informed partly, especially amongst some HIV positive gay men, by an awareness of the relations between clinical markers and infectivity (Rosengarten *et al.* 2000). However, it appears likely from the HIV Futures surveys that it is not that awareness itself which constructs safe sex. Rather, it is the practice of self-care as a disposition (in the sense of an embodied social history,

Bourdieu 1990: 56) that results in self- and other- regarding sexual practice, and self-care is not constituted solely by clinical markers (Willis *et al.* 2002, this volume). The emphasis here is on the resilience of safe sex cultures and practices and the contributions HIV-positive gay men make to these cultures.

Sexual practice has to be understood socially and culturally. This insistence has been present in Australian HIV social research since the Social Aspects of the Prevention of AIDS Project began in 1985 (Kippax *et al.* 1993a). Even so, it has varied in its formulation between quasi-behavioural notions and more fully fledged social conceptualisations. The challenge for health promotion and HIV prevention has always been that sexual lives are lived socially, not in a test tube. What Michael Bartos was able to point to in 1998, when reflecting on the data from the HIV Futures I survey and the Sydney Men and Sexual Health study, was not only how the meanings of sexual practice shift in relation to treatments, but also how the meaning of being infected with HIV was shifting. He linked this, as noted earlier, to 'a continuing proliferation of HIV risk assessment and minimisation strategies' (withdrawal, withdrawal before coming, only topping, only bottoming, using condoms when infected with STIs, ascertaining believed HIV status). These strategies for risk minimisation are creative embodiments of self- and other-regarding sexual care. They are the specific practices which link cultures of everyday life and various degrees of 'safe sex' practice.

It is the researched understanding of these everyday practices which allows for a clear, educationally justified, productive distinction between unprotected sex and unsafe sex and allows researchers to argue that much unprotected sex is, in fact, safe sex. This is the case most obviously where sero-concordant sex takes place, but it is also the case in some sero-non-concordant situations. It is here that the issue of risk reduction has the most salience and in the case of one partner being HIV positive this is precisely what 'strategic positioning' addresses. *Unprotected sex can be more or less safe or totally unsafe. It all depends on contextual factors.*

In this discussion of research into sexual practice as a self-care activity, two further issues seem to me to require comment. Firstly, there is the relation between the researchers, the researched and the research instruments (Dowsett and Davis 1998; McInnes 1998). Many of the main HIV social researchers and commissioners of research are also members of the affected communities or have close personal and/or professional relationships with them (Altman 1994; Ariss 1997; Dowsett 1999; Patton 1990). They may or may not be HIV-positive themselves and may have other roles in community and community-based organisations. The research instruments (the 'survey', the 'interview') used to collect the data in the HIV Futures I and II Studies are developed in close collaboration with both those who have a stake in what the data reveal and reflexive understandings of professional and personal practice. In other words, HIV social researchers don't do this by themselves. They develop their research instruments through continuous interaction with, amongst others, community-based organisations of people infected and affected by HIV (particularly educators), those responsible for care and support and the infrastructures which support these activities.

The research instrument is itself sometimes instrumental in affecting the nature of sociability, particularly when it is modified according to what has previously been

discovered, and in relationship to priorities set by national strategies or organisations of people living with HIV. It doesn't simply 'discover' this sociability, though this has been one of its primary functions. It doesn't just 'discover' it because key informants have influenced where it looks and how it looks and what sorts of experiences are 'seen' in the process. Much of this 'experience' is a matter of how people with HIV live with infection and that, in turn, is not determined by the instrument, even though the uses made of the data gathered with it may subsequently affect the lived experience of the respondents to the survey.

As Bartos *et al.* (2000b) put it:

The populations we study are not insulated from our research findings. We saw no optimism effects when we first conducted the HIV Futures Survey in 1997. Two years later, after considerable public and scientific discourse saying 'we are worried that HAART optimism will result in more unsafe sex' we indeed discover that for a small proportion of PLWHA there is an association between 'optimism' and unsafe sex. All we may be seeing is a post hoc effect: After all the public debate, perhaps some PLWHA are using 'treatments optimism' as the most available rationale to explain away their occasional unsafe sex.

Secondly, this relative independence of experience is particularly the case with lived sexual cultures. What Bartos went on to argue in 1998 in relation to 'disclosure' of an HIV positive status, was that:

in public sex environments, there are fewer bonds of social obligation which imply a duty of care towards another person. *It is not that HIV positive men in these circumstances are acting with callous disregard or recklessly [by not disclosing]. Rather, they are assuming that their casual sexual partners are autonomous adults able to make their own HIV risk management decisions.* (emphasis added)

Note carefully that the references to 'fewer bonds of social obligation' and 'duty of care' are made in the context of a discussion of 'disclosure' of HIV status in casual sex contexts, not in relation to either public space as such or to a more general recklessness.

The studies of Post Exposure Prophylaxis and earlier sero-conversion research data indicate that risk of HIV infection occurs within sero-discordant regular relationships as much as it is known to occur in public sex environments (Kippax *et al.* 2000). The work on context and the meaning of specific sexual acts (Connell *et al.* 1990; Bollen *et al.* 1998) and the data in the HIV Futures II survey all strongly imply that public sex environments in and of themselves are not the determining factor in unprotected sex and HIV transmission. Rather, it is the ways assumptions about the HIV status of casual sexual partners interconnect with, for example, the meanings associated with condom use and how these in turn interact with other practices of self care such as treatments uptake and 'strategic positioning' that make infection more likely.

All of the research reported here confirms that the sexual practices of people living with HIV are generally well informed and socially responsible. *It also confirms that*

the lived experience of people with HIV can be understood as a dynamic interaction between information, sociability and self-care practices. That it changes continually over relatively short periods of time, as indicated by the papers in this report, is a sign of an engagement with life; it is a lived engagement, sometimes fraught, sometimes celebratory, but always passionate.

This passion for life is central to the ways in which health promotion is required by the National AIDS Strategy to take into account cultural context (Commonwealth Department of Health and Aged Care 2000: 13).

1. TAKING CARE OF ME, TAKING CARE OF OTHERS: HIV POSITIVE GAY MEN, TREATMENTS AND SAFER RELATIONSHIPS

Jon Willis, Jeffrey Grierson, Michael Hurley and Sebastian Misson

Edited version of an oral presentation using data from the HIV Futures II Study delivered at the 13th annual conference, Australasian Society for HIV Medicine, Melbourne 2001.

Abstract

The paper is based on a secondary analysis of data collected in the HIV Futures II survey. The survey was of a sample of 924 HIV positive Australians. 706 of them were HIV positive gay men. We examine unprotected anal intercourse (UAI) reported in casual and regular sexual relationships by the gay men who responded to the survey. These men made up 76.4% of respondents. Our analysis examines the impact of a range of indices of risk of transmission on patterns of UAI. These indices include:

- Partner serostatus, particularly where this is perceived as HIV negative or is unknown;
- Whether respondents were on antiretroviral therapy (ARV) or not; and
- Their most recent viral load.

The results demonstrated that the relationships between all of the variables are much more complex than public discourse might suggest.

The most striking result is that an overwhelming majority of HIV positive men avoid unprotected anal intercourse with partners of negative or unknown status, regardless of whether the partner is casual or regular. A second important result is that the very small amount of unprotected anal intercourse reported in this study is as likely to be with a positive partner as with one negative or unknown serostatus.

The findings suggest that:

- Lower viral load is less likely to be associated with UAI than higher viral load;
- Clinical markers may not be relevant to decision making about sexual safety;
- Evidence of self care, particularly uptake of antiretroviral therapies and consequent reduction of viral load, is a significant predictor of care-of-others in sexual situations; and
- Cultures of care, as systems of meaning, extend beyond the clinical.

Background

This reanalysis of the Futures II data was prompted by a number of recent observations about changes to the culture of safety in sexual practices of HIV positive gay men in Australia. These observations, which appeared in publications in 2000 and 2001, related particularly to how knowledge of viral load affected the place of UAI in regular and casual sexual relationships. They were drawn from data collected in the Clinical Markers Study reported in '*Touch wood, everything will be OK...*' (Rosengarten, Race & Kippax, 2000), from data in the Gay Community Periodic Surveys (reported in NCHSR, 2001), and from data in the Male Out 2000 study presented in the "Facts & Figures" Report (Van de Ven et al. 2001).

Rosengarten, Race & Kippax (2000) presented data from a qualitative study (N=56 of whom 23 were HIV positive) designed to sample understandings and practices amongst both HIV positive and HIV negative (tested or self-assuming) gay men. The report's findings focussed on 'interview extracts selected for their ability to shed light on attitudes to UAI and the extent to which clinical markers may be contributing to this practice' (n=21 of whom 11 were HIV positive) (Rosengarten, Race & Kippax, 2000: 10). The report did not include interview material that focused solely on sustained protected anal intercourse or no anal intercourse. The authors acknowledged the limits of the study and concluded generally that clinical markers were having an impact on the practice of UAI. More specifically, they concluded that 'there was evidence to suggest that those who practice UAI are more likely to have undetectable or low viral load than high viral load' (Rosengarten, Race & Kippax, 2000: 30). In addition to this observation about the likelihood of positive men engaging in UAI and its relation to viral load, they concluded that HIV positive men were using individually tailored risk minimisation strategies which incorporated a range of elements including: 'the results of viral load tests; epidemiologically proven reduced risk according to sexual position and non-ejaculation; full disclosure and/or reading non-verbal cues to indicate the positive serostatus of a partner and/or consensual participation in UAI' (Rosengarten, Race & Kippax, 2000: 30).

In the context of continuing reports of increased HIV notifications in Victoria, and associated media commentary from May 2000 onwards, including reports of an alleged increase in NSW, these findings rang considerable alarm bells (AAP 2000; Age 2000). This was particularly so when coupled with findings of the *Annual Report of Behaviour* (NCHSR, 2001) where a key observation was that:

HIV positive men are (almost universally) more likely to engage in unprotected anal intercourse than HIV negative men, *although some of this unprotected anal intercourse is safe with regard to HIV transmission as it occurs between HIV positive partners* (emphasis added) (NCHSR, 2001:5).

The *Annual Report of Behaviour* was not able to quantify the extent to which partner serostatus was affecting positive men's decision making about UAI. However it did attempt some quantification of the relative importance of

strategic positioning and of withdrawal to HIV positive and negative men in relation to UAI from an aggregation of data collected in the Sydney Gay Community Periodic Surveys over the five-year period to August 2000. The report concluded that 'among men who had unprotected anal intercourse which involved ejaculation inside with a sero-discordant regular partner, *there was a clear pattern of strategic positioning based on serostatus*' (emphasis added) (NCHSR, 2001: 63). The pattern among those who practiced consistent withdrawal with a sero-discordant regular partner was less clear cut, but still aligned with a pattern of HIV positive-receptive and HIV negative-insertive behaviour. With casual partners, whether UAI included ejaculation inside or consistent withdrawal, the patterns of strategic positioning identified for regular partners were repeated.

The findings reported in the *Annual Report of Behaviour* seemed to reinforce concerns that HIV positive gay men were abandoning conventional safe sex strategies (i.e. consistent condom use and reduction in partner numbers) on the basis of somewhat flawed understandings of risk reduction. These understandings included reducing infectivity by maintaining a lowered viral load, and taking the position in unprotected anal intercourse that presented the least risk of disease transmission to a partner of negative or unknown status. Concerns escalated with the release of *Facts & Figures* (Van de Ven *et al.* 2001), which showed that rates of UAI with both regular and casual partners were rising, regardless of the serostatus of partner. Particular concern was raised by findings that there were significant differences between HIV positive and negative gay men over issues of HIV disclosure with sexual partners, although these data were not linked to practices of UAI.

Participants in *Male Out 2000* were asked about avoiding sex with people thought to be HIV positive, and about their expectations that an HIV-positive man would reveal his HIV status before giving sex. The pattern revealed in responses to these questions was that most HIV negative participants expected HIV positive men to disclose their status before sex, but large numbers of men stated that they avoided sex with HIV positive men. Although there were no questions about actual disclosure in this survey, and the number of positive respondents was relatively small (n=80), the authors conclude that 'in such a climate *there is little incentive for HIV positive men to disclose at all*' (emphasis added) (Van de Ven *et al.* 2001: 32). Indications from the relatively small number of HIV positive men in the study were that they did not believe that disclosure was as important as the HIV negative men believed.

Official responses to these three research reports and media reporting of them gave the impression that HIV positive gay men in Australia were increasingly abandoning sexual safety as part of a wave of complacency around HIV transmission among gay men. Televised media coverage of the launch of *Facts & Figures* included Chris Puplick, Chairman of the Australian National Council on AIDS, Hepatitis C and Related Diseases, who characterised the findings of the report as:

...the emergence of significantly more negative attitudes towards condoms, a significantly higher incidence of drug use in gay community attached men – another challenge for educators – and greater use of sex on premises venues by men who practice unprotected anal intercourse and the seeking out and use of these venues for precisely this behaviour. (ABC Lateline, 2001)

The Lateline report concluded with the reporter, Tony Eastley, blaming a 41% increase in HIV infections in Victoria on complacency (ABC Lateline, 2001).

However, none of these three studies was designed to deliver a definitive and representative picture of HIV positive gay men's sexual practices, and conclusions drawn from one do not map straightforwardly onto the results from the others. Neither the findings from *'Touch wood, everything will be OK'* or from the Male Out survey really tell us anything reliable about the practices of men who responded to the periodic surveys reported in *Facts and Figures*. On their own, even the *Facts and Figures* data tell us very little about the configuration of transmission risk in the UAI reported by HIV positive men who responded in the periodic surveys, as they don't tell us what proportion of this unprotected sex was, epidemiologically speaking, unsafe.

For this level of information, we need to examine the data collected in the Futures II survey, which did ask questions about safe and unsafe practices, as well as questions about protected and unprotected sex. The distinction we are making between safe and protected is based on the acknowledgement (extending Van de Ven et al. 2001) that within a strategy of safety there are a range of tactics that gay men adopt to reduce HIV transmission risk in sexual activity, of which wearing a condom is one of the most effective. Other forms of what we suggest might be called *tactical safety* include (from the point of view of HIV positive gay men):

- Not having sex;
- Not having UAI with partners who are HIV negative or of unknown serostatus;
- Using condoms in anal intercourse with partners who are HIV negative or of unknown serostatus;
- Only choosing HIV positive partners for UAI;
- Not being the insertive partner in UAI, especially with partners who are HIV negative or of unknown serostatus;
- Not ejaculating inside your partner in UAI, especially with partners who are HIV negative or of unknown serostatus;
- Disclosing your serostatus and knowing your partner's serostatus (and not making assumptions about partner serostatus on the basis of their behaviour);
- Maintaining a low viral load.

Futures II asked sufficient questions for us to examine the configuration of tactical safety in both regular and casual sexual relationships of HIV positive people. It also asked them of a reasonably representative sample of HIV positive people.

Method

The HIV Futures II survey was an anonymous, self-complete, mail-back questionnaire consisting of 193 items organised into eight sections: demographics; accommodation; health and treatments; services and organizations; sex and relationships; employment; recreational drug use; and finances. The survey, once completed, was returned in a reply paid envelope to the Living with HIV program. As the broad aim of the study was to represent the collective and individual experiences of people with HIV/AIDS in Australia, a purposive, multi-faceted community sampling strategy was employed. Participants were recruited using a multi-pronged approach including mail-out, organisational distribution, and advertisement. Active recruitment took place between August and October, 1999. The survey was completed by 924 HIV positive people, which represents approximately eight percent of the HIV positive population estimated in Australia at the time (NCHECR, 1999).

This paper is based on a secondary analysis of a sub-sample of the gay men who provided data to the Futures II survey. Gay men, of whom there were 706, represented 76.4% of all respondents. The analysis examined responses to questions relating to sex and relationships in order to explore the relationship between treatment uptake and a range of indicators of tactical safety within casual and regular relationships.

Questions about sex and relationships were contained in section E of the questionnaire. Respondents who had had sex with casual partners in the last six months were asked:

- how many of their casual sexual partners had been HIV positive;
- had they had anal intercourse with a casual male partner in the past six months;
- how often did they use condoms during intercourse with casual partners in the last six months;
- the HIV status of their most recent casual partner; and how they knew that partner's HIV status;
- did they have anal intercourse with that partner; were condoms used; and did they ejaculate inside their partner?

Respondents were also asked if they were in a regular relationship at the time, and a series of questions in relation to their primary regular relationship. These questions included:

- the duration of the relationship;
- partner's HIV status;
- whether they had disclosed their HIV status to their regular partner; at what stage in the relationship they made this disclosure; their partner's reaction to their disclosure;
- whether they had anal intercourse with their regular male partner in the preceding six months; and how often they used condoms in anal intercourse (never, sometimes, usually or always). For the purposes of this analysis, we counted 'never', 'usually' or 'sometimes' used condoms as a negative response, and only 'always' counted as a

positive response in relation to use of condoms in a regular relationship.

We also asked respondents to report their most recent plasma viral load and CD4 count.

Results

Casual relationships

Of the 706 gay men in the survey, 472 had had a casual sexual encounter in the past six months. Of these, 333 were on treatments, and 139 were not on treatments. Results in relation to these encounters are described in Figures One to Three (see end of this section), which examine casual relationships in terms of the treatment status of the respondent and the serostatus of his partner.

Sixty-three men were on treatment and had an HIV positive partner, and 270 men on treatments had a casual sexual encounter with a man whose HIV serostatus was negative or unknown. A significantly greater proportion of those with an HIV positive partner had anal intercourse compared to those with a partner of HIV negative or unknown serostatus (96.8% versus 71.2%, $X^2=18.06$, $p<.001$). Of those who had anal intercourse, a significantly greater proportion of those with an HIV positive partner didn't use a condom compared to those with a partner of HIV negative or unknown serostatus (62.1% versus 17.0%, $X^2=44.97$, $p<.001$)¹.

Of those on treatments who had UAI with a casual partner, the difference in the proportion of those who ejaculated in their HIV positive partner (38.9%) compared to those with a partner of HIV negative or unknown serostatus (54.8%) was not significant. Of those who had UAI, there were no significant differences in median viral load between those with an HIV positive partner and those with a partner of HIV negative or unknown serostatus (median VL for both groups was below detectable levels); neither were mean CD4 counts (521.7 versus 572.3) significantly different. There were also no significant differences in median viral load (both groups below detectable levels) or mean CD4 count (539.5 versus 555.9) between those who had protected anal intercourse (PAI) with an HIV positive partner and those who had PAI with a partner of HIV negative or unknown serostatus.

Thirty-four men were not on treatment and had an HIV positive partner (including 15 who had never been on treatments), and 105 men who were not on treatments had casual sexual encounters with partners whose HIV serostatus was negative or unknown (including 58 men who had never been on treatments). A significantly greater proportion of those with an HIV positive partner had anal intercourse in casual contexts compared to those with a partner of HIV negative or unknown serostatus (94.1% versus 78.8%, $X^2=4.167$, $p<.05$). Of those who had anal intercourse, a significantly greater proportion of those with an HIV positive partner didn't use a condom

¹ This means that of the total men in each of these sub-groups, a significantly greater proportion of men with *casual* HIV positive partners had UAI than those whose partners were of HIV negative or unknown serostatus (60.0% versus 12.0%, $X^2=68.24$, $p<.001$).

compared to those with a partner of HIV negative or unknown serostatus (71.9% versus 25.9%, $X^2=20.37$, $p<.001$).²

Of those not on treatments who had UAI with a casual partner, the difference in the proportion of those who ejaculated in their HIV positive partner (52.2%) compared to those with a partner of HIV negative or unknown serostatus (45.0%) was not significant. Of those who had UAI, differences in median viral load between those with an HIV positive partner and those with a partner of HIV negative or unknown serostatus were not significant (48,420 versus 11,000); neither were mean CD4 counts significantly different (460.4 versus 612.6). There were also no significant differences in median viral load (22,587 versus 13,265) or mean CD4 count (438.8 versus 516.2) between those who had PAI with an HIV positive partner and those with a partner of HIV negative or unknown serostatus.

A summary point: of the 105 men not on treatments who had a casual sexual encounter with a man of HIV negative or unknown serostatus, only 21 had UAI, and only 9 of these ejaculated in their partner.

In relation to all casual sexual encounters with partners of HIV negative or unknown serostatus, there were significant differences in the proportion of men who had UAI with their partner between those on treatments and those not on treatments (12.0% versus 20.4%, $X^2=4.22$, $p<.05$).

The median viral load of those who had UAI with a casual partner of HIV negative or unknown serostatus was significantly lower for the group who were on treatments than for those not on treatments (below detectable levels versus 11,000, $z=-4.08$, $p<.001$). Mean CD4 count for the group on treatments was also lower than that of the group not on treatments, although this difference was not statistically significant (572.3 versus 612.6). In relation to those who had PAI, median viral load was also significantly lower for those on treatments than those not on treatments (below detectable levels versus 13,265, $z=-6.88$, $p<.001$). Mean CD4 count for the group on treatments was somewhat higher than for the group not on treatments, although this difference was not statistically significant (555.9 versus 516.2).

Regular Relationships

Of the 692 gay men in the survey, 340 were in a regular relationship at the time of the survey. Of these, 269 were on treatments, and 71 were not on treatments. Results in relation to these relationships are described in Figures Four to Six (see end of section), which examine regular relationships in terms of the treatment status of the respondent and the serostatus of his partner.

One hundred and seventeen men were on treatment and had an HIV positive regular partner, and 152 men on treatments had a regular relationship with a partner whose HIV serostatus was negative or unknown. A significantly

² This means that of the total men in each of these sub-groups, a significantly greater proportion of men with **casual** positive partners had UAI than those whose partners were of HIV negative or unknown serostatus (65.7% versus 20.4%, $X^2=24.71$, $p<.001$).

greater proportion of those with an HIV positive partner had anal intercourse compared to those with a partner of HIV negative or unknown serostatus (82.6% versus 57.0%, $X^2=19.76$, $p<.001$). Of those who had anal intercourse, a significantly greater proportion of those with an HIV positive partner didn't use a condom compared to those with a partner of HIV negative or unknown serostatus (83.9% versus 31.4%, $X^2=50.74$, $p<.001$).³ Of those who had UAI, differences in median viral load between those with an HIV positive partner and those with a partner of HIV negative or unknown serostatus were not significant (below detectable levels for both groups); neither were mean CD4 counts (576.2 versus 537.8) significantly different. There were also no significant differences in median viral load (746 versus below detectable levels) or mean CD count (611.8 versus 568.3) between those who had PAI with a regular HIV positive partner and those who had PAI with a regular partner of HIV negative or unknown serostatus.

A summary point: of the 152 men on treatments who had a regular sexual relationship with a man of HIV negative or unknown serostatus, only 27 men “sometimes, usually or always” had UAI.

Twenty seven men were not on treatment and had a regular HIV positive partner (including 15 who had never been on treatments), and 44 men who were not on treatments had a regular partner whose HIV serostatus was negative or unknown (including 23 men who had never been on treatments). A greater proportion of those with an HIV positive partner had anal intercourse compared to those with a partner of HIV negative or unknown serostatus (88.9% versus 69.8%), although the difference in proportion was not statistically significant.⁴ Of those who had anal intercourse, a significantly greater proportion of those with an HIV positive partner didn't use a condom compared to those with a partner of HIV negative or unknown serostatus (91.3% versus 51.7%, $X^2=9.43$, $p=.002$).

Of those who had UAI, there was a significant difference in median viral load between those with an HIV positive partner and those with a partner of HIV negative or unknown serostatus (27,689 versus 4,438, $z=5.15$, $p=.001$); however mean CD4 counts did not differ significantly (490.4 versus 652.6). We were unable to reliably determine whether the differences in median viral load (7,862 versus 15,182) or mean CD4 count (750.0 versus 526.2) between those who had PAI with an HIV positive partner and those who had PAI with a partner of HIV negative or unknown status were statistically significant because sub-sample sizes were too small – there were only two men in the PAI with an HIV positive partner group.

³ This means that of the total men in each of these sub-groups, a significantly greater proportion of men with **regular** positive partners had UAI than those whose partners were of HIV negative or unknown serostatus (67.2% versus 17.9%, $X^2=66.99$, $p<.001$).

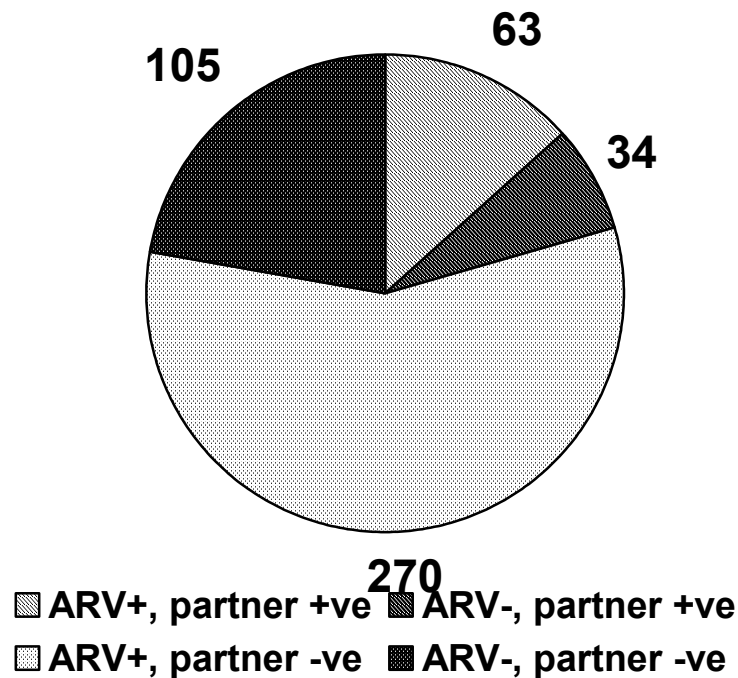
⁴ Nonetheless, of the total men in each of these subgroups, a significantly greater proportion of men with regular HIV positive partners had UAI than those whose partners were of HIV negative or unknown serostatus (77.8% versus 34.9%, $X^2=12.22$, $p<.001$).

A summary point: of the 44 men not on treatments who had a regular sexual relationship with a man of HIV negative or unknown serostatus, only 15 “sometimes, usually or always” had UAI.

In relation to all regular sexual relationships with partners of HIV negative or unknown serostatus, there were significant differences in the proportion of men who had UAI with their partner between those on treatments and those not on treatments (17.9.4% versus 34.9%, $X^2=5.70$, $p<.05$).

The median viral load of those who had UAI with a regular partner of HIV negative or unknown serostatus was lower for the group who were on treatments than for those not on treatments (below detectable levels versus 4,438), although this difference did not reach statistical significance. Mean CD4 count of those who had UAI with a regular partner of HIV negative or unknown serostatus was also lower for the group who were on treatments than for those not on treatments (537.8 versus 652.6), although this difference was also not statistically significant. In relation to those who had PAI, median viral load was significantly lower for those on treatments than those not on treatments (below detectable levels versus 15,182, $z=-4.73$, $p<.001$). Mean CD4 count was higher for the group on treatments than for those not on treatments (568.3 versus 526.2), although this difference did not reach statistical significance.

Figure 1: Treatment status and serostatus of casual partners



<p><u>On treatment, partner positive</u></p> <ul style="list-style-type: none"> • 63 men • 61 (97%) had anal intercourse • 38 (62%) of these were UAI • 15 (39%) of these ejaculated in their partner • For those who had UAI, median VL was below detectable levels (BDL), and mean CD4 count was 522 • For those who had PAI, median VL was BDL, and mean CD4 count was 540 	<p><u>Not on treatment, partner positive</u></p> <ul style="list-style-type: none"> • 34 men (15 had never been on treatments) • 32 (94%) had anal intercourse • 23 (72%) of these were UAI • 12 (52%) of these ejaculated in their partner • For those who had UAI, median VL was 48,420, and mean CD4 count was 460 • For those who had PAI, mean VL was 22,587, and mean CD4 count was 439
<p><u>On treatment, partner negative or unknown</u></p> <ul style="list-style-type: none"> • 270 men • 191 (71%) had anal intercourse • 33 (17%) of these were UAI • 18 (55%) of these ejaculated in their partner • For those who had UAI, median VL was BDL, and mean CD4 count was 572 • For those who had PAI, median VL was BDL, and mean CD4 count was 556 	<p><u>Not on treatment, partner negative or unknown</u></p> <ul style="list-style-type: none"> • 105 men (58 had never been on treatments) • 83 (79%) had anal intercourse • 21 (26%) of these didn't use a condom • 9 (45%) of these ejaculated in their partner • For those who had UAI, median VL was 11,000, and mean CD4 count was 613 • For those who had PAI, median VL was 13,265 and mean CD4 count was 516

Figure 2: Casual Summary

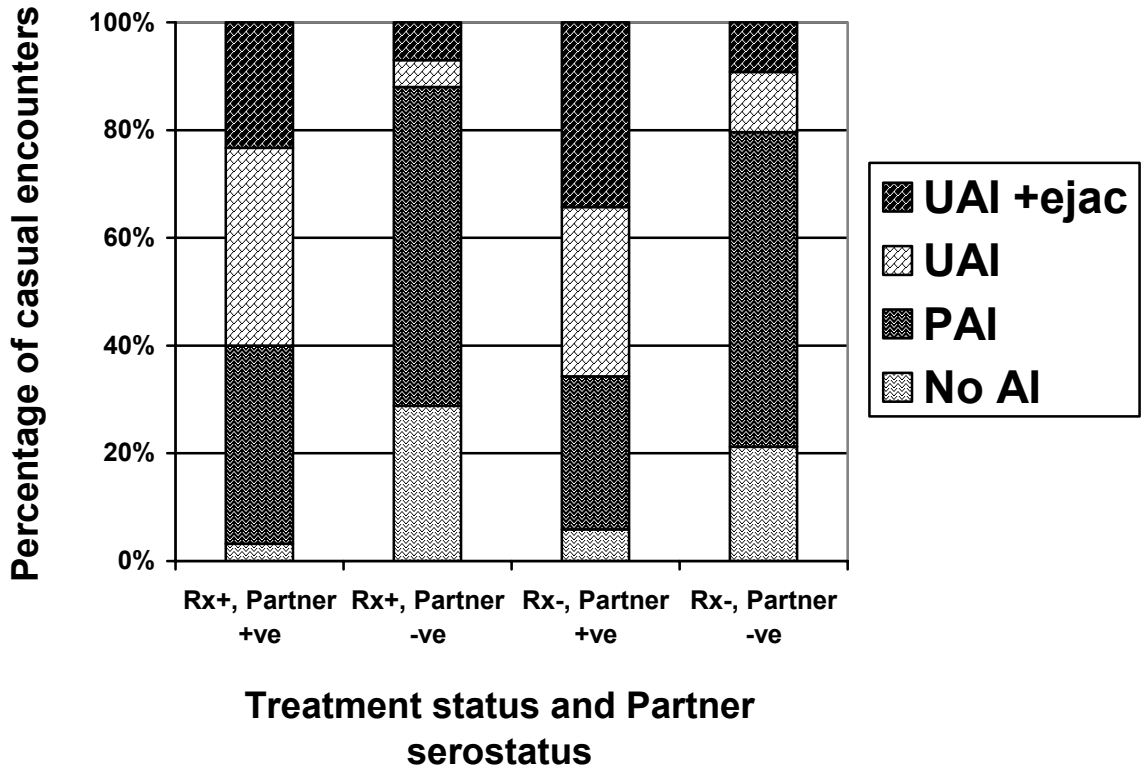


Figure 3: Mean log viral loads for UAI and PAI in casual encounters

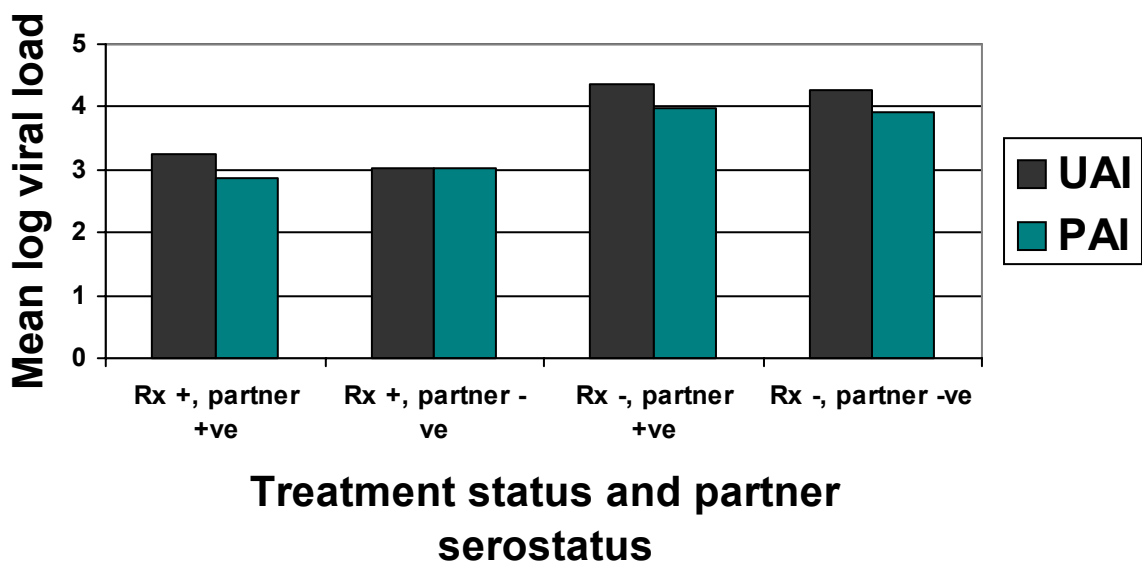
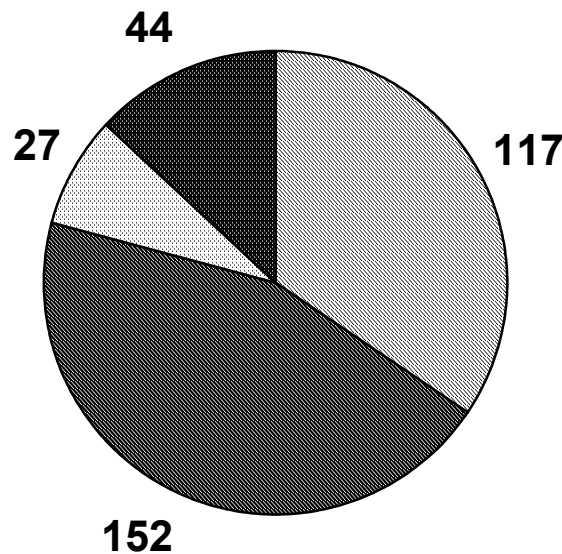


Figure 4: Treatment status and serostatus of regular partners



ARV+, partner +ve
 ARV+, partner -ve
 ARV-, partner +ve
 ARV-, partner -ve

<p><u>On treatments, partner positive</u> 117 men 97 (83%) had anal intercourse 82 (84%) of these were UAI For those who had UAI, median VL was BDL and mean CD4 was 576 For those who had PAI, median VL was 746 and mean CD4 was 612</p>	<p><u>Not on treatments, partner positive</u> 27 men (46% had used ARV in the past) 24 (89%) had anal intercourse 19 (78%) of these were UAI For those who had UAI, median VL was 27,689 and mean CD4 was 490 For those who had PAI, median VL was 7,862 and mean CD4 was 750</p>
<p><u>On treatments, partner negative or unknown</u> 152 men 87 (57%) had anal intercourse 27 (31%) of these were UAI For those who had UAI, median VL was BDL and mean CD4 was 538 For those who had PAI, median VL was BDL and mean CD4 was 568</p>	<p><u>Not on treatments, partner negative or unknown</u> 44 men (48% had used ARV in the past) 31 (70%) had anal intercourse 16 (52%) of these were UAI For those who had UAI, median VL was 4,438 and mean CD4 was 653 For those who had PAI, median VL was 15,182 and mean CD4 was 526</p>

Figure 5: Regular Summary

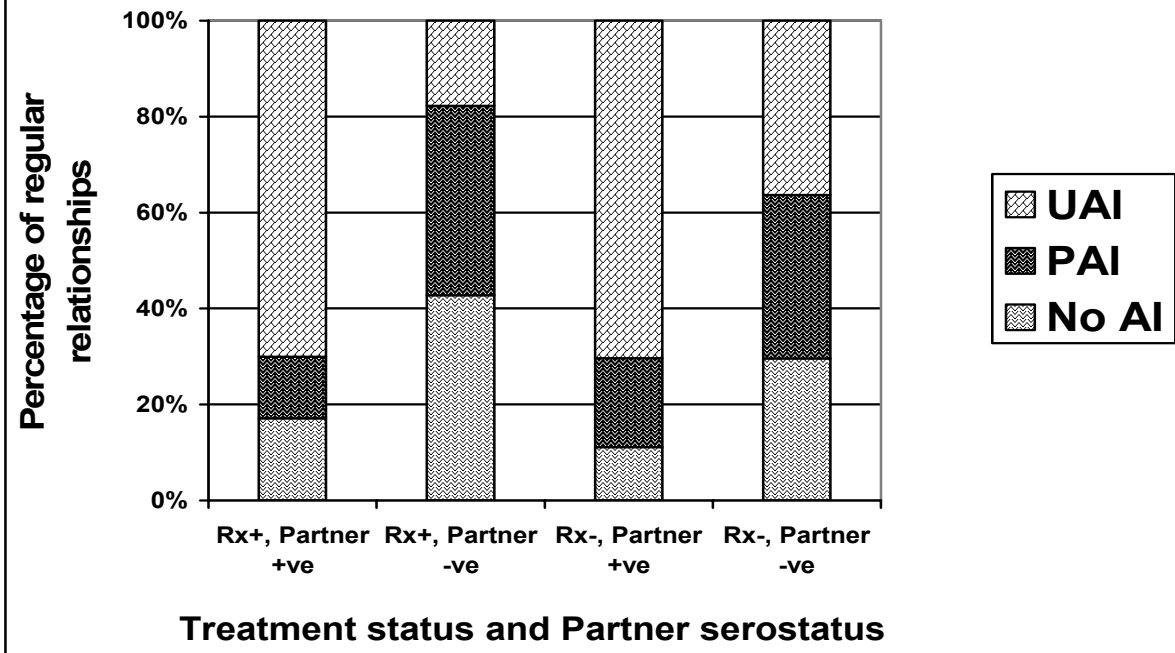
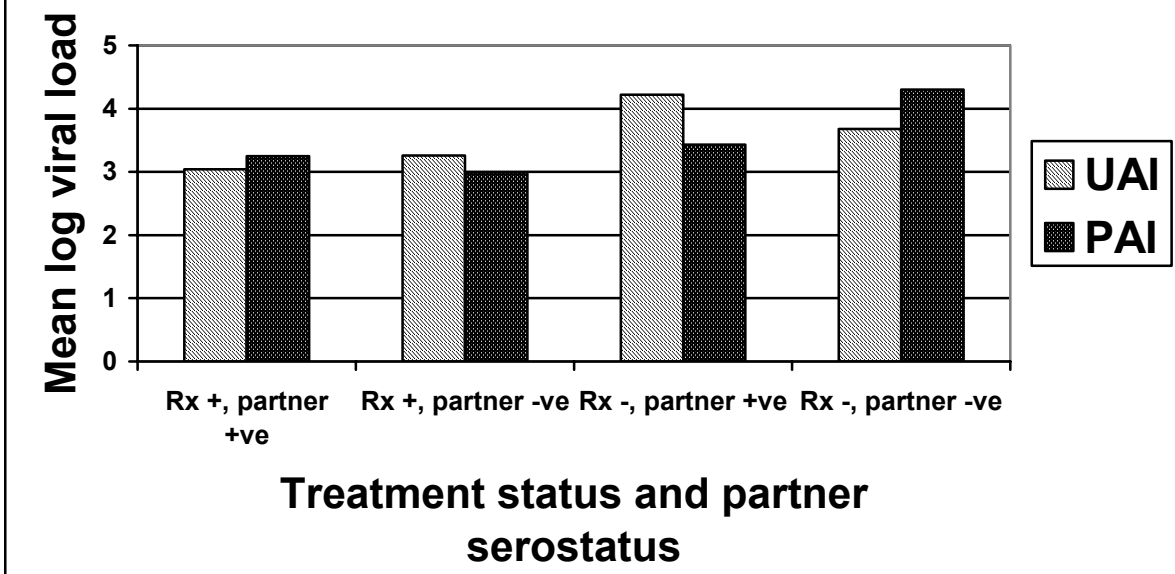


Figure 6: Mean log viral loads for UAI and PAI in regular relationships



Discussion

The 706 HIV positive gay men who responded to this survey were incorporating a range of the tactical safety measures described in the introduction to this paper into their regular and casual relationships. One hundred and five of the men in our study reported no sex at all in the six months prior to filling in the survey. A further 144 men had a regular partner who was also HIV positive, and the last casual partner of 97 men was also HIV positive.

Regardless of treatment status, viral load, CD4 count, or whether relationships were with regular or casual partners, there were marked and statistically significant differences in patterns of UAI with HIV positive and HIV negative partners.

Across the board, HIV positive gay men were much more likely to have UAI if their partner was also HIV positive, and much less likely to have UAI if their partner's HIV serostatus was negative or unknown. Our respondents were much more likely to use a condom in anal intercourse with HIV negative partners, whether casual or regular, than if their partner was HIV positive.

These differences were not just statistically significant, but also epidemiologically meaningful. They give us considerable insight into the ways that HIV positive gay men are practically utilising the distinction between *unprotected* and *unsafe*. If we examine the 472 casual sexual encounters reported in this paper, only 115 of them involved unprotected anal intercourse. Of these 115, only 54 were potentially unsafe (at least in terms of HIV transmission). Of these 54, only 27 involved ejaculation inside a partner whose HIV serostatus was negative or unknown. So even though the overall rate of *unprotected* sex in our survey (24.7%) might suggest a relaxed attitude to sexual safety, only 11.4 percent of casual sex could actually be characterised as unsafe in terms of HIV transmission, and in only half of these cases (6.43%) did a positive man ejaculate inside his partner where that partner's serostatus was HIV negative or unknown.

Although we did not ask a question about strategic positioning, we did ask respondents if they had ejaculated inside their last casual partner, which provides slightly different information about the risk of transmission. The results from this question were around the same for all sub-groups (that is, neither treatment status nor partner serostatus had a significant impact on whether the respondent ejaculated inside his partner in UAI). The least likely group to ejaculate inside their partner were men on ARV with their HIV positive partner. What we believe this indicates is that any "transmission risk decision" is made earlier in the sexual transaction. That is, the point at which the decision to have UAI or not is made seems to be the key point at which considerations of transmission risk have a significant influence on behaviour. Once the decision to have UAI has been made, men are as likely to continue to ejaculation as they are to withdraw.

It has been argued elsewhere that clinical markers, and particularly viral load as an index of infectiousness, are being used by positive men to assist

decision making about sexual safety. Particularly, it has been suggested that low viral load may be associated with a relaxation of sexual safety with HIV negative partners. What our findings suggest is that viral load is not being used in this way by men in this study, and that there was no significant difference in the mean log viral load of those who had UAI compared to those who didn't. What differences there were suggest, albeit without statistical significance, that lower viral loads are more likely to be associated with PAI, except in the case of regular relationships between men who are on treatments with their HIV positive partners, and men who are not on treatments with partners of HIV negative or unknown serostatus (see Figures 3 and 6).⁵

How do we explain this finding, which seems to run counter to what common sense suggests? The patterns in our data in relation to UAI and PAI and their connection with treatment status and partner serostatus are clearest in figures 2 and 5. What these demonstrate, supported by the statistics reported earlier in this paper, is that partner serostatus has the biggest impact on whether HIV positive men have UAI in both casual and regular relationships, and that a person's treatment status is the second most important factor. The only significant difference in median viral load was between those on ARV who had UAI with a partner of HIV negative or unknown serostatus, and those not on ARV who had UAI with a partner of HIV negative or unknown serostatus. Again, this difference translated into a significantly lower rate of UAI in the group with the significantly lower median viral load. The difference in median viral load of those who had PAI in these groups was also significant, and again the difference signalled that those with the significantly lower viral load – those on ARV - were more likely to have safe sex. What we propose is that the relationship between viral load and sexual safety is mediated (or confounded) by whether an HIV positive person is on ARV or not. What our data show is that if a person is on treatment, he is more likely to choose sexual safety, particularly when his partner, whether casual or regular, is HIV negative or of unknown serostatus. In simple terms, if treatment uptake can be taken as an index of self-care, then a person who takes care of himself is more likely in our analysis to take care of others in sexual situations, and the degree of care that he takes is directly related to the extent of his partner's vulnerability.

Conclusions

Our reading of treatment status (and by extension, viral load) in the context of sexual decision-making is as an indicator of self-care, and we suggest that self-care is an indicator of care of others in sexual situations. In this interpretation, we are following Michael Hurley, who has shown elsewhere that with HAART, clinical decision-making is increasingly a technique of self-care exercised by PLWHA, and that these decisions engage patients' sense of self, their history of health service access – though not their clinical

⁵ Although we use median viral load as a measure throughout this paper, for this comparison median viral load was not a useful measure of difference because for men on treatments, median viral loads were below detectable levels for all groups, regardless of partner status, relationship status, and whether partners had UAI or PAI.

histories – and the increasingly blurred line between good lives and good health in the context of HAART (Hurley 2001c).

In this paper, we want to affirm that the boundaries of what Hurley has characterised as cultures of care extend beyond clinical considerations, and for positive gay men encompass the public health implications of their sexual behaviour. Again following (and paraphrasing) Hurley, we suggest that sexual decision-making, in the context of HAART, engages positive men's sense of self, their history of sexual safety, and the increasingly blurred line between good sex and safe (not just protected) sex.

Hurley's development of the concept of cultures of care comes from a sustained, collaborative engagement with people living with HIV and the work of HIV educators, advocates and other researchers, including that of Kane Race. Race (2001) has challenged social scientists (and gay community members) to find other ways to model belonging in the gay sphere, ways of being gay that are accessible, that appeal to memory, and that are collective. In his view, we need to destabilise individualised and transgressive masculinities as 'the way' of being gay, and position treatments so that they provoke questions about belonging. In this paper, we have attempted an interpretation of sexual risk data that considers the implications for sexual practice of belonging to gay and HIV positive cultures of care. Our interpretation of these data proceeds from a starting point, which displaces 'risk' from its privileged position at the centre of sexual decision making, and puts 'care' there instead. That is, we take it as axiomatic that HIV positive gay men are part of communities *sui generis*, and that the impact of shared histories of the HIV/AIDS pandemic influences community standards, practices, meanings and values.

The cultures of care that have grown up around HIV positive men and their interactions with both clinic and community need to be understood as systems of meaning, as systems of shared history and values that extend beyond the clinical sphere, beyond the intensely permeable boundaries of the HIV positive gay community, out into the wider gay community, and its spaces and practices.

2. CULTURES OF CARE. THE EFFECTS OF COMBINATION ANTIRETROVIRAL THERAPY ON PEOPLE LIVING WITH HIV AND AIDS IN AUSTRALIA 1995-2001

Michael Hurley

Modified version of a poster exhibited at the Sixth International Congress on AIDS in Asia and the Pacific, Melbourne, October, 2001, incorporating data from the HIV Futures I and II Studies.

The National Association of People Living with HIV & AIDS (NAPWA) argues that health promotion is: *the proactive engagement of people living with HIV in creating a broad, life wellness construct as the lived Australian HIV reality* and that this requires moving *beyond the medical response frame to encompass a much wider understanding of health and wellness in the presence of HIV (NAPWA 2000)*

OVERALL PURPOSE: To highlight key social, cultural and clinical aspects of the uptake of combination therapies amongst people living with HIV and AIDS in Australia from 1995-2001.

AIMS

- To describe the social relations between the taking of treatments, their effects and complications and the everyday life of people living with HIV and AIDS in Australia.
- To introduce the notion of 'cultures of care' as a way of conceptualising the relations between health service providers, the people taking treatments, their social support networks, international media relays, community-based treatments media and the development of practices of self care amongst people living with HIV/ AIDS.

What is a 'culture of care'?

A 'culture of care' refers to the everyday social spaces created when self-care practices are actively supported and relayed amongst and by people (i) affected by the presence of a disease, and/or (ii) sharing or negotiating a community of interests.

What is meant by 'living with HIV'?

In this discussion 'living with HIV' is understood from a cultures of everyday life perspective that includes several different emphases according to context: clinical, quasi-clinical and non-clinical experiences of living with HIV. That is, sometimes living with HIV involves no clinical reference to the virus or treatments, but has much to do with how being infected does and/or doesn't play out in personal social relations.

No government could have led the fight against AIDS here unless the affected communities (largely and at first the gay communities) were willing to be brought into the process, were consulted about it and were offered a central place in that fight (Dowsett 2001).

THREE STAGES IN UPTAKE OF COMBINATION ANTIRETROVIRAL DRUGS

People with HIV in Sydney were involved in clinical trials of 'new' drugs in 1995-96. Word of mouth from trial participants 1995- was reinforced by mass media coverage. This coverage, announcing the success of combination antiretroviral therapy clinical trials, before, during and after the Vancouver AIDS conference in mid 1996, reached saturation levels in urban, regional and rural Australia (Hurley 2000b).

Mediascapes refer both to the distribution of the electronic capabilities to produce and disseminate information...and to the images of the world created by these media...What is most important about these mediascapes is that they provide...large and complex repertoires of images, narratives and ethnoscapings...in which the world of commodities and the world of news and politics are profoundly mixed. (Appadurai 1990: 9)

STAGE 1: BEFORE THE DRUGS WERE WIDELY AVAILABLE, 1995-1996

- Hope based on peer and media relaying of results of clinical trials in Australia and the USA indicating better health, fewer opportunistic infections, falling mortality rates and fewer AIDS diagnoses overtakes treatments scepticism. Representation of the drugs as a quasi-'cure' for HIV infection leads to a trade in hope divorced from experience (Brotherton 1997; Hurley 1997).
- Treatments activists and advocates saw the 'new treatments' as a major breakthrough, but disagreement developed over the hard 'selling' of drugs by pharmaceutical companies and advocates ('hit early, hit hard) and about optimism (Brotherton and Duffin 1997; Clarke 1997; Goddard 1997; King 1998).
- Community-based organisations (CBOs) took up the challenge:

Within the National Treatments Project of the Australian Federation of AIDS Organisations [we] have subverted the tools of [pharmaceutical] social marketing in an attempt to change the negative cultures of disease and death that surround HIV and AIDS in popular culture...we have not got a product to sell. Information is the medium, and reflection and understanding, not consumption, is the aim. (Batrouney and Haire 1997)

There is strong evidence for thinking that between 1995-1997 the density, speed and volume of treatments information rapidly constituted a saturated information matrix (Hurley 2000b). In this situation, 'information and noise are indistinguishable' (Wark 1994: 205) and any subsequent response based primarily on more information compounds the problem.

Solving the problem of 'noise' lies in different understandings of how education might connect with the lived practice of people with HIV at different moments in their lives, including, but not restricted to, medical moments: initial diagnosis, choosing whether to treat, choosing to stop treating, changing combinations as well as to the active negotiating of everyday life.

DISCUSSION: ISSUES CENTRAL TO INITIAL UPTAKE OF DRUGS IN AUSTRALIA

1. Relative ease of access to drugs, water, food, refrigeration, sewage and sanitary needs.
2. Feedback loop between clinical practice and community-based, HIV living print resources and media supported sustained adherence to drug regimens and quality of life.
3. Education challenged by the speed with which informed, treatments practices develop amongst treaters and centrality of mass media and community-based treatments media in this process.
4. Understanding of this quasi-clinical space as a culture of care in which:
(a) treatments are framed by people with HIV and AIDS within wider living perspectives
(b) people with HIV develop repertoires of informed self care practices, whether currently treating or not.
5. Managing side effects and adherence/compliance becomes ongoing challenge involving trade-offs between quality of life, life expectancy, and decisions to continue drug treatments and/or drug regimes.
6. Shifts in patterns of acute care needs from opportunistic infections to side effects.
7. A strong initial clinical push for undetectable viral loads as the marker of health.
8. Sustaining of dynamic safe sex cultures, especially amongst HIV positive people.

Community-based, HIV/AIDS treatments media broker the relations between living with uncertainty as a form of knowledge and making information useful and audible by monitoring feedback distortions. The key questions are how is education best thought in this context and how is the media/education interface constituted and how best utilised?

STAGE 2: UPTAKE OF THE DRUGS 1996-1997

- *Rapid uptake* of drugs leads to falls in deaths, AIDS diagnoses and opportunistic infections and major shifts in how people with HIV and AIDS live their lives (Brotherton 1997; NCHECR 1999; Honnor 2000).
- *Doctor prescribers* become the main source of treatments information and are under pressure to understand and manage complex treatments regimens. Successful treatment seen to rely on adherence to taking drugs as prescribed. Matching drug regimen & lifestyles identified as a major issue affecting routinisation of dosing (Race & Wakeford 2000a). Continuous adjustments are made to number of pills prescribed, size & format of pills, timing of dosage & relation to meals.
- *Increasing awareness* of side effects of drug regimes (especially nausea, diarrhoea, headaches), co-infection and the need for management strategies to maintain uptake and adherence. Increased reliance on expensive testing for monitoring treatments effects (blood counts, viral load, & later resistance assays). Different degrees of treatments success for individuals (de Visser *et al.* 2000)
- *People with HIV* access dense networks of information, relying on community treatments media, prescribers, the internet, advocates and peer support for information on living with HIV. Patterns in use of community-based organisations shift away from activism (Batrouney 1999) toward using services.
- *Government funding* starts to move away from CBOs and social research (Dowsett 2001).

STAGE 3. LONGER TERM ISSUES 1997-2001

- *People with HIV* continue to distinguish between quality of life and clinical indicators of health, as treatments uptake peaks. Community-based HIV treatments media and educational events become the only public, quasi-clinical spaces where treatments information and living with HIV are reported on and negotiated by people living with the virus (Hurley 2001a).
- *Doctors* negotiate tensions between adapting drug regimens to treaters' lifestyles and prescribing the therapeutically most powerful drugs. Expectations increase that prescribers know optimum treatments options, likelihood of drug resistance, and side effect management. Shift to the prescribers' clinics as 'one stop shop' treatments, counselling and educational centres.
- *Recognition* of clinically serious side effects (eg lipodystrophy, diabetes, heart problems, neuropathy, dementia). Increasing number of treaters developing drug resistance. Self-managed 'treatment holidays' by people treating quickly codified clinically as 'pulsed dosing' and 'structured treatments interruptions' (STIs) (Delaney 2000). Individual clinical reactions to STIs vary considerably, and recent research reported in *AIDS*, June 2001, is still limited (Garcia *et al.* 2001).
- *Decreasing reliance* on hospital based, multidisciplinary teams (Lowth *et al.* 1999), accompanied by a dissipation of specialist knowledge of acute opportunistic infections in hospitals.
- *Affected communities* mostly disengage from community-based organisations leading to shifts toward generic gay/lesbian health organisations. Safe sex cultures amongst the most affected communities adapt to new realities posing new challenges for HIV education (NCHSR 2000).
- *Major decrease* in public representations of Australians living with HIV & AIDS and increase in representation of living with HIV as a problem for people in developing countries.

DISCUSSION 2: LONGER TERM ISSUES

1. Celebrations of having lives to live as well as times of uncertainty in face of this.
2. Sustained reliance on treatments providers for advice and management of side effects
3. Continuous dynamic development of practices of self-care and clinical best practice with shifts in how clinical markers are related to treatments decisions (Hurley 2001c; Rosengarten *et al.* 2000)
4. Slow increase in proportion of people living with HIV and AIDS with limited treatments options.
5. Greater visibility of self -care practices, especially in relation to:
 - (a) peaks in cultural festivals with the likelihood of breaks in routine and interactions between prescribed and recreational drug use
 - (b) sustained side effects and associated management stresses;
6. Clinical and social manifestations of psychological difficulties amongst some people with HIV
7. People with HIV maintain a high commitment to safe sex. They are often in regular relationships (48%), are highly sexually responsible in regular sero-discordant relationships as well as in casual sex; and fear infecting other people (70%) (Grierson *et al.* 2000).

Social networks play a particularly important role in the development of a sense of capacity with respect to health practices...[and] in producing a different sense of selfhood than that associated only with doctors and treatment. (Race and Wakeford 2000)

These indicators of sociability can be understood as elements in a self and other regarding culture of care.
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8. Much lower social and cultural visibility of effects of HIV diagnosis in the most directly affected and wider populations with some suggesting this is implicated in increases in unprotected sex.
9. Policy and educational practices challenged by speed of changes in lived cultures.

CONCLUSIONS

1. Combination antiretroviral treatments markedly improved life expectancy and often quality of life for most people living with HIV in Australia and they have changed how they live their lives accordingly.
2. Access to drug treatments is accompanied by a continuous negotiation of key issues: adherence, dealing with side effects and monitoring quality of life.
3. How people with HIV and AIDS benefit from and make sense of drug treatments varies considerably for the same individual at different times and between individuals and social groups. (For information on differences between gay men, women, heterosexual men and Indigenous people see the other publications listed at the end of this report.)
4. Sustaining cultures of care involves ongoing links between health providers, CBOs and treatments media, media relays and peer support and education.
5. Sustaining quality of self-care practices requires support for cultures of care.
6. Cultures of care broker the relations between living with uncertainty as a form of knowledge, treatments information and practices of self-care, including safe sex.

There are two fundamental things I believe about HIV. One is that the response to it must be firmly located within the communities where the epidemic is present or threatening. The second thing is that HIV is an extremely sophisticated, cunning, ever evolving, totally heartless bastard. You wanna work in HIV? Then get used to living with uncertainty. (Bill O'Loughlin 2001)

An additional note

I developed the concept of 'cultures of care' while working as a Researcher in Residence on the HIV Treatments Education Project in 1999-2000 (Hurley 2000a, b, 2001b, Hurley *et al.* 2002). I was employed by ARCSHS but based at the Australian Federation of AIDS Organisations in Sydney. The research involved an intense engagement with HIV education, HIV advocacy and what people with HIV were saying about their lived experience (Hurley 2001b). I investigated how treatments information circulated, the roles of HIV treatments media and the mass media and practices of self-care amongst people living with HIV. Key informants at various points included Alan Brotherton, Levinia Crooks, Garrett Prestage, Kirsty Machon and Jo Watson. In the process of doing this research, I was also reflecting on the ongoing work of Race *et al.* (1997, 2000a, 2000b) on treatment practices, working closely with McInnes, Prestage and Hendry on rethinking sex and risk (McInnes *et al.* 2001a) and considering the implications of displacing notions of community with notions of 'living gay' (McInness *et al.* 2001b). All of these projects influenced my thinking about the sociability of everyday life in relation to gayness and to HIV. I want to emphasise here the formal and informal intellectual collaborations that were occurring, the fruitfulness of these interactions and their importance for my own work. It was and is a collaborative process that has continued with my shift to ARCSHS in Melbourne where Jon Willis, Marian Pitts and Jeffrey Grierson have each encouraged me to develop the concept of 'cultures of care' further.

3. POSITIVE PEOPLE'S SEX AND TREATMENTS OPTIMISM

Michael Bartos, Karalyn McDonald, Richard de Visser and Jeffrey Grierson

Edited poster presentation using data from the HIV Futures I and II Studies at the AIDS in Europe conference, 2000. Referred to in the Introduction as Bartos *et al.* 2000a

The HIV Futures Survey is a large-scale biennial survey of the social, medical and economic aspects of the experience of living with HIV/AIDS in Australia. In the second half of both 1997 and 1999 a purposive sample of People Living with HIV/AIDS (PLWHA) was recruited through HIV/AIDS organisations, mailing lists of HIV-related publications, hospitals, doctors' surgeries, and a targeted advertising campaign. The size of the sample in both 1997 (n = 925) and 1999 (n=921) represents over 8% of the total estimated population of PLWHA in Australia.

We report here on data from HIV Futures II concerning the sexual practice of Australian PLWHA.

Condom Use With Regular Partners

Respondents whose regular partner was HIV-negative or whose serostatus was unknown were significantly more likely than those with HIV-positive partners to always use condoms (63% vs 20%; $c^2_{(2)} = 110.43$, $p < .01$).

Table 1: Frequency of condom use with regular partners

Partner HIV status	Frequency of condom use with regular partners		
	always	sometimes	never
HIV-positive	28 (20%)	19 (13%)	97 (67%)
HIV-negative/unknown	104 (63%)	44 (27%)	16 (10%)

Condom Use With Casual Partners

There was a significant association between condom use with casual partners and the HIV status of respondents' casual partners ($c^2_{(4)} = 61.07$, $p < .01$). Consistent condom use was more likely with HIV-negative casual partners.

Table 2: Frequency of condom use with casual partners

Partner HIV status	Frequency of condom use with casual partners		
	always	sometimes	never
All partners HIV-positive	5 (19%)	11 (41%)	11 (41%)
Some partners HIV-positive	180 (48%)	181 (48%)	17 (4%)
No partners HIV-positive	18 (78%)	5 (22%)	0 (0%)

Treatment Optimism And Sexual Practice

The association between treatments optimism and sexual practice was examined in relation to a number of attitude statements. Patterns of condom use with casual sexual partners were NOT related to agreement with the statement 'combination antiretrovirals mean better prospects for people with HIV' ($c^2_{(4)} = 8.05, p = .09$).

Table 3: Do you believe that combination antiretrovirals mean better prospects?

Condom use with casual partners	Do you believe that combination antiretrovirals mean better prospects?					
	yes		no		too soon/ don't know	
Always	141	(48%)	8	(80%)	55	(44%)
Sometimes	136	(47%)	2	(20%)	58	(46%)
Never	15	(5%)	0	(0%)	12	(10%)

Unsafe Sex And New Treatments

In relation to the statement 'I feel more confident about unprotected sex because of the new treatments' the great majority (88%) of people living with HIV/AIDS disagreed. However, compared to respondents to the first HIV Futures Survey in 1997, there was a small but statistically significant increase in 1999 respondents reporting agreement (6% in 1997 vs. 9% in 1999, $c^2_{(2)} = 14.54, p < .01$).

Table 4: I feel more confident about unprotected sex because of the new treatments

Year	I feel more confident about unprotected sex because of the new treatments					
	agree		disagree		don't know	
1999	86	(9%)	812	(88%)	27	(3%)
1997	53	(6%)	801	(89%)	50	(6%)

Those who agreed with the statement "I feel more confident about unprotected sex because of the new treatments" in 1999 were less likely to always use condoms with their casual partners (27% vs. 52%, $c^2_{(4)} = 14.68, p < .01$). (See Table 5, next page.) Gay and bisexual men, heterosexual men and women showed similar patterns but the numbers of women and heterosexual men with casual partners was too small to establish statistical significance.

Table 5. More confident about unprotected sex because of new treatments

Condom use with casual partners	More confident about unprotected sex because of new treatments					
	agree		disagree		don't know	
Always	13	(27%)	185	(52%)	5	(33%)
Sometimes	30	(61%)	152	(42%)	10	(67%)
Never	6	(12%)	23	(6%)	0	(0%)
Gay/bisexual men	71	(9%)	685	(88%)	20	(3%)
Heterosexual men	7	(12%)	50	(83%)	3	(5%)
Women	7	(10%)	58	(85%)	3	(4%)

Conclusion

Partner serostatus rather than antiretroviral treatments governs the use or non-use of condoms within HIV-positive people's regular partnerships. [See *Introduction for discussion of this finding-editor.*] In relation to casual partners, there is no direct association between optimism about treatments and unsafe sex by HIV-positive people, but there is a small but growing number of positive people who report they agree they are "more confident about unprotected sex because of the new treatments" and they are more likely than other HIV-positive people to report unprotected sex with casual partners. This association may reflect a post-hoc rationalisation for not using condoms rather than genuinely cause this change in behaviour.

4. ANTIRETROVIRAL TREATMENTS AND HIV-POSITIVE ADULTS' SEXUAL PRACTICE

Michael Bartos, Karalyn McDonald, Jeffrey Grierson, Richard de Visser
Referred to in the Introduction of this report as Bartos *et al.* 2000b.

Oral presentation using data from the HIV Futures I and II Studies, 13th World AIDS Conference, Durban, July 2000.

It is now some four years since the first evidence that combination antiretroviral treatments could substantially reduce HIV-related morbidity and mortality. In that time, highly active antiretroviral therapy (HAART) has become the standard of care for those affected by HIV disease and who can afford access to the treatments. In Australia, uptake of HAART increased rapidly through 1996 and into 1997, since which time it has stabilised. Currently, around three-quarters of the estimated total population of people diagnosed with HIV are using combination antiretrovirals.

Along with the penetration of HAART as preferred therapy for people living with HIV/AIDS have come a range of concerns about the wider social and public health implications of HAART. Prominent among these concerns has been the fear that the improved clinical outlook for people living with HIV/AIDS as a consequence of HAART would result in the relaxation of efforts to prevent the further transmission of HIV, and specifically that the good news on HAART would lead to increased levels of unsafe sex.

While many studies in industrialized countries have started to look at the relationship between HAART and HIV transmission, to date few have focussed on people living with HIV/AIDS themselves, despite the fact that positive peoples' behaviours have the most immediate impact on transmission dynamics.

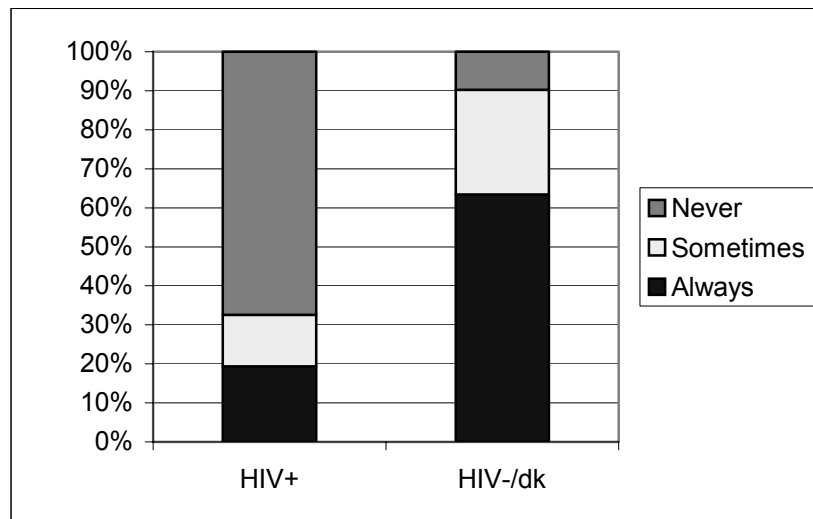
This paper reports on results from the Australian HIV Futures Surveys. These surveys were first conducted at the end of 1997 and again at the end of 1999. It is a national, anonymous mail-back questionnaire, widely distributed through community organisations, the mailing lists of HIV-related publications and various health and social service agencies.

There were 924 valid responses to the 1999 survey representing over 8% of the total estimated population of PLWHA in Australia. The survey includes PLWHA from all Australian regions; from inner urban, suburban and rural areas; men and women; gay and straight. The majority of respondents are gay men, reflecting the epidemiology of HIV in Australia, but particular recruitment efforts were made to ensure representation in the sample of numerically smaller groups such as HIV-positive women, and those infected through injecting and through blood products. The survey covered behavioural and attitudinal aspects of a number of domains including health care and treatments, social and economic life and sexual practice.

In this paper we will mainly present results from the 1999 survey, but where there are major changes we will make comparisons with the 1997 results. Only results achieving significance below p-values of .05 are reported.

If there are any 'optimism effects' on sexual practice then it is necessary to have some point of comparison in order to get the magnitude of the effect into proper perspective. Therefore in this paper we look closely at the impact on condom use of partner sero-status (that is, whether the sexual partner is known to be HIV-negative, HIV-positive or whether their status is not known) and then compare the relative impacts of partner sero-status and of optimism on condom use. In order to be most salient to HIV transmission, the sexual practice we focus on is condom use for vaginal or anal intercourse and we are particularly interested in those cases where the sexual partner of our respondent is of HIV-negative or unknown status (remembering that all our respondents are HIV-positive).

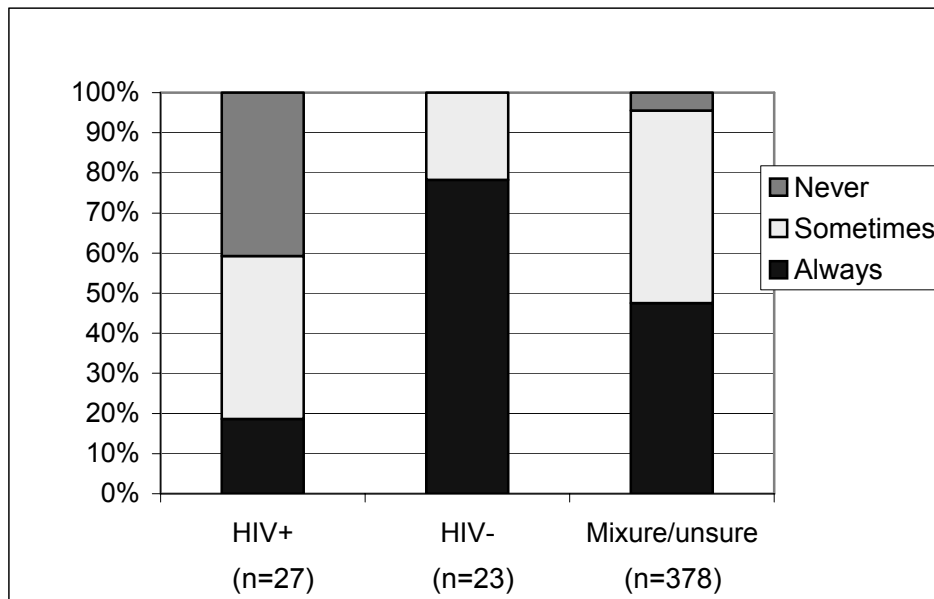
Figure 1: Condom use among HIV positive respondents with regular partners by partner's serostatus



When we look at sexual practice with regular partners, 63% of respondents whose regular partner was HIV seronegative or whose serostatus was unknown always used condoms, while only 20% of those with HIV-positive partners always used condoms. By way of background, note that, 98.3% of respondents had disclosed their own HIV-status to their regular partner, and almost all also knew the HIV-status of their partner - only 1.6% reported that the status of their regular partner was unknown. When we look at results by sexuality, they were similar for gay and bisexual men, for women and for heterosexual men.

In the case of casual partners, there is also a strong association between partner status and condom use, although the issue is a little more complicated given that it is less likely that the HIV-status of a casual partner will be securely known.

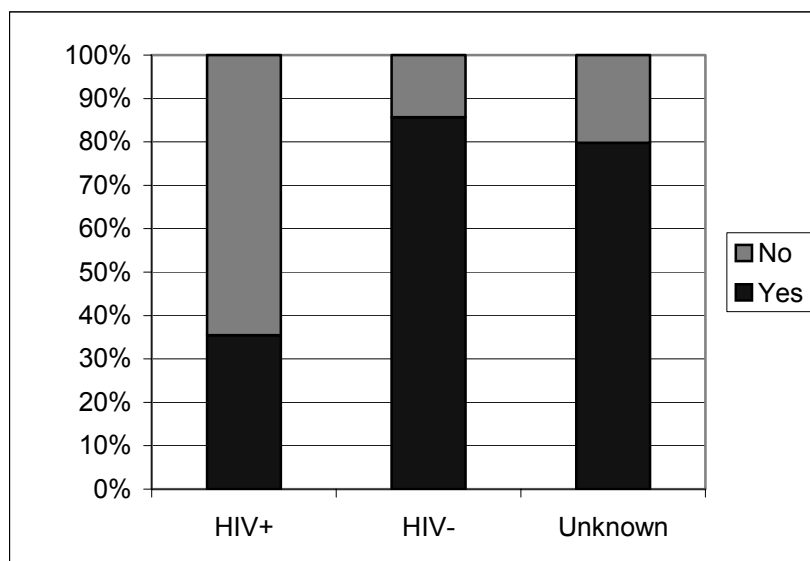
Figure 2: Condom with casual partners in the past six months by partners' serostatus



When we look at the pattern of condom use with casual partners in general over the past six months, those with only HIV-positive casual partners are much less likely to always use condoms than those with only HIV-negative casual partners, however, (looking at the n's) most people who had casual partners reported they were a mixture of positive and negative, or that they did not know the status of their casual partners.

In order to have more precise information about casual partners we also asked about sex with just the most recent casual partner in the past six months.

Figure 3: Condom use among HIV positive respondents with most recent casual partner by partner's serostatus



Here when we look at whether a condom was or was not used for anal or vaginal sex with the most recent casual partner, there is a strong association between condom use and partner sero-status. Condoms were used in 86% of cases where the casual partner was HIV-negative, 80% where their status was unknown and in only 36% of cases with a partner also HIV-positive.

Turning to the impact of HAART on patterns of condom use, there are two ways of addressing the question. One is to look at whether the sexual practices reported by those who are using antiretrovirals differ from those who are not using - measuring a direct behavioural association. The second is to look at reported attitudes to antiretrovirals, and to see whether differences in attitudes are reflected in sexual practice.

Focussing just on sero-nonconcordant partnerships - that is, where the positive person's partner is HIV-negative or unknown status - there are significant differences between those using and not using antiretrovirals.

These apply to regular partners, where condoms are always used with a sero-non-concordant regular partner by 68% of those using antiretrovirals, but only 50% of those not using antiretrovirals.

Figure 4: Condom use with regular sero-nonconcordant partner by ARV use

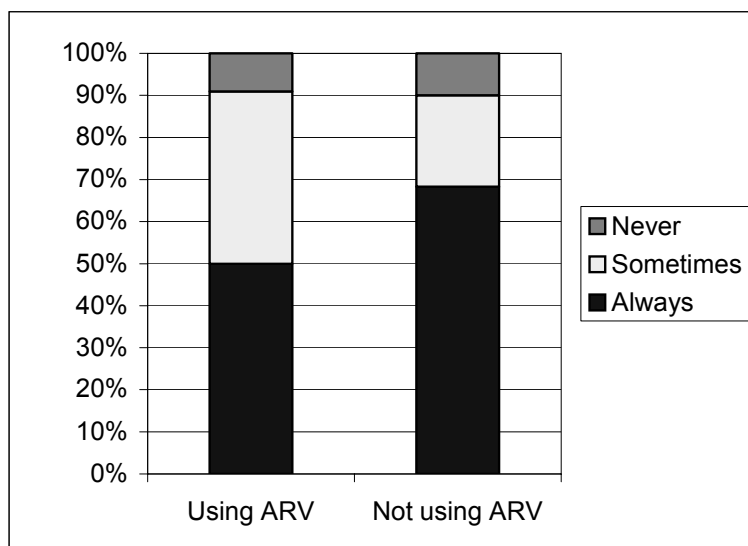
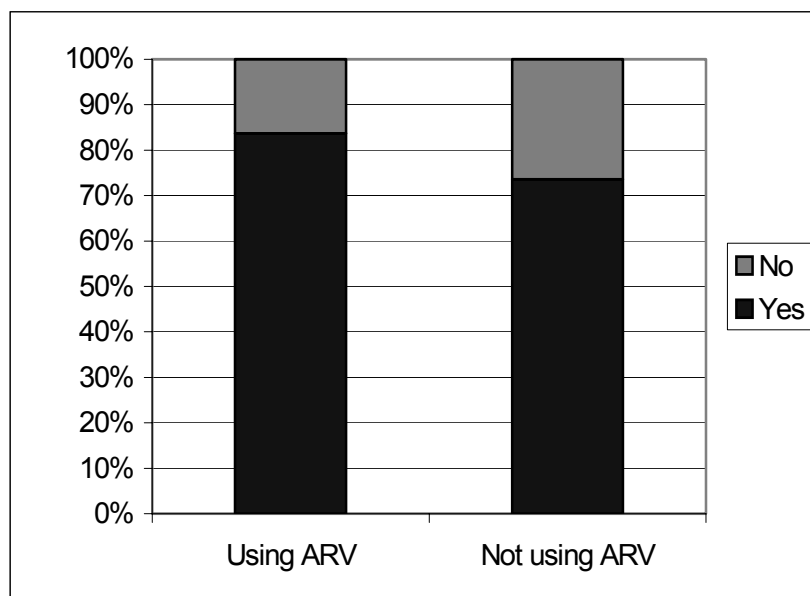


Figure 5: Condom use with most recent sero-noncordant casual partner by ARV use

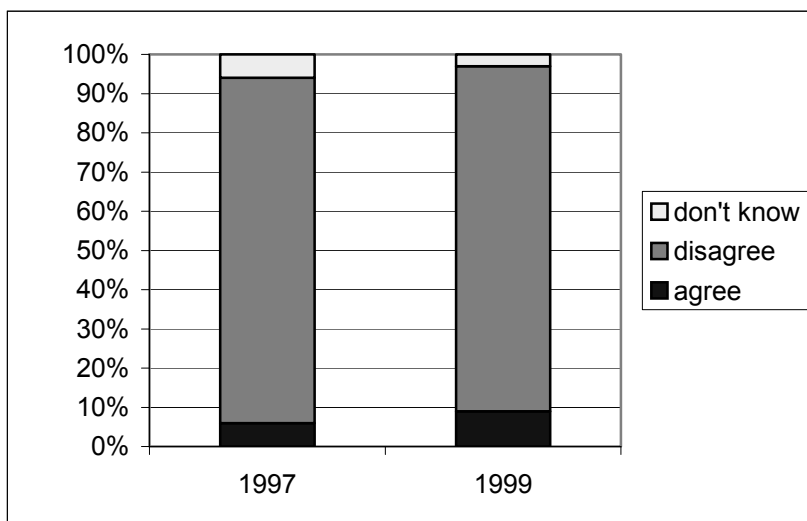


A similar but less pronounced result is found with most recent casual partner. When the most recent casual partner is HIV-negative or of unknown HIV status, 84% of PLWHA on antiretrovirals used a condom while 74% of those not using antiretrovirals did so.

Thus we find that those using antiretrovirals are more consistent condom users than their counterparts not on therapy. *This runs counter to any hypothesis that being on antiretrovirals of itself leads to safe sex laxity.*

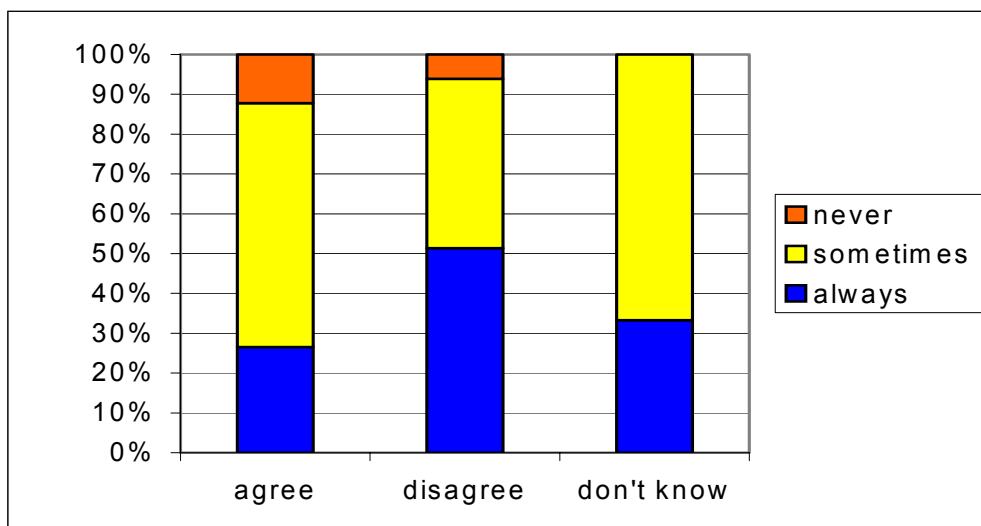
The second way at looking at the impact of HAART on sexual practice is to examine attitudes to antiretrovirals. In both 1997 and 1999 HIV Futures Survey our most direct measure of treatments optimism was responses to the statement "I feel more confident about unprotected sex because of the new treatments" answered on a five point scale of strongly agree, agree, disagree, strongly disagree and don't know.

Figure 6: Response to the statement 'I feel more confident about unprotected sex because of new treatments' as measured in 1997 and 1999



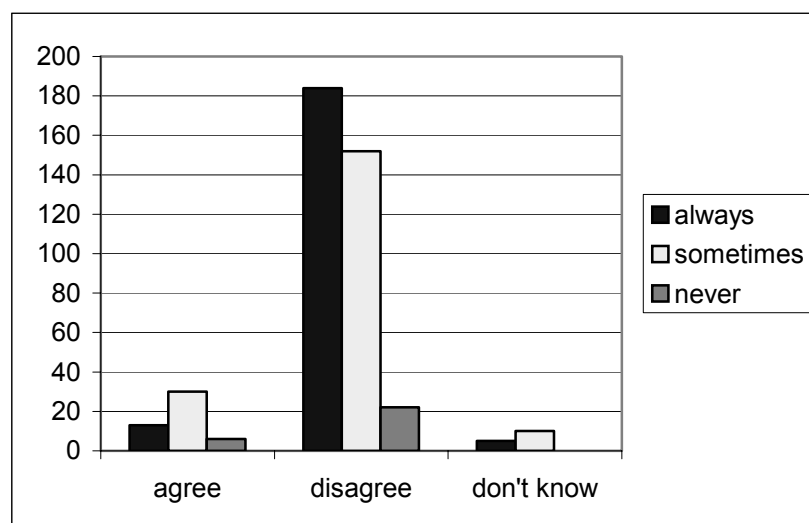
While in both 1997 and 1999 the large majority of respondents disagreed with the statement, there was a small but significant rise in the most recent survey in those agreeing, with a smaller number saying 'don't know'.

Figure 7: Response to the statement 'I feel more confident about unprotected sex because of new treatments' by condom use with casual partner(s) in the past 6 months.



There were no significant associations between attitudes on this confidence measure and condom use with regular partners. However, those who agreed they were more confident about unprotected sex because of new treatments were less consistent condom users with their casual partners.

Figure 8: “I feel more confident about unprotected sex because of new treatments” by condom use with casual partner(s) in the past 6 months



Remember, though, that the absolute numbers of those agreeing with the statement were low, so it is perhaps more accurate to represent the results by number than percentage.

Our results therefore suggest that there may be some optimism effects on the sexual practice of PLWHA but they are relatively small.

To get an idea of the importance of HAART optimism in relation to condom use we looked multivariately at the relative impacts of partner sero-status and optimism as predictors of condoms use, and here the contrast is stark.

Table 1: Partner serostatus and sex optimism scale scores as predictors of condom use with casual partners

	n	OR	(95%CI)
Partner serostatus			
HIV seropositive	81	1.00	
HIV seronegative/unknown	254	8.46	(4.97-14.39)
Sex optimism			
Scale score	363	0.82	

PLWHA are almost 8 times more likely to report using a condom if their most recent casual partner is HIV-negative or of unknown status compared with sex with an HIV-positive casual partner. In contrast, agreement with the statement ‘I feel more confident about unprotected sex...’ has a smaller, albeit still significant, effect on condom use with the most recent casual partner, with those agreeing with the optimism statement half as likely to use a condom as those disagreeing.

Given the recent interest in the relationship between optimism and sexual practice we also included in the 1999 HIV Futures survey a number of additional items exploring treatment optimism attitudes. Among there were the five statements which our Australian colleagues Van de Ven and others have used as a treatments optimism scale in their surveys which include both HIV positive and negative gay men.

Table 2: Partner serostatus and confidence about unprotected sex as predictors of condom use with casual partners

	n	OR	(95%CI)
Partner			
HIV seropositive	85	1.00	
HIV seronegative/unknown	267	7.52	(4.4812.62)
I feel more confident			
disagree	41	1.00	
agree	302	0.45	(0.220.91)
don't know	9	0.91	(0.2232.95)

When we examined these five items they scaled well in our survey with a Cronbach's α of 0.81. Gay and bisexual men, heterosexual men and women reported comparable sex optimism scale scores. In the case of regular partners overall there was not a significant relationship between optimism and condom use, and nor was there when HIV-negative regular partners were looked at separately. However, respondents in a regular relationship with an HIV-seropositive regular partner were less likely to always use condoms if they had more optimistic attitudes. With casual partners in the past six months greater optimism was significantly related to less consistent condom use. However, when we looked at condom use with the most recent casual partner, there was no relationship with sex optimism scale scores both overall and when examined by partner sero-status.

Table 3: Optimism scale items

- A person with undetectable viral load cannot pass on the virus.
 - New HIV treatments will take the worry out of sex.
 - People with undetectable viral load do not need to worry so about infecting others with HIV.
 - The availability of treatment (PEP) immediately after unsafe sex makes safe sex less important.
 - It's never safe to fuck without a condom regardless of viral load.
- (Van de Ven *et al.* 2000)

We also compared the relative impacts of partner sero-status and sex optimism scale score on condom use with the most recent casual partner and as the odds ratios show, the effect of partner sero-status is marked but the sex optimism scale score is not a significant predictor of condom use.

Conclusion

Our work with the Australian PLWHA has revealed patterns of growing complexity in recent years. The most conclusive impact of HAART is to make it increasingly difficult to talk in unitary terms about a single HIV-positive population. There are very high levels of engagement with the medical system, antiretroviral uptake is high and self-reported adherence as measured by not missing any doses in the previous two days is also high at 87%. But *people's experience of treatments is starting to diverge*, for example nearly half have taken a drug holiday or some other form of structured break in their treatments. There is also increasing evidence of a split between those HIV-positive people who have good resources available to manage their health, social and economic life, and those who are struggling under triple burdens of ill-health, precarious finances, and other health conditions on top of HIV.

In this context, it would be simplistic to expect a neat relationship between optimism about HAART and sexual practice. Instead, we find that condom use by PLWHA is strongly dependent on whether or not their partner is also HIV-positive, both in relation to regular partners and casual partners. Those on antiretrovirals also turn out to be more consistent condom users than those not using antiretrovirals, perhaps because their use is associated with the increasing normalisation of HIV-positive people, and that condom use with discordant partners is a strong community norm.

The effects we find with optimism associated with HAART at best have a marginal impact on condom use. Although marginal, this effect may nevertheless be important. However, we end with a cautionary note. The populations we study are not insulated from our research findings. We saw no optimism effects when we first conducted the HIV Futures Survey in 1997. Two years later, after considerable public and scientific discourse saying 'we are worried that HAART optimism will result in more unsafe sex' we indeed discover that for a small proportion of PLWHA there is an association between 'optimism' and unsafe sex. All we may be seeing is a post hoc effect: after all the public debate, perhaps some PLWHA are using 'treatments optimism' as the most available rationale to explain away their occasional unsafe sex.

5. HIV-POSITIVE GAY MEN'S RISK ASSESSMENT AND THE CHANGING MEANINGS OF HIV INFECTION

Michael Bartos

(Michael moved from the National Centre in HIV Social Research in 1997 to what became the Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne. He is now Senior Adviser, Executive Office, UNAIDS, Geneva, Switzerland.)

Edited version of an oral presentation using data from *HIV Futures 1* to complement other research studies from the National Centre in HIV Social Research at the New Challenges for Social and Behavioural Sciences, Second European Conference on the Methods and Results of Social and Behavioural Research on AIDS, Paris, 12-15 January, 1998. Emphases added during editing.

In 1992 I was part of a team of volunteers and professional staff at the Victorian AIDS Council/Gay Men's Health Centre working on a new community education campaign addressing HIV-positive gay men. It was an initiative of the HIV education unit, which had been established to bridge the gulf in education campaigns between, on the one hand, an HIV-negative audience, being enjoined to remain HIV negative, and on the other hand, an HIV positive audience which had hitherto been seen as needing only treatments or support information. The result of our work was a poster showing two naked male bodies (no faces) intertwined, with the slogan: 'One of us has HIV; two of us have safe sex'. Characteristically, this poster, while relatively well received, was not followed up with the promised comprehensive education program bringing HIV-positive and HIV-negative people together in a shared commitment to HIV prevention and health education goals.

The political calculation which was in the forefront of this campaign initiative, and which was resolved only temporarily in the context of the poster, was that of responsibility. *How were HIV-positive people (in this case gay men) to be addressed as sexually active subjects, affirming their rights to sexual expression, without also placing on their shoulders the sole responsibility for ensuring they did not transmit HIV?* Delving too deeply into this question risked fracturing one of the sustaining tropes of the gay community response to HIV. As was later noted, for the gay response to AIDS in the 1980s 'maintaining solidarity between antibody positives and antibody negatives became inseparable from the possibility of political unity and the preservation of a gay identity politic' (Briefing 1996).

By the beginning of the 1990s this solidarity, which had always been adhered to more in public discourse than in private practice, was beginning to fracture. For our campaign in 1991[sic] the furthest we could go was to juxtapose an affirmation of positive sexuality and the commitment to safe sex, only a modest advance on the anodyne: 'HIV positive or negative, it's the same for all' slogan. By the mid-1990s, though, the fracturing solidarity between HIV positive and negative had moved to centre stage. One manifestation was a focus on the psychological needs of HIV-negative gay men, one example of which was the extraordinary attention given to Walt Odets' work. Another was the emergence of a critical debate about the extent to which conflating the concerns of the HIV positive and negative either represented the subtextual reality of most prevention education, or was a useful strategy for future education (Odets 1995; Hart 1996).

Until very recently, the issue of the relationship between HIV positive and HIV negative gay men as targets of public health education has been overdetermined by political considerations. That is, public health campaigns, and particularly those sponsored by community based organisations, have been shaped by the perceived prior need to sustain a necessary fiction of positive/negative solidarity and its corollary, to avoid adding to the stigmatisation of people living with HIV/AIDS (Keogh 1996). In this context, social research into the lived experience of HIV positive gay men and their sexual practice has been largely irrelevant (perhaps fortunately given how little there is).

As has been often observed, much of the social research into sexual practice and HIV risk has been limited by its individual, psychologistic bias, to the detriment of understanding cultural, environmental and interpersonal factors implicated in the sexual transmission of HIV. In relation to the sexual practice of people with HIV there is a further limitation in much of the extant research: its implicit or explicit purpose of identifying those factors which have contributed to HIV-negative individuals remaining uninfected. Often, therefore, HIV positive subjects have been attended to only insofar as they retrospectively reveal characteristics which predict becoming HIV infected (or do so prospectively, in the case of cohort studies which analyse predictors of sero-conversions which occur in the course of the study). *None of these perspectives pays much attention to the ways in which HIV-positive individuals negotiate their sexual practice in relation to their HIV infection, and the possibility of infecting another person.* It is to these issues that I now turn.

Among the myriad dimensions of gay men's HIV risk assessment, I want to nominate two as central. The first is well established: a distinction must be made between sexual practice with a regular partner and that with a casual partner. The second is more novel: the nature and meaning of HIV risk has changed over the course of the epidemic, influenced both by changing cultural norms and in response to changes in epidemiology, HIV testing, and treatments. To discuss these two dimensions I want to draw mainly on long interview material collected over a number of years by the National Centre in HIV Social Research in Australia.

Different Risk Assessments for Regular and Casual Partners

One of the most consistent findings in socio-behavioural literature on sexual practice and HIV risk is that gay men are more likely to practise unprotected anal intercourse within a regular relationship than they are with casual partners. A number of studies have also distinguished between the risk practices of HIV positive and HIV negative gay men. However, investigations of the impact of partner status and HIV status have not been combined. Van de Ven *et al.* note 'there is a growing literature correlating unprotected anal intercourse and being in a regular relationship' but that no other studies have 'analysed predictors of unprotected anal intercourse separately for both HIV-positive and non-positive respondents' (Van de Ven *et al.* 1996).

The quantitative data reported by Van de Ven *et al.* drawn from the Sydney Men and Sexual Health Study showed different factors were associated with unprotected anal

intercourse within HIV non-concordant regular relationships⁶ for HIV positive men and for non-positive men. For the positive men, factors significantly associated with risk practices were: greater political involvement in the gay community, greater general drug use, and believing withdrawal to be safe. For the non-positive men, there were a range of factors, including: a greater range of anal practices, less favourable attitudes to condoms, and having been paid for sex in the past. These results can be interpreted to indicate that for the positive men in this Sydney sample those most likely to have sex with their partner where there is a risk of HIV transmission are those most involved in the core inner-city gay community, where recreational drug use is common, and also men for whom the perceived risk is ameliorated by withdrawal as a risk reduction strategy. However, for the non-positive men, risk is associated more with their sexual pleasure both in the importance and range of anal practices and in their dislike of condoms.

More recent Australia-wide data on the sexual practices of HIV positive people is available from the *HIV Futures I* survey conducted in the second half of 1997 by the Australian Research Centre in Sex, Health & Society at La Trobe University. This survey is the first comprehensive psycho-social survey of its type in Australia. Its 925 respondents represent some 7% of the total population of people living with HIV or AIDS in Australia, as estimated by the National HIV Surveillance Strategy⁷ and includes people infected by all transmission routes. Preliminary data concerning condom use by [HIV positive] gay and bisexual men in regular relationships shows 49% always used condoms, 22% sometimes used condoms and 30% never used condoms. Condom use depended significantly on whether the relationship was sero-concordant or sero-discordant:

Table 1: Frequency of condom use in sero-concordant and sero-discordant relationships

EDITOR'S NOTE: This table was based on preliminary analysis of HIV Futures data in 1997 produced for the purposes of this conference paper and should not be reproduced. Final analysis can be found in Ezzy *et al.* 1998. The table is included here only because it informed the argument of the paper at the time of delivery.

Relationship	Frequency of condom use		
	Always	Sometimes	Never
Sero-concordant relationship	32 (24%)	26 (20%)	73 (56%)
Sero-discordant relationship	97 (72%)	32 (24%)	6 (4%)

Of the gay and bisexual men who had intercourse with a casual partner, 49% always used condoms, 49% sometimes used condoms, and 2% never used condoms. While

⁶ Non concordant relationships are those where the partners know themselves to be of different HIV-status, or where one or both partners is of unknown status. Non-positive is defined as being HIV-negative or of unknown HIV status.

⁷ Australian HIV and AIDS surveillance data is widely considered to be very reliable. A national system of coded HIV notification appears to have overcome confidentiality concerns for potential testers. The level of HIV testing among gay men, who account for 85% of both cumulative and new HIV infections, is as high as 90%. Sentinel testing among other population groups, together with blood donor testing, suggest that the existence of any major hidden pool of unidentified infection is highly unlikely.

information about the HIV status of a casual partner cannot be considered as reliable as that about a regular partner, respondents were asked whether they had casual sex with HIV positive partners only, positive and negative partners, or negative partners only. The consistency of condom use was significantly related to the reported status of casual partners:

Table 2: Frequency of condom use with casual partners

EDITOR'S NOTE: This table was based on preliminary analysis of HIV Futures data in 1997 produced for the purposes of this conference paper and should not be reproduced. Final analysis can be found in Ezzy *et al.* 1998. The table is included here only because it informed the argument of the paper at the time of delivery.

Casual partners	Frequency of condom use		
	Always	Sometimes	Never
HIV positive only	2 (18%)	5 (46%)	4 (36%)
HIV positive & HIV negative	124 (49%)	128 (50%)	3 (1%)
HIV negative only	18 (67%)	9 (33%)	-

More detailed qualitative data on the risk practices of HIV positive men comes from the Gay Couples Study conducted by the National Centre in HIV Social Research from the end of 1995 through to early 1997. Given my consideration below, of the impact of changing meanings over time of HIV infection, I will consider in this section only data from initial interviews, unless otherwise noted. The purpose of the gay couples study was to identify the meanings and contexts of sex between men in relationships. It focussed particularly on the meanings associated with anal sex and its connections to intimacy, and the nature and extent of negotiated agreements between partners concerning sex and condom use both within and outside their regular relationships. It used long, unstructured conversational interviews, following a schedule of floating prompts.

Fifty-one men were recruited for the study from three Australian cities (including Sydney), using a mixture of snowballing techniques and direct recruitment via advertising. Initial interviews took place from December 1995 to March 1996. Follow-up interviews with 37 of the original participants were conducted a year later. Selection quotas were used to ensure the inclusion of men of different ages, HIV status and concordance or discordance in the HIV status of their relationship. 16 men in the study were HIV positive at first interview, 12 of whom were also interviewed at follow up. One participant was known to have sero-converted in the course of the study, and one participant died.

Men were recruited into the study on the self-defined criterion of 'being in a relationship'. All the men in the study self-identified as gay. Where both members of a couple were interviewed, separate, simultaneous (or almost simultaneous) interviews were conducted. Of the HIV-positive participants at initial interview, 9 were in relationships with another positive man (*viz.* concordant) and 7 were in a discordant relationship. All the men in HIV-positive concordant relationships were interviewed at follow-up, compared with just over half the men in HIV-negative

concordant and discordant relationships. All the positive concordant relationships remained intact for the year of the study.

Sex with regular partners

HIV-positive gay men apply very different risk assessments to sex with regular partners and casual partners. Of the 17 positive men in this study, 5 reported that they had sex only with their regular partner. The remaining 12 men reported sex with casual partners as well, although a few nevertheless described their relationship with their regular partner as monogamous, in which case their sex with a casual partner was described either as a temporary lapse or as being merely physical with no impact on the 'emotional monogamy' with their partner.

Regardless of whether their relationship was described as open or monogamous, a clear distinction was made between the nature of the sexual activity with regular partners and with casual partners. Many of the men reserved anal sex for their regular partner. Some others described anal sex and a high degree of physical intensity, passion or excitement in relation to sex with casual partners, while sex with their regular partner was described in terms of intimacy, relaxation, depth and feeling comfortable.

All of the men had at least some anal sex with their regular partner, although for a small minority of the men anal sex was not their preferred sexual activity and took place only rarely. Some men preferred anal sex with their regular partner but for health related reasons, including as a side effect of HIV medication, it was physically uncomfortable and only rarely practised.

Whether or not condoms were used for anal sex⁸ with a regular partner depended in the first instance on whether the men were in sero-concordant or discordant relationships. The 9 men who knew their partner also to be HIV positive at least some of the time did not use condoms for anal intercourse within their relationship. For many of these men, intimacy with their partner was expressed precisely in their capacity to share unprotected anal sex given their shared HIV status. In the following quotes all names have been changed.

Everest mistrusts condoms entirely, and describes his anal intercourse with his monogamous partner as particularly special:

Once you're a HIV positive man, it's a great privilege because without a partner on that basis uh you shouldn't be out fucking anybody, condoms or not.

Andrew similarly constructs giving and receiving ejaculate as something special within an HIV positive partnership:

⁸ In this paper I restrict my discussion of HIV risk practice to unprotected anal intercourse, receptive or insertive, with or without ejaculation. This is consistent with the majority of education materials targeting Australian gay men in recent years. There is, of course, an interesting scientific debate which could be had on the relative HIV transmission risks of, say, receptive oral sex with ejaculation compared to insertive anal sex without ejaculation, but that is outside the scope of this paper.

It is very special partly because it is just inherently an extremely intimate thing to do. It's also very special because people don't do it any more. It has a little bit to do - a little bit scary. It is something that no one in their right mind does with just anyone, but if you choose to do that with someone you are really sharing something.

Many of the men noted that they had chosen their current partner on the basis of a shared HIV positive status, or, in the case of some long-standing relationships, that they were relieved that both had turned out to be positive. Many also said that they would only consider a future relationship with another positive person. Colin notes:

I would have sex with people who are not HIV positive, but if I were to have another relationship I really don't think I wouldn't consider having one with an HIV negative person. ... it's the mechanics and the dynamics. The mechanics of sex um grappling with condoms all the time is a drama.

Viewing a shared HIV status as part of a shared life together is the positive corollary of the pattern Adam and Sears draw attention to in discussing unprotected sex in discordant (or asymmetrical) partnerships:

The asymmetrical 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 (Adam and Sears 1994: 74)

For most of the men in sero-concordant relationships, condoms were never used for anal intercourse, and anal intercourse included ejaculation and usually a degree of reciprocation of insertive and receptive positions. For a few of the men, though, there was a lack of trust with their partner which combined with a fear of reinfection or of infection with a sexually transmissible disease. Colin said of his current partner:

I probably would feel more comfortable having anal sex if we used a condom, but then again, you know, it does seem inappropriate at this stage in our relationship and the fact that we are both um you know, both HIV positive.

Chris and Darsh used withdrawal. Chris said:

I don't want to put another load of HIV in Darsh and I certainly don't want to take another load of HIV in me.

And Darsh agreed:

Normally um he wouldn't come inside me. He would withdraw um or over my back or something like that. I mean there are different strains of virus and um blah, blah, blah...

Not surprisingly, *for men whose regular partners were HIV-negative issues surrounding unprotected anal intercourse were much more problematic*. Three relatively distinct patterns of HIV risk assessment emerged for the 8 men in discordant relationships.

Four of the HIV positive men consistently avoided unprotected anal intercourse with their partner. Their motivation for doing so could be characterised as paternalistic, and was associated with a strong protective urge towards their partner. Their relationships were characterised by disparities between partners, where the HIV positive partner was considerably older or more socially mobile than his partner. All regarded anal sex as the most intimate of sexual practices, but their sexual practice had been modified in the light of their HIV-status and their current relationship. One man avoided anal sex altogether. The other three were only ever receptive in anal sex and reported consistently using condoms. For these men, sex had become incidental to the quality of their relationship, as Clifford says:

The whole relationship is not surviving on sexual things. It's surviving on love and sharing and caring for each other and that type of thing.

Two of the men consistently practised unprotected anal intercourse with their respective negative partners, but in circumstances where they denied or dismissed the risk of HIV transmission. Neither of these men nor their partners were employed, and they spent a great deal of time with one another, but very little with any outside person. They were adamant advocates of monogamy, and their domestic environment was the focus of much of their daily work and future aspirations. In their domestic concerns, and in the contrast they drew with a violent and uncaring world outside their relationship, these men simulated the construction of a safe domestic space for unprotected intercourse, characteristic of the men in HIV-negative sero-concordant relationships in the gay couples study (Bartos and Middleton 1996).

These men were inconsistent in their discussion of whether their unprotected anal intercourse with their HIV negative partner constituted a risk of HIV transmission. Alan speculated that his partner may already have been infected by a previous partner, despite repeated negative tests. He had displaced the risk of sex on to the test itself: 'it's like Russian roulette, he's up to his third or fourth test and he's still negative'.

Gordon modifies the risk of transmission by being receptive only, but has also given up insisting his partner should use a condom:

It's not my place to turn around and say well, you should wear them or you shouldn't um he knows the risks and he knows that um they're there and it is his choice whether he wants to use them or not.

The remaining two men usually used condoms for anal intercourse, but had occasions of unprotected penetration, usually without ejaculation. These men, and their partners, were immersed in the inner-city gay culture of Sydney, where HIV is most prevalent. While physically practised with the use of condoms, they regarded them as a symbolic barrier to the intimacy they desired with their partner. Ian observes:

I just feel - the last time [of unprotected sex] just felt that much closer ... you can actually feel skin to skin. So - actual sexuality of it. But also emotionally probably - cause he was letting me. Well I think on his part, he's more or less saying well you know, well not - I'd die, I mean I - I'd die for you is a bit dramatic.

Thomas says:

Safe sex, it doesn't paint a picture, that same sort of picture of commitment.

His partner, Vincent, who was HIV negative at first interview, manifests the symbolic nature of the barrier condoms represent by locating the feeling of unprotected sex somewhere in the confusion between the physical and the emotional:

Its some sort of closer emotional thing. ... I think I just meant the physical sense.

At the second interview, Vincent had sero-converted, and his relationship with Thomas had ended. In retrospect, his infection seemed inevitable:

There's almost sort of that feeling of why fight it, you know. So many people infected and things are going to happen I mean you see it all the time. I don't know I just - maybe just laziness, I don't know. ... You know all the risks. ... I sort of had the feeling that [it was a] sort of an uphill battle I was fighting anyway. So, I'll take my chances and this is the way it turned out.

All of the HIV positive men in the gay couples study had revealed their HIV status to their regular partners. In many cases, their status had been known before they began the relationship. In some cases, one or both partners had sero-converted in the course of their relationship, and had shared with the partner the process of testing and its results. In a few other cases, men had disclosed their HIV status to their partner after they had had sex one or more times. In these cases, disclosure was reported as part of the transition between a casual and a more significant partnership. Disclosure was accompanied by some anxiety, but had positive consequences in terms of deepening the emotional commitment between partners.

Sex with casual partners

Eleven of the HIV positive men in the gay couples study also had sex with casual partners. Unlike their sex with their regular partners, *the nature of sex with casual partners was governed above all by the issue of disclosure of HIV status.*

For some of these men, and in some circumstances, disclosure of their HIV positive status prior to sex with a casual partner was preferable. *For many of the men, being open about their HIV status was part of a strategy of finding other positive men for sex.* Many preferred other positive men for casual sex as it relieved the anxiety around the possibility of infecting another person. Nicholas observes:

With someone usually positive and they knew we were positive and the whole stuff wasn't there. Then sexually I found I could perform a lot better, enjoy it a lot better and was much more adventurous than the whole stuff like if I didn't know the other person's status and then I never really felt comfortable.

In some cases condoms were used or anal sex avoided in order to guard against reinfection or STDs, but in other cases anal sex with another positive casual partner was unprotected.

Another reason for disclosing HIV status prior to sex was to shift the burden of responsibility for the degree of safety of the sex, whether with positive or negative partners. Colin says:

I tend not to have sex with people unless I know them well enough and am comfortable enough to tell them about my status, my sero status. Because I feel, yeah, not only it is my responsibility, but I feel more comfortable in the act of sex if the other person is aware of my status and I'm aware of theirs. So, we can take the appropriate protection.

More often, however, *HIV status was not routinely disclosed to casual partners. In some cases, non-disclosure of their HIV status was concomitant for these men with a commitment to safe sex.* As Andrew explains:

I would not have unprotected sex with somebody unless we had negotiated that and uh generally, no, I wouldn't know the status of a casual partner and no I wouldn't ask and I wouldn't volunteer my status to them anyway. If he wanted to talk about it I would be honest with him and certainly tell him the truth and make an agreement to be very safe.

In other cases, responsibility for determining whether sex was safe or not was judged to be mutual. If a casual partner was willing to have unprotected anal intercourse, then that was their responsibility. Felix argues:

When it came to a relationship or not even a relationship, when we started dating a bit and then I thought, okay, I've got to be more honest about this, but a casual thing, well, then it's a 50:50 arrangement, you know.

And at his second interview is even more explicit:

I just feel it's a 50:50 thing, you know, this if he wants to - if I was fucking any guy and he didn't indicate that I should use a condom well he's - it's a 50:50 deal, you know, I feel like well, baby it's your problem.

The distinction made by Felix between very casual partners and dates is shared by Ian. His attitude to very casual partners is:

We've had enough education now, and it takes two to tango, I don't think I cared whether they were negative or positive to be honest.

Whereas with more intimate friends:

I mean I did use condoms. On a couple of occasions with people I know. Well, I'd met them intimately like in my social circle so I think I kind of looked at that differently from looking at someone I'd just picked up in the bar.

The *centrality of HIV disclosure in the negotiation of different patterns of sex with casual partners by the HIV positive men* in the gay couples study is consistent with the findings of Keogh and Beardsell (1996) on recently HIV diagnosed men in London. They distinguish two patterns of response to an HIV diagnosis: celibacy and increased numbers of anonymous partners. They propose that 'the seemingly opposed reactions [celibacy and sexual anonymity] are different reactions to the same problem, that is a new and increased complexity in sexual negotiation'. From this point of view, anonymous sexual partners have the advantage of obviating the need for disclosure of HIV status, or subsequent recriminations after non-disclosure.

In developing coping mechanisms to overcome the difficulties of sexual negotiation Keogh and Beardsell found 'formal or informal contact and support of other HIV+ gay men' was key. They also report that 'many men expressed a preference for other HIV positive sexual partners'.

Australian HIV positive gay men would appear to share with their London counterparts the sense that sex with an anonymous or nearly anonymous partner relieves them of the need to disclose their HIV status. It also makes each person individually responsible for the degree of risk they are willing to take in sex. Especially where sex takes place in sex on premises venues, in anonymous groups, or in public sex environments, there are fewer bonds of social obligation which imply a duty of care towards another person. It is not that HIV positive men in these circumstances are acting with callous disregard or recklessly. Rather, they are assuming that their casual sexual partners are autonomous adults able to make their own HIV risk management decisions. Often, they assume partners willing to have unprotected intercourse must themselves be positive, but in a sense that is immaterial: if they wish to run a risk that is their affair. As Felix puts it in relation to the man he encountered in a sling in a sauna taking all comers:

I would assume he was HIV or the biggest dumbwit in the whole world.

Changes over time in the meaning of HIV infection

The initial interviews for the gay couples study were conducted in late 1995 and early 1996. Although questions about health status and HIV treatments were not part of the interview schedule, many of the positive men volunteered information about these issues. Consistent with prevailing clinical practice at the time, many of the positive men, especially those who reported AIDS-related illness, seemed to be on anti-viral medications. Second interviews were conducted towards the end of 1996 and into 1997. Once again, treatments were not explicitly discussed with participants, but many seemed to be on new combination anti-viral therapies including protease inhibitors. Many reported that their viral load had been tested and that it had fallen.

More generally, in 1996 the number of deaths from AIDS in Australia continued to decline. Whether measured by the statistics of the National AIDS Register, or by the number of obituary notices appearing in the gay press, AIDS deaths peaked around 1993-1994, declining somewhat in 1995 and more sharply in 1996.

More remarkably, nearly all the HIV positive men in the gay couples study were more optimistic at the end of 1996 than they had been at the end of 1995. For some this meant they were having more sex, whether with their regular partner or with casual partners. For others, sex remained in the background, but they had begun to get their lives in better order and to plan their future further ahead. Some of these observable changes may be attributable directly to improved health as a result of combination therapies and protease inhibitors. Certainly, it could be anticipated that these therapies would be at their maximum apparent effectiveness at the end of 1996, given that they would have been both widely and recently available at that time for most Australians with HIV or AIDS, but in relatively few cases would there be evidence of drug failure.

I do not want to argue that the advent of protease inhibitors in 1996 caused a mass change in the mood of Australian people living with HIV/AIDS. However, there does seem to have been a widespread shift in the meaning and significance of HIV infection occurring around this time. Clinical experience of the new treatments may have contributed to it, but more significant influences are likely to have been the media hype associated with the treatments, together with more gradual cultural changes which have, for example, seen diminishing levels of discrimination against people living with HIV/AIDS and less exceptional treatment of the disease. What these changes do suggest is a need to be more attentive to the changes in the meanings of HIV infection which have occurred since the outset of the epidemic. These changes have been influenced by many factors, including: the patterns of infection; advances in medical technology, including HIV testing and treatments; and collective changes in the patterns of sexual practice and norms. While some of these changes have been analysed at societal level, they also have their impacts on individual risk assessments in relation to HIV.

At this stage, I want merely to make some brief suggestions as to the ways in which different meanings of HIV infection can be considered to characterise different periods. While I believe evidence for each of the characterisations can be gleaned from long interview material gathered in a series of studies undertaken since the late

1980s by the National Centre in HIV Social Research difficulties of analysis are formidable given the different purposes of different studies.

As Michael Pollak observed some years ago,

The assimilation of all behaviours that might increase risk and their opposition to risk avoiding behaviours changes the dividing line between the normal and the abnormal. The opposition is no longer the 'normal' majority heterosexual behaviour as opposed to perversity. The new dividing line separates the 'reasonable' (highly valued) from the 'irrational' (to be combatted) in terms of the criterion of fatal risk. This is the basis for a redefinition of a hygienic approach to sexuality centred around conceptions of self-control and risk management. (Pollak 1992: 88-89)

In the first period I want to characterise, which in Australia lasted from 1983 until around the late 1980s, *HIV risk was characterised as a collective experience*. For HIV positive gay men, their HIV infection was largely attributed to the 'old days' where unprotected sex with many partners was the norm. The creation of a collective safe sex culture implied gay men would either fall in the camp of condom users for anal intercourse, or fatal risk takers. *For HIV positive men there was a notional commitment to participation in the safe sex culture regardless of HIV status, but the reality was more likely to be the disavowal of sex altogether*.

One participant interviewed in 1990 described his past sexual practice thus:

One bloke screwed me and somebody else would come along, it was dripping down the inside of your legs. It's probably where I got what I've got.

Whereas now, he has no anal intercourse:

I think at that stage once we knew there was AIDS that was it I haven't been screwing since.

Similarly, another younger man describes the past:

I mean I used to go to the [sauna] and there'd be - you'd go through a dozen men a night.

About current sexual practice he argues in principle:

It's all safe, if you go about it the right way and sensibly. And if you know what you're doing, then it's safe. Condoms and stuff like that. Pulling out before you blow.

In practice, though, he says he has had no sexual partners for the past four years.

The second period I want to suggest existed in Australia from roughly the end of the 1980s through to the mid 1990s. *It was characterised by an increasing differentiation*

of HIV risk management strategies, and a divergence between the expressed attitudes of HIV positive and HIV negative men. For HIV negative men it saw the public acknowledgment in the term 'negotiated safety' of strategies which had existed privately since the beginning of the epidemic, that is an agreement to unprotected intercourse with a regular partner known to be negative also, provided that any sex with outside partners was safe. For HIV positive men, it saw differentiated risk strategies between regular and casual partners, and a tendency to seek out HIV positive partners for sex. The varied risk strategies which emerged, particularly towards the end of this period, are those which I have described above.

The third period I propose is only beginning to emerge in Australia. It is characterised by a continuing proliferation of HIV risk assessment and minimisation strategies. There remains a divergence between HIV positive and HIV negative men, although the range of risk reduction strategies within sero-discordant regular relationships is broadening. For HIV positive men, treatments and health status information, particularly viral load testing, are beginning to have an impact on risk assessment. At this stage, there is no evidence that positive men with low or undetectable viral loads are using this knowledge to justify unprotected sex with partners of a different or unknown HIV status. However, there is some suggestion that this information does have a bearing on how HIV risk is viewed by those men who feel some risk taking is inevitable, especially in the context of sero-discordant relationships. At a more general level, there is also a suggestion that HIV positive men are becoming more willing to establish new partnerships, and that the sero-status of a prospective future regular partner is becoming less important.

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