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Morality, Responsibility and Risk: Negative Gay Men's Perceived Proximity to HIV

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Abstract

In order to examine the ways in which men's perceptions of their social surroundings influence how they experience and negotiate sexual risk, we conducted a qualitative study with 36 men who lived in London or Birmingham, had 5 or more male partners in the previous year and believed themselves to be HIV negative.

Men were recruited into two sub-samples (18 men each). The high proximity group personally knew someone with HIV and had a positive sexual partner in the year prior to interview. The low proximity group had never personally known anyone with HIV and had never had a sexual partner who they knew or believed to be HIV positive. Data was collected via semi-structured interviews.

Men in the low proximity groups used moral discourses to articulate beliefs and social norms around the disclosure of HIV which may act as a deterrent to sexual partners disclosing. Although most expected positive sexual partners to disclose, they had difficulty in articulating how they would respond to disclosure and how they would manage any consequent sexual risk.

For the men in the high proximity group, living around HIV constituted a part of everyday life. Disclosure and discussion of HIV did not violate their social norms. The majority did not expect positive sexual partners to disclose to them and knew how they would respond to such disclosure if it occurred. Men in this group did not use moral discourses but talked practically about better and worse ways of managing disclosure.

Proximity to HIV is mediated by strong social norms and self-perpetuating moral discourses which effectively creates a social divide between men who perceive themselves to be in low proximity to HIV and their HIV positive contacts and sexual partners. Men with perceived low proximity to HIV are appropriate as a target group for HIV prevention.

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Background

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

Social networks and social norms are also central to our understanding of the dynamics of HIV risk among gay and bisexual men. The nature and density of social networks have been found to be connected to sexual risk practices and susceptibility to HIV infection in gay men (Smith *et al.* 2004). Moreover, networks influence gay men's perceptions and understandings of the HIV epidemic (Grierson, 2005). In addition, social networks may have a role in influencing an individuals' knowledge of and access to new technologies such as PEP (Korner *et al.* 2005, *Dodds et al, 2006)*. Finally, social norms have been found to be important in influencing gay men's attitudes towards safer sex and risk-taking especially among disempowered groups (see Wilson *et al.* 2002, Peterson *et al.* 2003, Amirkhanian *et al.* 2005a, Zea *et al.* 2005). Findings from the 2003 *Gay Men's Sex Survey* (GMSS) reinforce the importance of social and sexual proximity to HIV in targeting gay and bisexual men who know or believe themselves to be uninfected. Reid et al (2004) show that men in certain social and cultural networks had limited experience of HIV and these men tended to have greater HIV prevention need. Considering a gay man as part of a social network involves engaging with the social and cultural factors that shape his experience. Rather than thinking of his relationships as essentially

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random, we characterise them as being profoundly influenced by his social environment.

In this paper, we present the results of a qualitative examination of perceived social proximity to the epidemic among gay and bisexual men who knew or believed themselves to be HIV negative. This study measured *perceptions of proximity* to the epidemic rather than actual proximity (to study actual proximity would require a very different analysis). Studying men's perceptions of their proximity to the epidemic allows us to examine the ways in which their perceptions of their social surroundings influence how they experience and negotiate sexual risk. Moreover, an individual's perception of the world around him influences the types of information and messages he is likely to notice. Thus this study also aimed to inform interventions targeting men based on their perceived proximity to the epidemic.

Recruitment & Methods

We recruited a sample of men who were currently sexually active men and who lived in urban areas with relatively high local HIV prevalence. To qualify for the study, a respondent had to meet all of the following criteria:

- Lived in Greater London or Birmingham at the time of interview.
- Had 5 or more male partners in the year prior to interview.
- Believed himself to be HIV uninfected (negative) at the time of interview.

Men were recruited online via banner advertising placed in the London and Birmingham chatrooms on www.Gaydar.co.uk. All respondents completed a brief online screening questionnaire and those who qualified were asked for contact details. Seventy-nine men did so of which 36 were recruited to the study and took part in face-to-face semi-structured interviews. The screening instrument assigned men to one of the following two groups.

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Perceived high proximity group (18 men)

Men in this group met both of the following criteria:

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

Perceived low proximity group (18 men)

Men in this group met both of the following criteria:

- Never personally known anyone with HIV at the time of interview.
- Never had a sexual partner who they knew or believed to be HIV positive at the time of interview.

Interviews covered the following topics:

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

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

Sample

The high proximity group were similar to the low proximity group in terms of age (mean

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ages of both groups were 34 years with a similar age range in both groups); city of residence (in each group, roughly half lived in London and half in Birmingham); HIV status belief (similar numbers believed themselves to be probably HIV negative or definitely HIV negative). The men in the high proximity group had more sexual partners overall than the men in the low proximity group and slightly more of these partners were casual in the high proximity group. However, the groups were broadly similar in the numbers of regular and casual partners with whom they had anal intercourse (AI) in the year prior to interview and unprotected anal intercourse (UAI) in the year prior to interview (see Keogh *et al.* 1996 for more detailed information on the sample).

Results

Low Proximity men

Men in the perceived low proximity group were asked about their social networks, attitudes towards disclosure and how disclosure of an HIV positive diagnosis from a partner might impact on sexual safety.

Social stigma and morality emerged as a central discourse in the accounts of men in this group. The description of HIV as a highly stigmatising condition allowed the speaker to represent himself as a moral actor. For example, there were morally correct ways of talking about HIV. Individuals were rumoured to be HIV positive. However, either listening to, or being the source of such rumours was seen to be morally unacceptable.

> ...I've heard rumours that one person has HIV that I know. But I would never personally listen to them and confront him.

The idea of a moral self was often reinforced with affirmations of one's own acceptance of people with HIV.

> I've got nothing against having a friend who [has HIV]. They'd be more

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> welcome in my home than anybody else would.

HIV was therefore discussed in terms of what it may or not indicate about the moral character either of the person who has HIV or the person who talks about HIV. Moral discourses also suffused talk of sex and risk. Respondents often talked about the moral character of the individual with HIV or his sexual partner.

> I think that people don't talk about [HIV] much. There is a group of people who do talk about it all the time and will only do bareback sex. [...] A friend had bareback sex with a man who much later told him that he was HIV positive.

These moral discourses tended to insulate men from a day-to-day relationship with HIV. Men with HIV were seen either as victims of or vectors for infection. Disclosing a positive HIV status was seen as a moral act rather than merely the exchange of information which allows the actors to behave in one way or another. Such reductionism places life with the virus at a distance and insulates the uninfected self from the infected other. This meant that the men in this group were heavily implicated in stigma around HIV. Not only did stigma compel people with HIV to remain silent but is also compelled those around them to maintain this silence.

Morality and stigma also influenced the attitudes of the men in this group towards sex. As disclosure is a moral act, the majority believed that a partner with HIV *should* disclose to them.

> I would expect [disclosure] because I would imagine they would feel a sense of duty.

The moral responsibility to disclose becomes stronger the more risky the sex on offer is.

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> If someone has HIV then they should say. If you are going to do something that puts somebody else at risk. [If it's] a very small risk then, ok, maybe there's a discussion to be had but if you're fucking, then certainly you should have a conversation about it.

This presents us with a very problematic conception of responsibility. According to the accounts of men in the perceived low proximity group, men with HIV *should* disclose (a) because it's the right and moral thing to do and (b) so that the negative partner can decide how much risk he wants to take. The difficulty here is, how is the positive partner to know (a) what the moral code of the negative partner is and (b) what risk is acceptable to his partner and when should he disclose? The role of the partner qua responsibility was therefore elaborated in a non-functional way while the responsibility of the negative partner is hardly considered at all. This makes it difficult to say the least, to support such men in forming tactics around risk-taking or negotiating safety.

High Proximity Men

The experiences of the men in the perceived high proximity group were very different. Having friends who were positive meant being part of a social network which generated its own norms and meanings. Rather than being an exceptional and moral act, in mixed positive/negative social networks, disclosure was a commonplace.

> **You said you know three or four friends who are positive?**
>
> Yeah. And I often hear of people that I didn't know were [positive]. And I find out they are you know through some way or another.
>
> **So something that's around you?**
>
> Yes. Yeah.

Disclosure was not seen as the intrusion of a stigmatising act into normal daily

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discourse. Rather information about a person's HIV status was carried through the exchange of information on a network. It neither had the currency of gossip nor did it infer anything about the moral character of the person imparting or receiving the disclosure. In these social networks, information about health and HIV status was freely exchanged.

> [In my group], there's more than one person who's positive and if you happen to know one [in the group] you will have access to a friendship group that has more people who are out and open about it.

When it came to sex and risk for the men in this group, the context of the sex was important. For example, in anonymous settings such as saunas or darkrooms, disclosure was not expected. Men tended to assess the proportion of men with whom they came into contact who might have had HIV. As they assumed that any man might be infected, disclosure was redundant.

> **But do you believe a man with HIV should tell you before having sex?**
> No, because if I believed that then I wouldn't go out to [names sex club] where obviously statistically, more people are [positive].

Once an encounter had gone beyond the anonymous or casual, disclosure was generally expected. For the most part, this was because a more meaningful or permanent relationship was indicated. Knowing that one's partner was HIV positive was seen as vital to managing expectations. The following respondent talks from the perspective of a hypothetical HIV-positive man managing the expectations of his negative partner.

> I don't think [HIV] would be initially discussed. I think it would be as things progressed. If it was just a bit of a play around, you're not really

For Peer Review Only

> going to do them any major harm. But then if they start doing things or wanting things, then you'd be like 'well... hang on'.

Context was key not only to whether or not disclosure was expected, but also to the ways in which this information was used. Often disclosure was considered undesirable, neither because the individuals involved were in denial nor because they harboured stigmatising attitudes about HIV. Rather, it was because the sexual context precluded it. Finally, men sought disclosure or non-disclosure for reasons above and beyond the question of sexual safety. Disclosure profoundly influenced the sexual content and emotional tone of an encounter or relationship.

This leads us to a more complex and more robust conception of responsibility. On one hand responsibility was seen as taking responsibility for ones own actions.

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

However, more complex conceptions of responsibility are discernable and social context was key to understanding them. Men knew that HIV-positive men constituted a significant part of their social and sexual networks. Moreover, certain settings were likely to contain more men with HIV than others. Therefore responsibility consisted not only in knowing about one's own networks, but also about local or even social epidemiology

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

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In addition, the work involved in knowing one's HIV status came into play when men talked about responsibility. Men were aware that their presumed negative HIV status is always contestable and only ever as good as their last test. Establishing one's negative HIV status at a time when one is sexually active involved *work*. It meant ongoing regular testing and retrospective risk assessment. It also meant being constantly alive to the possibility that one might have contracted HIV. Most men felt that this level of self-interrogation and self-awareness was emotionally unsustainable. They therefore appreciated the not inconsiderable *work* that went into establishing and living with a positive HIV diagnosis (testing for HIV, dealing with a negative outcome and managing sexual risk as an HIV-positive man). They therefore did not expect total transparency or accountability from their positive partners.

> I don't expect [disclosure] because I don't surrender that information myself. So it's not fair for me to say 'well someone should tell me', if I'm not going to go and get tested regularly and then offer the same to them.

Moreover, this notion of responsibility recognised that sexual interaction was complex and the necessity for disclosure depended on the specificity and meaning of the sexual encounter.

> Well, what are we having sex for? Are we having sex because we're starting a relationship? Are we having sex because it's a casual fuck? Do we just want to get our rocks off and clear off? I know I'm going to have safe sex. However what happens if a condom splits? He doesn't tell me and it was causal sex and he clears off. And I don't realise that it's split until after. Hmmm. I don't know. Can I say I'd like him to (disclose) in those circumstances?

The uncertainty that was being expressed here is not one borne of risk avoidance, but

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was rather an uncertainty about when, in a sexual encounter it was appropriate for either partner to intervene with information about HIV status or past sexual risk? This may be before sex, before certain sexual acts or after unforseen circumstances (such as a condom failure). Overall therefore, we can discern a more functional, context bound notion of responsibility amongst perceived high proximity men,

Discussion

We drew many conclusions to be drawn from this study. However, for the purposes of researchers and practitioners doing work on negotiated strategies, two considerations are worth drawing out.

First, it's important for health promoters to refine their definitions of *knowledge (*specifically knowledge of own HIV status and that of others) to take better account of which values and meanings are ascribed to knowledge and to what purpose knowledge is put to.

Although men in both groups said that they were HIV negative, the nature of this knowledge differed remarkably between the two groups. The men in the high proximity group asserted their negative HIV status as a functional difference between themselves and others in their social and sexual networks who actually were positive. The men in the low proximity group did not have this functional awareness of difference. Because HIV did not have a social presence in their lives, was not embodied in their friends or partners, it did not have a social dimension. By this, we mean that these men did not partake in social norms and practices whose purpose was to manage the flow of information about one's own and others' HIV status as well as maintain that difference between individuals.

For men in the high proximity group, knowledge had a variety of uses and meanings. For men in the low proximity group, it served the function of reinforcing notions of the moral

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and responsible self and maintaining a distance between self and other.

Second, it's important to re-think notions of responsibility. Definitions of 'safer sex' have become ever more complex informed by negotiated safety and risk reduction arrangements (strategic positioning, coitus reservatus or coitus interruptus, peeping etc) as well as the presence of new technologies (specifically the availability of post exposure prophylaxes for sexual exposure). The question of who should be responsible and in what being responsible consists becomes ever more fraught. We have seen that the men in the perceived low proximity group use a concept of responsibility which does not have the capacity to deal with this complexity. The men in the perceived high proximity group have a more flexible, context-related and hence more a more functional notion of responsibility.

Finally this research should detract us (as health promoters and researchers) against our tendency to reify the risk reduction tactics of gay and bisexual men. We need to be aware that our current assessments of the relative riskiness of behaviours and tactics are based on an insufficient range of variables. Attempting to 'shoehorn' such behaviours and tactics into pre-defined categories of unsafe vs safer vs safest although useful is not sufficient. Preventing HIV transmission also lies in attending to men's capacity for flexibility in response to sexual and social complexity. To do this, we must understand the social world they inhabit and the social norms they observe. Some men are better equipped in this respect than others.

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For Peer Review Only

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