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METHODS OF PROMOTING SAFER SEX BEHAVIORS UTILIZED BY MEN WHO HAVE SEX WITH MALE CASUAL SEX PARTNERS

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Abstract

The purpose of this article is to report results of a qualitative investigation into the methods that HIV-positive men who have sex with men (MSM) use to initiate safer sex with casual sexual partners. In-depth, qualitative interviews were conducted with 57 HIV-positive adult MSM living in a large midwestern city. Using an inductive approach to data analysis, participants revealed a typology of safer sex strategies that can be placed into four primary categorizations: having a nonnegotiable sexual behavior policy, behaviorally controlling the interaction, being verbally direct, and being verbally indirect. Strategies varied by degree of explicitness and partner involvement. Men in this study often employed multiple strategies if their partner was not initially receptive to engaging in safer sex behaviors. The strategies described can be especially beneficial to those working in the area of HIV prevention. Providing MSM a variety of options to initiate safer sex may enhance current prevention efforts.

Men who have sex with men (MSM) remain disproportionately represented in national HIV/AIDS statistics. Currently, 69% of all adolescent/adult HIV diagnoses are men, and 49% of these cases can be traced exclusively to male-to-male sexual contact (Centers for Disease Control and Prevention [CDC], 2007). These statistics suggest that despite widespread educational campaigns and interventions, MSM continue to engage in risky sexual behaviors. Unfortunately, little progress has been made in understanding nuances of MSM sexual behavior that may be perpetuating the spread of HIV.

Currently there are 14 HIV prevention programs endorsed by the CDC as being proven to be effective and show positive behavioral change (e.g., use of condoms; reduction in number of sexual partners) and/or health outcomes (e.g., reduction in the number of new sexually transmitted infections). Surprisingly, of these programs, only three were originally designed and tested to be effective specifically for MSM, the population with the highest infection rate. These include the Popular Opinion Leader program (Kelly et al., 1991), MPowerment (Kegeles, Hays, & Coates, 1996), and Many Men Many Voices (Kelly, St. Lawrence, Hood, & Brasfield, 1989). Other endorsed programs include MSM in the context of programming for the general HIV-positive population such as Healthy Relationships (Kalichman et al., 2001), which can be utilized with heterosexual men and women and injection drug users (IDUs), as well as MSM.

Endorsed programs can be conceptualized as either community- or group-level interventions. Community-level interventions seek to change attitudes, norms, and values of an entire community/target population as well as the social and environmental contexts of risk behaviors in the target population/community. Community-level interventions typically combine the use of mass media messages (e.g., through TV or radio public service announcements) and/or small media materials (e.g., flyers, newsletters) with outreach by program staff or peer volunteers. These programs are designed to engage community members in discussion about HIV and call attention to or reinforce the prevention messages in the media (McAlister, 1991). For example, the Popular Opinion Leader (POL) program (Kelly et al., 1991) was developed from the theoretical perspectives of peer influence, behavioral standards and social norms, and diffusion of innovations. Bartenders at gay clubs are enlisted to nominate persons who were popular with others in the community. Popular opinion leaders received four sessions, 90 minutes each, of HIV education and communication strategies. Then, each opinion leader had at least 14 conversations about AIDS risk reduction with peers in the bar setting. Participants in this program showed a decrease in incidents of unprotected intercourse, an increase in condom use, and a decrease in the number of sexual partners. Population-level rates of risk behavior decreased significantly in the intervention cities compared with the control cities at 1-year follow-up.

Group-level interventions consist of a lecture and skills training delivered in a small-group format, usually in a community based organization (Valdiserri et al., 1989). Group-level interventions seek to change individual behavior within the context of a small peer group setting. For example, Many Men, Many Voices (3MV) (Kelly et al., 1989) is a six- or seven-session, small group-level STI/HIV prevention intervention for gay men of color. The 2–3-hour highly experiential sessions aim to foster positive self-image, educate participants about their STI/HIV risks, and teach risk reduction and partner communication skills. The intervention addresses cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia. Results suggest participants reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men who did not participate in the intervention.

Wolitski, Parsons, and Gomez (2004) posited that understanding the sexual behaviors of HIV-positive MSM as well as risk reduction barriers and facilitators is essential for the development of interventions that encourage HIV-positive MSM to protect themselves and their partners from HIV and other sexually transmitted infections. They reported that strategic positioning, serosorting, and withdrawal were methods of safer sex practices employed by the men in their studies (Wolitski et al., 2004). Researchers have also documented that some men serosort to avoid rejection from seronegative men and reduce fears about potential HIV transmission to uninfected individuals (Frost, Stirratt, & Ouellette, 2008; Stirratt, 2005). Despite increased reports of serosorting (Golden, Wood, Buskin, Fleming, & Harrington, 2007; Grov et al., 2007; Osmond, Pollack, Paul, & Catania, 2007) and seropositioning (e.g., acting as the receptive partner during unprotected anal intercourse) (Grov et al., 2007) among HIV-positive MSM, prevention programs have typically not incorporated strategies such as these because they are not uniformly viewed as effective.

Programs designed and developed specifically for HIV-positive MSM are relationship focused and identify safer behaviors, but they do not specifically address how to introduce these behaviors in an encounter. Therefore, interventions would benefit from providing men with specific strategies on initiating safer sex developed by other positive men to incorporate into their repertoire. Currently there are no known interventions that actually provide men with specific strategies on how to negotiate safer sex. The purpose of this article is to elucidate strategies MSM have used to initiate safer sex with casual sexual partners so that they might

be incorporated into prevention programming. The question addressed was, what are the ways in which men instigate safer sexual behaviors?

METHODS

RECRUITMENT AND PARTICIPANTS

Participants for this study were part of a larger investigation of HIV disclosure to casual sexual partners and were recruited in two ways. The first method was through advertising at local AIDS service organizations. Caseworkers were informed of the study and provided information about the project that they could distribute via flyers or through newsletters. Second, recruitment materials were made available at various HIV-related venues and forums (e.g., local AIDS Walk and gay pride festivities) held in the community. Eligible participants were those 18 years or older and who had, within the past 3 years, engaged in sexual behaviors that resulted in a decision about whether to disclose their serostatus. For this study, men who exclusively had sex with women, could not speak and understand English, and those under the age of 18 were excluded. Recruitment efforts resulted in 57 HIV-positive adult MSM from a large Midwestern city who were eligible to participate in the study.

Participants were primarily unemployed (64%), African American (51%) men between the ages of 21 and 57 ($M = 38$ years, $SD = 8.5$). At entry into the study, participants had been diagnosed with HIV for a period ranging from 1 month to 21 years ($M = 56$ months, $SD = 61$). These men were well educated, with 47% having had some college education and 21% holding a bachelor's degree.

PROCEDURES

Data for this study came from interviews with men regarding their experiences disclosing to casual sexual partners. As the data were analyzed it was consistently noted that these men utilized numerous strategies for engaging in safer sexual behaviors, sometimes to avoid disclosure. To explore the use of these strategic behaviors, a second qualitative data analysis of the original interviews was conducted.

All interviews were conducted by the first author and doctoral students experienced with qualitative inquiry. Interviewers received 4 hours of training including instruction on issues related to sex and HIV research (e.g., confidentiality, data safety and protection issues), clinical and ethical issues involved with interviewing, and expectations of the interview. Interviewers practiced their skills during a series of mock interviews in which more experienced interviewers would offer suggestions for improvement, particularly around questioning techniques.

Given the sensitive nature of the information elicited both male and female interviewers were trained and available. Participants could then choose with whom they might feel most comfortable discussing issues related to sexual behavior. Two thirds ($n = 38$) of the interviews were conducted by men. Interviewers were provided a protocol that contained both questions to ask the participant and areas where extra probing was appropriate. Interviewers were instructed to guide the participant through his three most recent sexual encounters. For each encounter, the participant was asked about his disclosure decision and how he specifically came to that decision. Interviews lasted between 1 and 2 hours, and participants were compensated \$40 for their time.

Each interview was audiotaped and transcribed by project personnel. The original interviewer then reviewed the transcript for accuracy. The data was then entered into NVivo to be analyzed and organized into increasingly specific codes. When analysis revealed that codes began to repeat and new information was not being revealed, we determined data saturation had occurred.

DATA ANALYSIS

Data analysis for this study was conducted in five steps using an inductive approach. Inductive data analysis is an appropriate data analysis strategy when the researcher seeks to interpret meaning from analyses of raw qualitative data without guidance of specific hypotheses (Miles & Huberman, 1994). First, at least two members of the research team thoroughly read each transcript. The goal during this initial reading was to identify episodes of safer sex in the data. The focus was to isolate sections of the transcript that captured the specific details of a sexual encounter. These sections served as reference data that would later be utilized for inquiry audits (Lincoln & Guba, 1995) and referenced for illustrative quotes and examples. During the second step each episode was read by at least three research team members and distilled into several descriptive sentences (e.g., “discloses HIV status to initiate safer sex” or “used hints to suggest condom usage”). The team then met to conduct a collaborative inquiry audit. Over three meetings, the team discussed each transcript and each episode to ensure that each sexual encounter was captured correctly and interpreted similarly. If the team disagreed about the nature and/or type of the episode, one member of the team would reread the transcript to provide the team clarification.

Building upon steps 1 and 2, in step 3 each member of the team began the process of initial axial coding. Berg (1995) defined axial coding as the refinement and organization of codes into a relational structure. The coded episodes were subcategorized so as to most accurately portray the different methods of initiating safer sex. Once the axial coding was completed, the team reconvened to reflect on the coding structure and coding definitions. At this point each episode could easily be explained by one code that was unique and descriptive. In the final step, two members of the team reread the reference data produced in step 1 and cross-checked the data. This final step was employed to ensure that the data were accurately interpreted and that the methods still fit into the coding categories.

RESULTS

Participants revealed a typology of initiating safer sexual practices resulting in four categories of strategies. These include a sexual behavior policy, behavioral control, verbally direct, and hinting. In this section, each typology is discussed and examples for each are provided. For illustrative purposes, the age and race of each participant is provided for each quote.

NONNEGOTIABLE SEXUAL BEHAVIOR POLICY

This category refers to practices that reflect a personal policy of “engaging in safer sex is part of who I am as a person.” Men who employed this type of strategy spoke of principles that guided their sexual encounters, such as only engaging in sex with fuck buddies who use safer sex or developing relationships with partners that also use safer sex strategies. Persons who utilized these strategies had established a safer sex routine or had incorporated safer sex into either their practices or sexual relationships. Possible motivators for a nonnegotiable sexual behavior policy include avoidance of the need to negotiate safer sex before or during each encounter, or avoiding disclosure of HIV status. Other motivators include the ability to screen partners based on serostatus or safer sex practices. Fourteen instances of this strategy were evidenced in the data and were grouped into two subcategories including partner type-specific and person-specific strategies.

The partner type-specific category included habitual safer sex with particular types of partners (e.g., casual flings, steady partners). For example, some men described developing a policy of always using safer sex strategies with men at the bathhouse but not necessarily with fuck buddies. Alternatively, person-specific strategies referred to developing rules and guidelines with a specific casual partner and then always implementing these rules with that person,

regardless of whether this person was a fling, fuck buddy, or steady partner. An agreement was struck and as long as the rules were followed the topic of safer sex never came up again. A 34-year-old Native American/African American man described his relationship with a fuck buddy where, after disclosure, condoms were always used.

Participant (P): When I told him, we didn't discuss it. He was like you were so worried about this, I know you didn't want to tell me and this and that, and we just always used them. I can't really even explain it. I keep them in my nightstand next to my bed. We just both did it. Actually it was noncommunicated, we just did it.

Another 40-year-old African American man describes a similar reaction when asking for condoms to be used:

Interviewer (I): When you requested the condoms, was that a conversation that you had or did you just put them on and--

P: It's a natural occurrence. It's something that's like second nature when you're going to have sex today . . . Funny, it's almost like a normal part of life, you know. It's like we should've been born with one that probably grows every 3 months or whatever.

Many participants who adopted this nonnegotiable sexual behavior policy indicated that the rules of sex were agreed upon by both parties and that their partners assumed condoms would be used as well. The primary difference between these two categories is that men either employ their policy with one person with whom safer sex had been previously negotiated or they made a habit of using safer sex with one particular group of men. Regardless, men who used nonnegotiable sexual behavior strategies had a personal policy that guided their behavior with varying degrees of negotiation in every interaction.

BEHAVIORALLY CONTROL THE INTERACTION

This category refers to the numerous behavioral strategies employed to encourage safer sex without the necessity to explicitly discuss safer sex techniques. In fact, many of these behaviors were typically implicit and employed low partner involvement. Frequently these tactics were couched as sexual desires, fetishes or preferences versus methods of safer sex. Sometimes individuals used these strategies as a reaction to the desires of a partner during a sexual encounter. Possible motivators for using behaviorally controlling strategies may include the difficulty of explicitly discussing safer sex or fear that doing so might imply one is HIV-positive. Fifty-four instances of this strategy were evidenced in the data and were grouped into eight subcategories including refraining from ejaculating, no penetration, engaging in less risky sex, only performing risky sexual activities with condoms, stopping sexual activity, putting condoms on self or partner, protecting self only, and having supplies ready.

Withdrawal involved the individual making the decision to not ejaculate inside his partner or allowing the partner to ejaculate inside of him. This was accomplished in numerous ways including being verbally direct about ejaculation. If there was a desire to not raise suspicion, other methods were employed. In one example a 32-year-old African American man described a strategy that involved slight deception.

P: I've learned to, to come up with kind of a, I don't want to say a, a trick or plan or what have you, but I guess it is a plan. Um, in order to make them feel comfortable with that, I tell them that I want to see them ejaculate. That way it's not coming off to them that I don't want them to, I make it seem more sexual . . .

In this example the individual initiated the strategy in a playful or sexually self pleasing way to avoid explicitly negotiating safer sex. Others reported a direct "withdrawal rule" that they conveyed to their partner.

P: Because usually if I have those kinds of encounters, even with anal sex, even with a condom, I prefer that they do not ejaculate you know, inside me at all. So that's, just I guess my kind of rule that I have with sexual encounters that I prefer that they don't do that at all. (32 years old, African American)

Activities involving *no penetration* were those that could be engaged in alone or with a partner that do not involve any direct physical penetration, such as masturbation. This strategy was not frequently used by the individuals in this study; however, some of the men found this to be their preferred way of reducing risk to themselves or others. The following individual described using mutual masturbation as a routine safer sex strategy when having sex with casual partners.

P: . . . mutual masturbation, just touching each other. With casual partners, that is as far as I have gone.

I: Is that typical for you?

P: With casual partners, yes. (54 years old, Caucasian)

Engaging in less risky sex, which also could be referred to as seropositioning, included the avoidance of certain sexual activities (e.g., insertive anal intercourse) or acting as the receptive partner in certain sexual activities. This strategy is frequently used by the men in this study as a means to protect their partner. Some men with HIV may believe that receptive anal sex is a safer behavior because they are more concerned with transmitting the virus to others than with personal reinfection or exposure to sexually transmitted diseases. For example, one individual described:

P: In general I don't like to penetrate- I mean I just, now that I'm HIV positive, even if I wear a condom there's, there's just more guilt involved with it. (45 years old, Caucasian)

Men also reported directly requesting safer sex or refusing offers of unprotected intercourse by insinuating or stating that certain activities are not sexually desirable without explicit discussion of risk, as seen in the following example.

I: And when he came over what kind of, activities took place? What kind of sexual activities did you engage in?

P: A lot of dry humping, and he liked, a lot of oral sex performed on him.

I: Any other types of activities?

P: He wanted to top me but, I told him I wasn't into that and he was fine with it. (44 years old, Caucasian)

Other men chose to *engage in risky sexual behaviors only with condoms* when a partner would be at risk for infection. That is, they consented to engaging in risky behaviors they or their partner enjoy but only when utilizing a condom. As one 42 year old African American man stated:

P: I guess that's like a border for me, or like a wall or something for me. yeah, I can give you oral sex, I mean, you know I can perform oral sex on you, and you can jerk me off, and I'm okay with that. But, as far as you giving it to me, you have to use a condom.

Individuals that *stopped sexual activity* used verbal and nonverbal tactics to interrupt sexual activity either to request the use of condoms or as a response to non-condom use. The following example describes interrupting the sexual experience between sex acts.

P: They said after I performed oral sex, they wanted to penetrate me so I told them to wear a condom and people said no and then I told them I was HIV and they had to wear a condom and so they got the condoms. (56 years old, Caucasian)

Although not explicit, it was implied that allowing foreplay to occur before requesting condoms or safer behaviors resulted in arousal that might increase compliance and reduce rejection; however this was not always the case. In some situations stopping sex to initiate a safer sex strategy resulted in an abrupt end to the sexual encounter.

P: . . . And this person was in the bathhouse too. He walked in my room and he started to caress me and then he wanted to directly perform oral sex on me so I told him, "Stop, I need to put a condom on." And he was like a 44 [-year-old] gentleman, nice clean. But then I told him "wear a condom" and he said, "No, I don't like condoms," and I told him, "Well, there's going to be a problem because I am HIV positive," and he said, "Well nice to meet you," and he walked away. (56 years old, Caucasian)

Others *put the condom on themselves or on their partner* without prior discussion during sexual activity. This can be done in a fun method. For example, one 29-year-old African American individual described, "I've just found that you have to do it playfully, so it can be a fun experience." Another described feeling uncomfortable asking a partner to wear a condom.

P: That's why for a while I was celibate, because you know, I just didn't want to deal with that whole thing of, you know making someone put on a condom, 'cause I've had a partner who was almost upset, well they were upset, because I asked them to do that, you know, in fact no, I didn't ask them, I got the condom and started putting it on and they looked at me like "What is this?"

I: Do you have to do that frequently, or do you do that frequently instead of asking or?

P: Um, no, for this person I did, because we have a more, closer relationship, I've known him for years and so, you know so I did that because I was not going to tell them my status, but I definitely wanted to make sure they were protected . . . (42 years old, African American)

Several participants mentioned *having supplies ready and easily accessible* before sexual activity begins as a way of introducing safer sex. For these men having supplies in plain view insinuated that safer sex was going to happen. Easy access to condoms can serve to increase partners' awareness that safer sex will occur and may eliminate a lengthy conversation. One participant noted:

P: you know I keep, I have that stuff anyway (laughs), but I'm just saying, if all that stuff is there, and it's just ready to go—Hi, how you doing, here hit the joint, and let's get busy, and it's just real superficial, very. (39 years old, African American)

VERBALLY DIRECT

This category refers to strategies that were always orally presented to partners and typically occurred before the encounter began. Each required that communication about safer sex occur but they can be viewed on a continuum of partner involvement. On one end of the continuum is low partner involvement, resulting in ultimatums, and on the other end was greater partner involvement, such as discussing safer sex. Potential motivators to use these strategies may include reluctance to disclose one's HIV status, suspicion that the partner may also be positive, or a concern of reinfection "with a stronger strain of virus." A felonious assault law exists in the state where this research occurred, which mandates that HIV-positive persons may not engage in sex with individuals they have not disclosed their serostatus. This law serves as a likely motivator for individuals fearful of criminal prosecution. Forty-nine instances of this

strategy were evidenced in the data and were grouped into five subcategories including ultimatums, insisting on safer sex or condom use, requesting safer sex or condom use, serostatus disclosure, or discussing safer sex options or sexual history.

Those individuals that used *ultimatums* delivered a clear message that required safer sex behaviors or no sex at all. The following individual described using an ultimatum as a strategy regarding unprotected anal intercourse that reflects low partner involvement:

P: If we're going to do this we need some boundaries, any further than that, that's a renegotiation policy and then there are some things that are not negotiable.
Unprotected anal sex is just not negotiable. (54 years old, Caucasian)

Another man described safer sex as a priority above and beyond being intimate with someone.

P: I don't care. No matter how attracted I am to someone, if they don't want to do it the right way and the safest way and whatever then it ain't going to happen. (46 years old, Caucasian)

Other participants mentioned *insisting on safer sex or condoms* for all sexual activities. Unlike an ultimatum, the outcome of insisting on condom use is unclear. That is, there is no defined ultimatum attached to the insistence of using condoms, therefore allowing for minimal partner feedback. A 44-year-old Caucasian man described how he insisted on condom use and describes the conversation between his partner and himself.

P: So he's at the house and we'd had this one night together and he's there during the day and now he wants to have sex but he wants to you know, top me and I just--it's like I just couldn't think of how to tell him at that point. Because I felt that everything we had done before was safe and now he wanted to try something unsafe so I just insisted if it's going to happen it's going to be safe sex. . . . He wanted to bareback. . . . I told him in this day and age I'm not having unprotected sex (laughing).

I: And what was his response to that?

P: He said that condoms, he doesn't have the same sensation with a condom, you know that it doesn't feel good; it feels better barebacking.

I: So he did end up wearing the condom despite his statements?

P: Um-hum.

Others requested for condoms to be used for risky sexual activities (though partners may not comply). Individuals who utilized this strategy often allowed for feedback from their partner to guide whether or not a condom was actually used.

P: They wanted to go down on me and that's when I had to go there and ask "Do you have any condoms?" (41 years old, African American)

Some participants *disclosed their HIV status* as a strategy of initiating safer sex behavior. Disclosure not only reveals the reason for the request but also allows room for some negotiation from the partner on what types of safer sex activities may take place. The following individual describes how he uses disclosure during a sexual encounter:

P: you know, when I have sex with men, I want them to know my status because I don't want to leave the burden on myself. I always tell them that "I'm HIV positive, you know, it's up to you to have sex with me or not. Or you can use a condom. you know there's condoms here, let's use them. you know, it's up to you." (34 years old, Caucasian)

Some individuals used the opportunity to discuss safer sex, protection, and sexual histories to negotiate what activities would be acceptable. This occurred either in person or, as one participant noted, online.

P: But these types of anonymous meetings I let them choose. This particular person, when we got around to fucking, I already had the rubber out and the lube and stuff and I already knew he wanted to play safe because that was part of the chatting that went on, the IM [instant messaging] -ing and things like that. So I already knew. I was already ready for him when he came over. (50 years old, Caucasian)

VERBAL INDIRECT (HINTING)

This category refers to strategies related to implying that one is HIV-positive without a clear declaration. These strategies may be precursors to behaviorally controlling or verbally directing the interaction but may also be successful in their own right and rely on a low level of explicitness. The onus of responsibility for engaging in safer sex is then placed on the partner. Four instances of this strategy were evidenced in the data. Several individuals mentioned *hinting about their serostatus* in order to facilitate use of condoms or other safer sex methods. One individual mentioned he may be sick without explicitly disclosing his status.

P: And then we just, I said, "Now wait a minute, I gotta get a condom" and he was like, "For what?" And I'm like, "I might be sick." He was like, "you ain't sick." I said, then I was like, I was, you know, like I told him, I said, "I am sick." He said, "Well okay, then get your condom then" and we had sex. (47 years old, Hispanic)

Another individual had HIV literature around his house.

P: I have different tactics, I just, it just with conversation wise, I mean I have a lot of literature and you know in my house on HIV, and I got posters up and stuff like that and the building that I live in is mostly HIV-positive people, so there's signs and stuff around. (33 years old, African American)

It should be noted that the men in this study often used multiple strategies in one encounter. This was particularly true if the partner was argumentative. For example, the following encounter described by this 36-year-old Caucasian male illustrates the use of multiple strategies.

P: Ah, told this, I've got a big bowl in my bathroom and it's clear full of condoms and lube [having supplies ready and easily accessible] that I get from the Taskforce and I said, "Buddy, there's clean towels and washcloths in there. you know, we've been in the park it's hot sweaty if you want to wash up. I prefer you to wash up and there's protection, condoms and lube in here, too [requested for condoms to be used for risky sexual activities]." He said, "Well I really don't like using them," and I said, "Well, if you're going to do anything here, you're going to use them because, there's things out there today that Epsom Salt won't even take off of you." He said, "yeah, I'm aware of what's out there." And I said, "Well then, you should know that you need to use some protection [discuss safer sex, protection, and sexual histories]." And I kinda felt like he might have in a roundabout way been trying to tell me or even if I would have dug a little deeper he would have been willing to tell me but this was one of those friendless fly-by-day things I was like "I don't care what you do. you're using a condom and you're out of here [ultimatum]." (36 years old, Caucasian)

DISCUSSION

HIV prevention programming for MSM has traditionally utilized a one-size-fits-all approach when emphasizing safer sex practices. Instructing men to use a condom consistently and

correctly every time they engage in anal sex can have some positive effect on behaviors, but typically it is short lived. Wolitski and colleagues (2004) described the importance of addressing the diverse needs of each individual when discussing safer sex practices with HIV-positive MSM and cautioned against blanket interventions. Providing MSM a variety of options to choose from may be a more realistic approach that can enhance current prevention efforts.

Results of this study suggest that HIV-positive men have developed numerous strategies to encourage safer sex with casual sexual partners. Four categories of strategies were identified: having a nonnegotiable safer sex policy, behaviorally controlling the interaction, being verbally direct, and hinting. In addition, numerous typologies within each of these categories were present. Strategies varied by degree of explicitness and partner involvement. Men in this study often employed multiple strategies if their partner was not initially receptive to engaging in safer sex behaviors. These data suggest that HIV prevention programs should prepare MSM to handle difficult sexual encounters successfully without surrendering. In fact, because resistance from partners frequently occurs HIV prevention programs should consider normalizing such interactions and educate men on how to negotiate safer sex. Perhaps a personalized continuum of strategies could be developed. This repertoire could then be practiced until an acceptable level of implementation comfort is achieved.

The results also revealed that men are not only using multiple strategies to negotiate safer sex, but they are using varying strategies with different partners. Men often described engaging in certain safer sex strategies or choosing not to engage in strategies depending on a partner's assumed or known serostatus; perceived risk of violent retribution, where the encounter was going to take place, or where the partner was encountered. If a partner was known to be HIV-positive, then verbally direct and partner involved strategies could be more easily employed. When a partner's status was not known hinting strategies or ones with low partner involvement seemed preferred.

Participants also discussed utilizing strategies based on personal safety and chose less confrontational strategies when they sensed the possibility of danger from a partner, did not want to risk sexual rejection, or believed that emotional intimacy with the partner was could develop. In contrast, more confrontational strategies were employed when they felt physically safe or when the availability and accessibility of other partners decreased the repercussion of rejection. For example, individuals may be most comfortable being verbally direct at a venue where multiple opportunities for sexual encounters is likely to occur (e.g., bathhouse). By contrast, they may be less likely to use a direct strategy in settings where they spent considerable time showing their interest in one specific partner or where the chances of meeting an alternative partner is lower. HIV prevention interventionists working to increase safer sex among HIV-positive men might consider helping MSM choose strategies based on such information and settings.

Evidence of seropositioning can be found in the results of this study, specifically in the behavioral control category of safer sex strategies. Several men described instances where they would engage in less risky sexual behaviors in order to protect their partner. This should be encouraging to those who seek to promote seropositioning as a HIV prevention strategy as it suggests MSM may be open to its utilization.

Data for this study were focused on the sexual encounter level therefore evidence of serosorting cannot be accurately assessed. Other researchers have suggested, however, that needs for intimacy motivations may play a role in serosorting. For example, Frost and colleagues (2008) found that among a sample of HIV-positive and -negative MSM partner selection practices were based on risk reduction concerns and motivations to establish intimacy with a partner. Although not specifically addressed in this research it is plausible that intimacy plays

a role in the development and utilization of men's person specific or partner-type specific sexual behavior policies. Future researchers should thoughtfully incorporate issues of intimacy that men consider when choosing to engage in safer sex into their work. The complex nature of sexual behaviors in the context of possible relationship development is not frequently considered for MSM yet this line of inquiry may yield insights into motivators for safer sex behavior.

Encouraging MSM to consistently use a condom has been at the core of HIV prevention since its inception but perhaps the message has yet to be delivered in a personally meaningful manner. For those working in HIV prevention encouraging MSM to adopt consistent condom use as described above is optimal. Rather than stressing condom usage as the only means of safer sex, it may be important to assist men with developing a safer sex identity that embraces multiple behaviors. Furthermore, prevention interventions should consider that HIV-positive men use different safer sex strategies with different types of partners. Offering numerous safer sex options such as the strategies utilized by the men in this study and taking into account men's motivations for sexual relationships may enhance program offerings and be more beneficial to those living with HIV.

Data for this study came from an investigation of HIV disclosure and not explicitly about initiating safer sex. Therefore, it is likely that other strategies have been developed that were not evidenced in the data. For example, gay men who seek sex in Internet chat rooms may indicate in their profile exactly what they expect in their sexual encounters. They sometimes indicate "safer sex only" or are even more specific, such as "condoms for anal"; others may declare "oral only." Still others are more explicit and include a photo of their penis with a condom on with the caption "This is how I play." In other venues men may indicate their preference for safer sex by wearing a hat or a T-shirt with a safer sex message on it. In bars where condoms are readily available some men may choose to put several condoms in the pocket of their potential evening sex partner, either on the sly or in an obvious manner to indicate that condoms will be used for sex. Some men are attracted to people who they believe engage in safer sex. The act of reaching into the condom basket and filling one's own pocket with condoms for others to see may increase the likelihood that one is approached for sex.

This study reveals that negotiation between serodiscordant men is occurring, and that some seropositive MSM have developed personal strategies to promote safer sex in casual encounters. The strategies elicited from these men, as well as the potential motivators to employ such strategies, may prove vital to the future success of prevention programming. The strategies identified through this research provide alternative methods to express intentions of having safer sex, to initiate safer sex, and to increase the likelihood that safer sex will occur.

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