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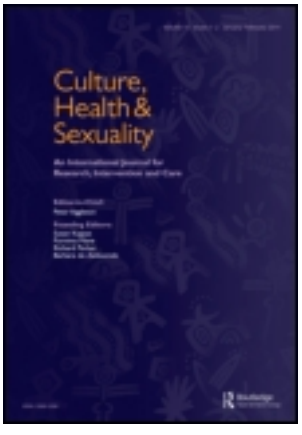

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HIV-negative gay men's accounts of using context-dependent sero-adaptive strategies

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We enrolled 166 gay and bisexual men who tested HIV-negative at a community sexual health clinic in Vancouver, British Columbia, into a year-long mixed-methods study. A subsample of participants who reported recent condomless anal sex ($n = 33$) were purposively recruited into an embedded qualitative study and completed two in-depth qualitative interviews. Analysis of baseline interviews elicited three narratives relevant to men's use of context- or relationally-dependent HIV-risk management strategies: (1) seroadaptive behaviours such as partner testing and negotiated safety agreements used with primary sexual partners, (2) serosorting and seroguessing when having sex with new partners and first-time hookups and (3) seroadaptive behaviours, including one or more of seropositioning/strategic positioning, condom serosorting and viral load sorting, used by participants who knowingly had sex with a serodiscordant partner. Within men's talk about sex, we found complex and frequently biomedically-informed rationale for seroadaptation in men's decisions to have what they understood to be various forms of safe or protected condomless anal sex. Our findings support the need for gay men's research and health promotion to meaningfully account for the multiple rationalities and seroadaptive strategies used for having condomless sex in order to be relevant to gay men's everyday sexual decision-making.

Keywords: HIV prevention; gay men; sexual behaviour; risk assessment; Canada

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Introduction

In British Columbia, as in the rest of Canada, the majority of new HIV diagnoses are among gay, bisexual and other men who have sex with men (PHAC 2010). While HIV infections resulting from injection drug use have been steadily declining (Gilbert, Buxton, and Tupper 2011), diagnoses among men who have sex with men have remained relatively stable over the past 10 years (BCCDC 2012). In response to this disproportionate burden of HIV incidence and prevalence, gay men have led prevention efforts, including the development of community-derived behavioural strategies such as seroadaptation (Frost, Stirratt, and Ouellette 2008; Eaton et al. 2009; Wei et al. 2011). The motivations of some gay men to 'actively develop strategies that balance precaution with an implicit preference for unprotected sex', along with emerging biomedical possibilities (e.g., increased availability of precise and timely information about HIV status and viral load) has

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influenced the development of a range of seroadaptive practices (Dowsett and McInnes 1996; Race 2001, 172–3, 2003).

The umbrella term 'seroadaptive behaviours' here refers to strategies for sexual-risk reduction that are based on the real or perceived HIV status of sexual partners (Eaton et al. 2009). Documented seroadaptive strategies include: (1) *serosorting*, choosing sexual partners known to be of the same HIV serostatus (Suarez and Miller 2001; Parsons et al. 2005), (2) *negotiated safety*, 'the strategy of dispensing with condoms within HIV-seronegative concordant regular sexual relationships under certain conditions' (Kippax et al. 1997, 191), such as engaging in protected anal intercourse outside of the primary relationship and committing to disclose to one's partner should this agreement be violated (Kippax et al. 1993; Eisenberg et al. 2011), (3) *strategic positioning* or *seropositioning*, taking a role in anal sex that reduces likelihood of HIV transmission or acquisition, such as being the insertive partner if you are seronegative (van de Ven et al. 2002; Snowden, Raymond, and McFarland 2009), (4) *condom serosorting*, in which condoms are used with serodiscordant partners (Wei et al. 2011; McFarland et al. 2012)[1] and (5) *viral load sorting*, the use of viral load by HIV-negative and HIV-positive persons – or possibly perceptions of treatment adherence – as a deciding factor to engage in sexual acts to reduce the possibility of HIV infection or reinfection (Prestage et al. 2009; Zablotska et al. 2009; Van Den Boom et al. 2013).

Existing research on seroadaptation is primarily quantitative and draws from public health surveillance data, clinical data and cross-sectional surveys conducted in largely US urban centres, with samples of both HIV-positive and HIV-negative gay men and other men who have sex with men. Data from Vancouver, British Columbia, indicates HIV-negative and HIV-positive gay men reported high rates seroadaptive behaviours, including asking about HIV status, seeking same-status partners (serosorting) and seeking partners with a low viral load (viral load sorting) (Trussler et al. 2010). While these strategies can be effective, some research has shown that both HIV-negative and HIV-positive gay men tend to assume (or seroguess) their partners to be seroconcordant (Flowers, Duncan, and Frankis 2000; Parsons et al. 2006; Zablotska et al. 2009), a tendency that has been termed 'confirmation status bias' (Suarez and Miller 2001, 475).

Men who discuss serostatus with their partners may not have accurate information about their current serostatus due to lengthy window periods in standard HIV tests (Butler and Smith 2007) and infrequency of HIV testing (MacKellar et al. 2006). These concerns are especially important given evidence indicating newly-infected individuals are highly infectious and account for a high proportion of new HIV infections (Steinberg et al. 2011; Chibo, Kaye, and Birch 2012).

Qualitative literature on serosorting with gay men has revealed diverse motivations for seeking seroconcordant partners, including reducing sexual risk and greater emotional and sexual intimacy (Frost, Stirratt, and Ouellette 2008). However, it has insufficiently considered these sexual decisions in the social and relational context of gay men's everyday lives (Braine et al. 2011; Grace et al. 2012). The qualitative data we present provides men's accounts of seroadaptive strategies employed in the Vancouver context of high rates of HIV among gay men despite the ongoing implementation of a 'treatment as prevention' strategy, which promotes HIV treatment as a way of reducing onward transmission to HIV-negative partners (Montaner 2011). The purpose of our analysis was to explore the quality of everyday social relations and sources of knowledge that inform gay men's sexual decision-making including understandings of sexual safety without condoms.

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Methods

Qualitative data we report on is drawn from a larger mixed-methods study of HIV-negative gay men conducted by the Canadian Institutes of Health Research Team in the Study of Acute HIV Infection in Gay Men. For a full description of the study, see www.acutehivstudy.com. Study recruitment occurred between June 2011 and January 2012 at a community sexual health clinic located within a central gay area of Vancouver. Clinic patrons were approached by a research assistant and told about the study. Men were enrolled if they agreed to participate and met the following criteria: (1) self-disclosed that they had had sex with men at the time of their recent HIV test, (2) were 19 years of age or older, (3) had recently received a negative HIV test result using a point-of-care HIV test and/or a pooled nucleic acid amplification test for HIV at our study recruitment site, (4) spoke and read English, (5) intended to reside in the Greater Vancouver area for the next 12 months and (6) were able to sign and fully comprehend the study consent form.

All study participants completed the baseline quantitative portion of the study (n=166). A subsample of participants who reported at least one instance of condomless anal sex in their last five sexual encounters during the baseline quantitative component (n = 33) were purposively-recruited into an embedded qualitative study and completed the first (T1) in-depth qualitative interview. Of these individuals, 29 (85%) went on to complete a follow-up qualitative interview approximately one year later (T2). An honorarium of CDN $25 was provided to participants for each study encounter (i.e., both the quantitative surveys and qualitative interviews). In this analysis, we report upon qualitative data collected at T1 related to participants' narratives of seroadaptation.

We developed semi-structured interview guides in consultation with our community partner, Health Initiative for Men, to understand men's lived experiences as sexually active gay men in Vancouver. Baseline interviews focused on five key objectives: gaining a rich picture of the importance, frequency and kinds of sex participants have; understanding men's sexual health knowledge and conceptions of risk; understanding the HIV-prevention strategies men practice and the importance they place on staying HIV negative; assessing their past and current HIV testing experiences, knowledge and behaviours, testing rationales and expected results; and reviewing sources of social support. This research made use of insider perspectives offered by the research team (e.g., interviewers were all working in Vancouver at community-based organisations in the area of HIV and/or sexual minority health and the majority of the study team are gay men) (Parker 2009). Interviewers were trained in the process of qualitative interviewing and coding through a series of practice interviews, feedback sessions and regular team meetings. During the course of interviews, which were conducted one-on-one and typically lasted 60–90 minutes, interviewers probed further to explore emerging information regarding the social and sexual lives of informants, with focused attention to experiences of condomless anal intercourse. Participants are identified by pseudonyms and their age at the time of study enrolment.

In this analysis, we have limited access to participants' experiences beyond their narrative accounts. As such, this paper is an analysis of ordinary participant talk about sex – everyday speech we have audio-recorded, transcribed verbatim, reviewed for accuracy, read as text and reassembled in themes and illustrative quotations. Interviews were independently coded by two research assistants under the supervision of the first author. Emergent themes were identified in an iterative process and discrepancies were discussed until consensus was reached (Creswell 2003; Mason 2005).

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Results

At the time of study enrolment, the mean age of qualitative study participants was 32 years. The majority of men lived in Vancouver (84%) and most had moved to the city in the last 5 years (61%), predominantly from elsewhere in British Columbia or Canada. Most participants self-identified as gay (91%) leading us to use this category to describe our sample throughout this paper. Most participants were employed full-time (59%), had completed a college or university degree or higher (72%) and identified as Caucasian (69%), Asian (13%) or Hispanic (13%). The median reported income was between CDN $40,000–49,000. The sample is split with respect to men's relationship status at the time of study enrolment with approximately half of men being single (41%) and half currently dating, partnered or married (59%).

In their interviews, participants overwhelmingly voiced the desire to remain HIV-negative. Men consistently emphasised the importance of staying HIV-negative despite many participants' recognition that living with HIV is much more manageable today than at the beginning of the epidemic due to advances in treatment and care.

Many of our participants spoke of enacting complex strategies to prevent their exposure to HIV. Overwhelmingly, they reported seeking seroconcordant partners and using condoms consistently when having anal sex with new and casual partners. The majority of condomless sex they reported occurred in the context of long-term relationships that participants classified as having low or no risk of HIV transmission. In some cases (including long-term relationships), participants described condomless sex in situations where they reasoned that some possibility of HIV transmission existed but the risk seemed acceptable given their simultaneous goals of sexual pleasure and intimacy. In the narratives that follow, men highlight the social and interpersonal factors involved in using various seroadaptive behaviours in their everyday sexual lives. We identified three interrelated seroadaptive narratives through our analysis.

Narratives of seroadaption with seroconcordant primary sexual partners

Anal sex with seroconcordant primary sexual partners, including boyfriends or husbands and regular, casual partners, was the most commonly described scenario of recent condomless sex. Participants rarely considered condomless sex with primary HIV-negative sexual partners to be a serious risk for HIV infection. For example, Stephen noted that 'barebacking' with his boyfriend would be 'all right' because of their agreement about 'safe' 'play' 'outside the two of us':

> We had an agreement at the time that any play outside of the two of us would be safe, but between each other, that we would technically, we felt it would be all right as far as barebacking was concerned. (Stephen, 48 years old)

Another participant seemed to equate togetherness with fidelity. Diego described his feeling of certainty about his primary partner's HIV-negative status and absence of sex outside of their monogamous relationship:

> … We were, like, we lived together. We were all the time together. There is no way that he would cheat on me, and there is no way I would cheat on him. … I know, I knew his status. He knew my status. (Diego, 26 years old)

Participants talked about rare occasions in which the terms of a negotiated safety agreement (e.g., only engaging in anal sex with additional partners if a condom was used) were not upheld. In these cases, men emphasised the importance of strategies such as condom use following a risk event until HIV-negative status was re-established.

Martin described his approach to establishing seroconcordancy prior to condomless sex and implemented a negotiated safety agreement to minimise the possibility of HIV acquisition with other partners. However, as Martin's relationship with his partner changed over time, what previously was embraced with enthusiasm and seemed safe on the bases of established 'rules', was later understood to present a degree of risk despite these precautions:

> Eventually [we] decided to go get tested together. And get results. And after that, stop using condoms. And, yeah. We had certain rules. Like, where it would be okay to mess around with others. And it would be safe with other people. … But once again towards the end, I just, there is always the understanding that you're never really 100% safe. Even in arrangements like that. (Martin, 27 years old)

A majority of participants indicated that they had tested for HIV with a current or previous sexual partner prior to engaging in condomless anal sex, and participants reported using this strategy in the context of monogamous and more open relationships. Participants described a variety of approaches to 'testing together', including a single joint appointment, back-to-back individual testing appointments and separate appointments within a short period of time. Some couples received HIV test results together, whereas others received results separately. Testing together was described as advantageous for men who reported increased opportunities for pleasure, intimacy and spontaneity:

> I mean, I personally like unprotected sex after we have been tested and all that, just because you can have sex more spontaneously, you know, without preparation and that kind of stuff, you know. And I like that. (William, 25 years old)

James discussed his earlier belief that HIV testing with a partner for the purpose of having condomless sex was 'what someone did in a relationship' – a relationship norm or a 'rule of the game':

> I kind of thought that [testing with a partner is] what someone did in a relationship. Because I was, like, 19. I thought you like went, and then you wouldn't use a condom. (James, 23 years old)

Some men indicated that while they had not yet tested for HIV/STIs with a partner, they were aware of this strategy and may consider it in the future. One participant noted that while he was thinking about using the testing together strategy, his partner was not interested. In their narratives about primary relationships, participants spoke in ways that seemed to place great confidence in the measures they had taken with their partners to maintain their HIV-negative status, although some acknowledged ongoing elements of risk.

Narratives of serosorting with new partners and first-time hookups

For the majority of participants who described condomless sex with new partners and first-time hook ups, HIV status was an important factor in their sexual decision-making. Participants described using a range of strategies to establish the HIV status of prospective sexual partners and the impacts of these determinations on decisions to engage, or not engage, in condomless anal sex. While participants were asked to share things that led them to believe a person was HIV-negative or HIV-positive, participants consistently provided more responses that highlighted indications of HIV-positive status. For example, some participants referenced physical signs such as fat redistribution may be noticeable. However, there was consistent acknowledgment that these indicators are less common now due to advances in HIV treatment:

> I know back in the day, like, before they had all the drugs, I guess it was a little bit easier, like, just to – you know, from someone's physical appearance to tell whether they were sick or not. But now, I mean, it's just a lot more difficult. (Matias, 27 years old)

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This participant's account of shifts in indicators of HIV status evidences knowledge of generational changes within gay men's experiences of HIV, as well as the limitations of using physical appearance to ascertain HIV status. However, a minority of participants described that HIV-positive men were unlikely to appear healthy and/or be physically attractive.

Many participants relied on asking prospective sexual partners about their HIV status. Thomas described remembering people's HIV status from earlier encounters:

> I always ask. I mean, it's just kind of a standard now. … If I go to the bathhouses to play around, you know, so I know who's who and I know who to play with, and who not to. … And I go, okay, 'Yeah, I remember this guy. He's negative, or he's positive'. (Thomas, 33 years old)

This participant's approach took HIV status as a stable, rather than dynamic, piece of information that he used to inform his sexual decision-making.

Participants also described the use of social cues from prospective partners, and information from their social networks, to determine their HIV status:

> But I feel you can learn a lot about people just based on how they interact with you, and how they interact with the wider community, and … it's pretty small online. Like, everyone knows someone who knows someone who slept with someone. So you can kind of ask around. (Matias, 27 years old)

> I feel like [sex] happens with someone that we know, or that we're going to see again, that, like, it's less risky. Somehow. It just narrows it down. Even to have our group of friends around it too, like, be able to know if that person is positive. (Dylan, 26 years old)

Some men reported that online profiles often explicitly state one's HIV status and a preference for seroconcordant partners.

In instances of explicit and implicit decisions not to use a condom, factors such as perceptions of their partner's seronegative status, relational context and knowledge of a partner's 'safe' sexual behaviour were used as indicators of safety. Matthew described how these factors may be considered simultaneously and mentioned the possible fallibility of his assumptions:

> … I took, I guess, quite a liking to him so, that made me more receptive to the idea of having unprotected anal sex. Plus he had, having been in a long-term relationship, and at the same time I didn't know, I guess, both of them could have been sleeping around for all I knew, and he hadn't been tested in a while. (Matthew, 21 years old)

Another participant presented a retrospective rationale as to why he did not ask his partner's HIV status:

> There was no decisions. It just happened. Yeah. I didn't really ask because …. Here's another thing, because he always says he's negative, so I trust him. And on the profile, he also says he's negative. Not that I think he would lie, but I'm not sure if he does regularly get tested. But I know he usually, when he does anal, he only tops. So the risk of him contracting HIV is not, is not null, but it is quite low. So, even if he wasn't testing regularly, I trusted him and I took the risk. (Kyle, 29 years old)

These participants' narratives indicate they considered a host of somewhat conflicting factors – from relational to biomedical – in determining the degree of safety felt in relation to condomless anal sex.

A minority of participants recounted instances of condomless sex with casual partners in the context of substance use in which no discussion of safer-sex strategies, or conscious sexual decision-making, occurred:

> Other than because I was fucked up? Yeah, that was really it. It wasn't belief. I wasn't thinking at that point. It was just … I was high, I was horny. And I wasn't really thinking. (Christopher, 24 years old)

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A few participants shared experiences in which someone they were interested in having sex with disclosed their HIV-positive status. For example, one man described conflicting feelings when someone with whom he had been on a few dates with (without any sexual contact) disclosed his HIV status:

> But, you know, I mentioned to him that it was something he should have told me before, and then he could see I was upset. And he left. And afterwards, I felt pretty guilty, because, you know, it's a difficult thing to tell someone, I feel, you know. I'm sure there is lots of rejection, lots of pain that comes from it. (Matias, 27 years old)

Jacob recounted his appreciation when someone he had met online and was interested in hooking up with disclosed his HIV status without being asked:

> And he was like, 'Oh, by the way, I want to tell you that I am HIV-positive, like I understand if you are not okay with that. That's fine with me, you can let me know'. And I thought, for some reason I thought, 'Okay, wow, like applaud you for being honest'. Like … I was just so shocked that he was so honest, you know. … HIV is a big concern of mine, and like, it makes me very uncomfortable. (Jacob, 20 years old)

While neither of these participants reported having sex with the men who disclosed their HIV status to them, both Matias and Jacob noted the complexities of disclosure faced by HIV-positive men, and conflicting feelings about their reactions.

With casual partners and hookups, perceptions of HIV status played a role in decisions about condomless anal intercourse. These perceptions were informed by many factors about a prospective partner, including knowledge of their sexual behaviour (e.g., from online or from social networks), relational contexts (e.g., being interested in the prospective partner or having a mutual friend) and, in some cases, direct conversations with sexual partners. In cases where prospective partners disclosed their HIV-positive status, participants felt conflicted about decisions not to pursue a relationship as a result of this disclosure.

Narratives of other seroadaptive behaviours with serodiscordant partners

None of the participants recounted encounters wherein they knowingly had sex with someone who was HIV-positive when discussing their most recent instance of condomless anal sex. However, more than a quarter of participants discussed having had sex with a partner they knew to be HIV-positive in the past. With the exception of one participant, the decision to have sex with someone who was HIV-positive included the conscious use of seroadaptive strategies, including seropositioning/strategic positioning, the use of condoms and consideration of viral load or if the person was on HIV treatment. Some participants combined these strategies, for example describing the use of condoms when bottoming with an HIV-positive partner.

Toby discussed that while HIV prevention was not always at the forefront of his mind when having sex with his serodiscordant partner, at times it informed decisions about sex:

> Well, okay, I'll be completely honest. We didn't always have safer sex because there is less risk with someone topping someone without a condom, and so if the bottom is HIV-positive versus the top is a good thing … if I was topping him, I wouldn't always wear a condom. … But the other way around, not to say that I never, because I did. … But sometimes. (Toby, 44 years old)

Some participants noted that condoms sufficiently reduced risks associated with having sex with HIV-positive partners and that they were 'comfortable' or 'fairly safe' having sex with HIV-positive partners when they used their 'fucking with a condom on rule' in these instances:

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> … over the past 11 years, I have played with numerous HIV-positive guys, and in all sorts of situations, every time there was fucking involved, [it was] always with a condom on. … I think that as long as the fucking with condom on rule is applied, I'm fairly safe. (Stephen, 48 years old)

Other men felt that having sex with someone with an undetectable viral load was a reasonable risk. However, several participants acknowledged they did not know very much 'solid information' about how viral load impacts risk and that current public health information on the topic is unclear:

> I feel like I don't know enough about that. I feel like there is not enough information, very solid information, on which everybody agrees, to make a decision that, yeah, if somebody has a very low viral load and if I'm going to make a decision to have unsafe sex with them, as if they are negative, yeah. (Martin, 27 years old)

Dylan, who described having condomless sex with an HIV-positive partner while intoxicated, indicated that in his conversation with this partner after having had sex, knowing that he had a undetectable viral load was reassuring: '[My partner's undetectable viral load] made it less worrisome in my mind, after' (Dylan, 26 years old). A number of participants who were open to having sex with HIV-positive men, but had not knowingly done so, said that viral load may impact their future sexual decision-making, but acknowledged limitations of their own knowledge:

> Well, if the viral load was high, I would definitely – no offence, but – do nothing with the guy. If the viral load was low, I think I would talk to him about it. Honestly … [there are] lots of guys who claim they are undetectable. So, I guess I am knowledgeable in that, you know, I have – I know that high viral load is bad news. Low viral load could be good news, but I'm not positive as to how safe exactly a low viral load is. (Kyle, 29 years old)

Two participants noted their use of seroadaptive behaviours in cases of performing oral sex on positive partners. These men indicated that they chose not to swallow when other risk factors were present, such as having a sore or irritated throat.

Another participant recounted the experience of his partner recently seroconverting. While they had been sexually active prior to the diagnosis, the participant noted he is currently abstinent while waiting for more information about viral load and the impacts of treatment.

Finally, some participants talked about the possibility that they may have unknowingly had sex with serodiscordant partners. Men acknowledged that knowing one's HIV status is complex and that factors such as testing frequency, the testing window period and both the sexual history of the prospective partner and his other partners since last testing impact knowledge of serostatus.

Discussion

Our findings reaffirm earlier research indicating that gay men commonly use a range of seroadaptive strategies to prevent HIV transmission (Eaton et al. 2009; Trussler et al. 2010). Our participants' accounts of sexual decision-making reveal that most are neither adrift in a landscape of folk science nor are they scientific experts about HIV. However, it is also clear that there is a paucity of clear and accessible sexual health information regarding the efficacy of some seroadaptive strategies, used individually or in combination, available to these men. Our analysis of men's narratives raises important considerations for existing conceptualisations of serosorting, including the various contexts in which sexual decisions are made and the need to provide HIV-negative gay men with information about the use of seroadaptive behaviours.

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Race (2003) describes 'homosexually and scientifically active men', who demonstrate 'a reflexive engagement with medical knowledge in terms of lived experience' (371). These men were among the first to develop seroadaptive prevention strategies beyond the scope of dominant public health messaging, based on their medical knowledge and their personal sexual practices and desires (Race 2001). These men, who include many of our participants, are savvy consumers of sexual health information. However, their narratives reveal that while they believe many sex-related risks can be reduced, not all risk can be eliminated and non-condom based strategies may be used as a pragmatic form of risk-management that allow them to experience desired sexual intimacy and pleasure.

Men's narratives illuminate that the processes of determining a prospective partner's HIV status, and subsequent decisions about safer sex strategies, are largely informed by contextual and relational factors and multiple rationalities. Contextual factors include sexual norms within gay communities (Dowsett 2009; Braine et al. 2011) and available medical information and services. For example, participants were aware of, or had participated in, the practice of testing together – a practice that requires accurate medical information regarding the efficacy of this strategy. These findings support the argument advanced by Race (2001, 2003) that, to an extent, medical knowledge informs community norms, and that these norms change in response to advances in medicine.

While earlier research has found that only a minority of men who serosort use testing to establish seroconcordancy with partners, and that these discussions are often based on test results that are a year or more old (MacKellar et al. 2006), men in our sample reported high rates of testing as a strategy prior to having condomless sex within both current and prior primary relationships. Health Initiative for Men's Executive Director noted that this strategy is used by many men in their clinic and that '[t]esting gay men in couples as couples can be an effective way to facilitate a conversation about sexual health' (Christopher 2013, 1). This finding highlights the importance of examining the impacts of initiatives to promote partner testing that have been introduced for gay men in some North American urban centres (e.g., see www.testingtogether.org; Sullivan et al. 2013).

Some men expressed wanting to learn more about emerging strategies for HIV prevention, such as viral load sorting. No men reported using pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). However, many participants described recently becoming aware of such risk-reduction measures. Interest in these strategies for some gay men can also be seen online, with the emergence of platforms to discuss the use of PrEP and other seroadaptive strategies (e.g., see http://myprepexperience.blogspot.ca).

Community-derived HIV support and prevention strategies, such as seroadaptation, have existed throughout the epidemic. For example, support and information-sharing groups emerged in the 1980s and were led by persons infected and affected by HIV and AIDS (Hardey 1999). These communicative platforms have evolved to include interactive internet-based conduits for information exchange across professional and lay audiences. We argue that further public health guidance regarding the efficacy of seroadaptive strategies is necessary. Such messages must be tailored to both scientifically active and 'lay' gay men alike (Race 2003).

Many men in our sample indicated that they expected men living with HIV to disclose their status, yet their narratives revealed they are unsure how to respond when HIV disclosure occurs. This may be explained in part by HIV stigma within and beyond communities of gay men and by limitations of current HIV-prevention efforts that often erase HIV-positive men and prioritise the health of HIV-negative men (Flowers, Duncan, and Frankis 2000). Further, this finding highlights the need for HIV-prevention initiatives

to provide HIV-negative and HIV-positive men alike with tools to negotiate HIV status disclosure (Adam 2005).

Adding to the literature on 'confirmation status bias' (Suarez and Miller 2001, 475), our data also reveals the ways in which interpersonal factors impact sexual decision-making. While participants often asked prospective partners about HIV status prior to sexual engagement, men's narratives indicate that they may be more likely to assume seroconcordancy with partners with whom they had relational ties. For example, talking about HIV status seemed less important with prospective partners who were 'familiar' from previous social encounters (e.g., online or in-person) or who were known to them through a shared social network. Physical attraction, and in some cases, 'really liking' a prospective partner also changed participants' usual strategies for remaining HIV-negative, whether that be always asking a partner about HIV status and/or always using condoms for first-time anal sex.

Relational elements of trust were prominent in men's narratives, particularly among participants in long-term relationships. Men repeatedly emphasised the importance of preventing their partners from becoming exposed to HIV by maintaining agreements and/or using condoms in cases of their possible exposure to HIV. These findings are consistent with research among couples that found a high degree of concordance between each partner's understanding of the agreement and that most breaches were reported and/or led to behaviour changes that maintained the objective of HIV prevention (Hoff and Beougher 2010).

Our sample reveals a plethora of factors involved in men's decision-making processes about condomless sex, including certainty of seroconcordance, sexual desire and familiarity of partners. Condomless anal sex within primary partnerships is often based on extensive discussion and, in many cases, HIV testing. In contrast, condomless anal sex in the context of casual relationships and hookups is often decided with minimal information about HIV status, or the discussion is eschewed altogether, making these practices more consistent with seroguessing.

Limitations

This analysis is subject to a number of limitations. Our purposeful sample, drawn from a single clinical site focused on gay men's health, may not be representative of gay men in Vancouver (e.g., men who do not test for HIV regularly) and less likely to be representative of non-gay identified men who have sex with men (see Benoit et al. 2012). Further, our sample may represent a more risk-adverse and clinically-engaged segment of the population who have relatively higher awareness of public health information, including information on HIV testing innovations.

In describing their accounts of most recent condomless sex, participants only talked about consensual encounters. Our analysis does not examine men's descriptions of previous forced or coerced condomless anal intercourse. Further analysis is required to more fully understand those contexts in which men feel they do not have the ability to negotiate safer sex and structural factors that may impact agency and sexual decision-making. In addition, our data largely reflects men's perceptions of HIV and, like much of this literature, does little to account for the ways other STIs (e.g., syphilis, chlamydia) factor in to men's decision-making.

While commitment to preventing HIV acquisition informs sexual decision-making, it is certainly not the only factor at play. We recognise the importance of considering how desire for pleasure and intimacy (Frost, Stirratt, and Ouellette 2008) and other contextual factors also impact sexual practices, rationalities and perceptions of HIV risk. Related

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research beyond the scope of this analysis demonstrates how experiences of violence, power asymmetry in condom negotiation (Grace et al. 2012) and substance use (Braine et al. 2011) may impact on the use of risk-management strategies.

Conclusion

The narratives we examined in this paper highlight the importance of considering the differential contexts, knowledge sources and everyday social and sexual relations that inform the use of diverse seroadaptive strategies and sexual decision-making among HIV-negative gay men. Many men in our sample describe instances of recent condomless anal sex as low risk based on their knowledge of a partner's HIV-negative status. This finding supports and extends existing research that, in many cases, the simplified equation of risk with condomless anal intercourse is a misnomer (Kippax et al. 1997), and emphasises the ways in which the relationship one has with sexual partners impacts constructions of 'risk' and 'safety' (Grace et al. 2012). Data in the USA indicating that main sexual partners represent a predominant source of new HIV infections among men who have sex with men (Goodreau et al. 2012), underscores the need for more research in the Canadian context on the proportion of seroconversions among Canadian gay men that are attributed to sex within relationships, and expanded HIV-prevention efforts designed for couples, including HIV testing and counselling (Sullivan et al. 2013). However, our findings also reveal that some men are aware that despite their best efforts to reduce their risks while engaging in condomless sex, there is still a possibility of HIV transmission.

Despite the prevalence of seroadaptive strategies used by men in our sample, these practices are largely occurring outside of adequate public health guidance. While some argue that strategies that incorporate condomless anal sex are indicative of a return to high-risk HIV behaviours, Kippax and Race (2003) contend that condomless anal sex does not, in fact, indicate failure. Our research supports the need for health practitioners and others working with gay men to more robustly engage with information and programming related to seroadaptive behaviours in order to be relevant to men's sexual decision-making.

As public health institutions develop further strategies to address the current gap in messaging around the use of seroadaptive behaviours, there are many considerations to account for including the needs articulated by gay men and the contested efficacy of using serosorting as a prevention strategy. Possible initiatives may include increased information about viral load and HIV risk (Leahy 2012), partner counselling and testing initiatives (Wagenaar et al. 2012), targeting subgroups of gay men (e.g., those who are not using condoms) with messaging about the use of seroadaptive behavious being a second-line prevention strategy (Vallabhaneni et al. 2012) and providing more spaces for open discussions about sex, intimacy, trust and desire among gay men, HIV-positive and HIV-negative alike. Our findings support the concerns articulated by Dowsett (2009), who warns that it is insufficient to 'enable each man to make a generically informed, but de-contextualised, decision about risk management' (236). We urge public health institutions to renew their efforts to work with gay men's health organisations to develop culturally-responsive interventions at the individual, community and structural level.

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Note

1. Wei et al. (2011) define *condom serosorting* as 'men who had at least one partner of unknown HIV serostatus or of known serodiscordant status, but only had UAI [unprotected anal intercourse] with known seroconcordant partners', contrasting this with *pure serosorting,* which they define as 'men who had some unprotected AI (UAI), but only had partners of the same serostatus' (24).

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Résumé

Pour une étude multi-méthodes d'une durée d'un an, nous avons recruté, dans un centre communautaire de santé sexuelle à Vancouver, 166 hommes gays et bisexuels dont le dépistage du VIH était négatif. Certains des participants qui avaient déclaré avoir récemment eu des rapports anaux sans préservatifs, ont été recrutés selon l'échantillonnage délibéré dans un sous-échantillon de cette recherche, destiné à une étude qualitative. Deux entretiens en profondeur qualitatifs ont été conduits avec ces hommes ($n = 33$). L'analyse des entretiens initiaux a mis en lumière trois récits dynamiques qui décrivent les stratégies de gestion du risque lié au VIH adoptées par ces hommes, celles-ci dépendant du contexte ou des relations: (1) des comportements séroadaptatifs, tels que le dépistage du partenaire et une négociation pour des rapports sans risques avec les partenaires sexuels principaux; (2) le sérotriage et la sérosupposition lors de rapports sexuels avec de nouveaux partenaires et des partenaires occasionnels; et (3) des comportements séroadaptatifs, comprenant un (e) positionnement/stratégie ou plus de séropositionnement, le sérotriage en fonction de l'usage du préservatif, le triage en fonction de la charge virale, adoptés par les participants lorsqu'ils étaient conscients d'avoir des rapports sexuels avec un partenaire sérodifférent. Les récits de ces hommes sur les rapports sexuels ont révélé un rationnel - complexe et fréquemment nourri d'informations biomédicales – de séroadaptation, sur lequel se basait leur décision concernant ce qu'ils comprenaient comme des formes diverses de rapports anaux sans risques ou protégés, mais sans préservatifs. Nos résultats mettent en avant combien il est nécessaire, pour la recherche et la promotion de la santé ciblant les hommes gays, de prendre sérieusement en compte les rationalités et les stratégies séroadaptatives multiples sur lesquelles se fonde la décision d'avoir des rapports sexuels sans préservatifs, afin d'être pertinentes auprès de ces hommes dans leurs décisions de tous les jours concernant leurs rapports sexuels.

Resumen

En un estudio con métodos combinados de un año de duración participaron 166 hombres homosexuales y bisexuales que dieron negativo en la prueba del sida en una clínica pública de salud sexual en Vancouver, British Columbia. Se seleccionó una submuestra de participantes que informaron haber tenido recientemente relaciones anales sin preservativo para un estudio integrado y cualitativo y dos entrevistas exhaustivas y cualitativas ($n = 33$). El análisis de las entrevistas de base aportó tres narrativas dinámicas relevantes en cuanto a las estrategias dependientes del contexto o de las relaciones que utilizaban los hombres para abordar el riesgo de contraer el VIH: (1) conductas de adaptación serológica, tales como que la pareja se haga la prueba del sida y los acuerdos para

negociar relaciones seguras con las parejas sexuales principales; (2) parejas con el mismo estado serológico y suponer el estado serológico de la pareja al tener relaciones sexuales con nuevas parejas y encuentros informales por primera vez; y (3) conductas de adaptación serológica, incluyendo una o más de las conductas de posiciones estratégicas/según el estado serológico, relaciones sexuales utilizando preservativos con parejas serodiscordantes y relaciones con parejas seropositivas según su carga viral por parte de participantes que de manera intencionada tenían relaciones sexuales con hombres con un estado serodiscordante. Al hablar con los hombres sobre el sexo, observamos que con frecuencia utilizaban argumentos complejos con información biomédica sobre la seroadaptación en las decisiones de los hombres de tener lo que entendían como varias formas de sexo anal seguro o protegido sin preservativos. Nuestros resultados confirman que es necesario que los esfuerzos para fomentar la investigación y la salud de los hombres homosexuales respondan de manera efectiva a las diferentes lógicas y estrategias de adaptación serológica que se utilizan para tener relaciones sexuales sin preservativo a fin de que sean relevantes a las decisiones que los hombres homosexuales toman en su vida diaria con respecto a sus relaciones sexuales.

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