

EMERGING BIOMEDICAL DISCOURSES ON HIV AMONG GAY MEN AND THEIR SERVICE PROVIDERS

COMMUNITY REPORT APRIL 2016



As a guiding concept in this project, *resonance* refers to the waves of discourse and resulting action generated by new information about biomedical knowledge of HIV, and its incorporation into the community wisdom and individual decision-making in gay men.



DEFINITIONS OF "RESONANCE"

IN PHYSICS:

The tendency of a system to oscillate at a greater amplitude at some frequencies than at others

IN ACOUSTICS:

Intensification and prolongation of sound, especially of a musical tone, produced by sympathetic vibration

IN CULTURE:

Richness or significance, especially in evoking an association or strong emotion

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RESONANCE PROJECT SUMMARY: KEY FINDINGS AND CONCLUSIONS

Background

The prevention landscape is changing, and gay men have been leading the way

There have been rapid advancements in the science of HIV prevention over the last 10 years. One of the biggest factors that will impact Canada's HIV epidemic over the coming decade will be the extent to which biomedical knowledge of HIV risk, transmission and prevention is integrated into our programs and services, and into individual behaviours.

In the Resonance Project, we wanted to know more about how gay men and other men who have sex with men, and their service providers, understand, perceive and integrate these new prevention approaches. The focus was on gay men because they are the group that accounts for the largest proportion of new HIV infections in Canada, and the largest group of people living with HIV. Also, gay men tend to be early adopters of new information, new technologies and new trends, and thus they have been among the first to take on new approaches to HIV prevention.

What did we want to find out?

The Resonance Project: Emerging Biomedical Discourses on HIV Among Gay Men and their Service Providers is a community-based research project led by researchers and representatives from four national HIV organizations and three gay men's health organizations. The Resonance team set out to critically examine:

- how gay men are taking up biomedical knowledge of HIV;
- how biomedical knowledge of HIV impacts or influences their everyday lives;
- the dialogue gay men and their service providers use to make sense of risk, and inform sexual decision-making and practices; and
- the roles and responsibilities of institutions and service providers to shape and respond to these discourses.

Who did we talk to?

We conducted five types of focus groups with 86 participants in Vancouver, Toronto and Montreal, including:

- 1) gay men connected to HIV organizations;
- 2) gay men in serodiscordant relationships (where one partner is HIV positive and the other is HIV negative);
- 3) sexually-active HIV-positive gay men;

- 4) HIV-negative gay men at "high risk" for HIV; and
- 5) service providers who provide sexual health, counselling and HIV prevention services to gay men.

We also conducted individual interviews with four gay men, eight nurses and physicians working in a clinic or public health setting, and eight service providers who identify as gay men.

Summary of Key Findings

In what ways do gay men—individually and as communities—make sense of, incorporate into their understanding, and modify their behaviours based on, biomedical knowledge of HIV?

Gay men discussed a wide variety of biomedical aspects of HIV risk and prevention, but here we highlight what they said about preexposure prophylaxis (PrEP) and undetectable viral load (UVL).

- •PrEP awareness and concerns. Some men had never heard of PrEP, while others were already using it. Being HIV-positive, knowingly interacting with positive men, or being connected to HIV organizations seemed to increase knowledge and confidence levels in PrEP. HIV-negative participants without these connections tended to have lower levels of knowledge and confidence than others. Concerns included the cost of PrEP in the absence of health insurance coverage, PrEP not being preventive against sexually transmitted infections other than HIV, potential side effects, and the ethics of providing antiretroviral drugs to people who are HIV negative.
- **PrEP users are responsible/sluts.** Judgments about PrEP users were rooted in how the men experienced the HIV crisis, and their experiences around ARVs and condoms. They debated whether PrEP users were sluts, responsible men, or both at the

same time—responsible sluts. Some of the participants who were HIV positive could, in retrospect, see how PrEP would have been beneficial in their own situations.

- Calculating risk with PrEP. For some gay men—both positive and negative—PrEP provided sufficient reassurance to have condomless sex, while others remained committed to condom use regardless of PrEP's effectiveness. The participants also wondered: Are men on PrEP safer sexual partners than others? Can I trust that a sexual partner is really on PrEP?
- **PrEP** and the sex gay men desire. For some participants, PrEP provided a false sense of security in the pursuit of condomless sex, and was helping to precipitate it. For others, PrEP was introduced into a context where gay men were already pursuing the type of sex they desire (by which they meant condomless sex), allowing them to do so with lowered risk of HIV. Especially for men who found condoms an impediment to sexual satisfaction, PrEP promised enhanced sexual pleasure.
- Undetectable viral load awareness and concerns. As with PrEP, levels of awareness and confidence were highest among those who were living with HIV, knowingly interacting with positive men, or connected to HIV organizations. They noted that UVL was an exciting new concept for HIV prevention, but all members of the gay community did not understand what that meant in the same way.
- Undetectability and risk calculation. For some gay men, an UVL provided sufficient reassurance to have condomless sex, while for others it did not. Many gay men emphasized that while it might lower the risk, some risk remains. And some gay men wondered: Can I know that a sexual partner really is undetectable?

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• Undetectable as "the new negative." Many HIV-positive men talked about the idea of undetectability as an identity (as opposed to "poz" or "positive"), signifying that they were healthy and posed a lower risk of transmission. They felt this helped reduce stigma. But participants questioned the impact of identifying as undetectable when the concept was not well understood in the community.

Gay men in our focus groups revealed the many ways that they were grappling with new and evolving HIV prevention information:

- •Frustration with, distrust and sometimes avoidance of, inconsistent information. Many gay men noted the inconsistency of information around HIV prevention in the public domain (e.g., social media, mainstream media, HIV organizations' messages, gay media, public health messages, hook-up apps or websites). Some described the information as overwhelming, sensationalist, inaccessible and/or contradictory. As a result, some gay men felt that they might as well just wait for the confusion around new biomedical prevention options to pass, and actively avoided any new information on HIV prevention as they found it unhelpful. Several gay men expressed considerable distrust of the pharmaceutical industry and of the biomedical research establishment, often linked to profit motives. Trusted sources were healthcare professionals or people working in the HIV field.
- Feeling like information was withheld. Some gay men expressed frustration at the lack of evolution in HIV prevention messages, with its persistent emphasis on condom use. They acknowledged that messages around condom use were simpler,

but felt that information about risk reduction strategies other than condoms was being withheld from them, considered taboo, or forbidden by public health.

• Synthesizing a personal strategy. Even when facing a vast and complex array of information sources and opinions, many gay men described making their own autonomous decisions after reviewing information that they could understand and deemed credible. Some of the gay men stated that they refused to pay attention to new information, relying instead on what they already knew.

For gay men, questions around trust and responsibility were important factors in calculating risk, in addition to the biomedical information that they had to consider:

- •Trust and deception. Gay men discussed whether or not they could trust other gay men around sexual encounters, particularly in regards to claims about serostatus (especially HIV negative or undetectable), testing frequency and test results, use of condoms, use of PrEP and being monogamous. They also wondered whether some gay men deliberately lied or sought to deceive, particularly in the online dating scene.
- •Responsibility and good citizenship. Gay men discussed the burden placed on the gay community for HIV prevention, and how biomedical strategies both entrench and change norms around risk reduction. They described what they thought constituted responsible and irresponsible behaviours for "good gay citizens," and discussed the tension between the idea of shared responsibility for prevention and that everyone should look after their own health.

How are community-based organizations and service providers succeeding and struggling in integrating new biomedical knowledge of HIV within their existing HIV prevention efforts?

Not surprisingly, service providers identified several challenges in managing new HIV prevention information:

- Staying on top of it all. Finding the time to read, interpret and distill research findings, and translate them into simple lay terms in ways that clients understand was a challenge. Some service providers noted the high expectation from clients and colleagues to have 'all the answers' despite their own knowledge limitations.
- Consensus versus multiple interpretations. Service providers expressed a contradiction in their risk counselling: on one hand wanting to have consensus and to be able to provide a definitive statement about a particular biomedical intervention, while on the other hand wanting to be able to provide a variety of viewpoints and interpretations of the science. The lack of consensus led to conflicting interpretations, messages and advice between service providers and organizations.
- Erring on the side of caution. Some service providers tended to give the most conservative messages possible, such as condom use only, but also acknowledged that being overly simplistic, overly complex or too conservative in HIV prevention messages could frustrate or alienate clients who knew of risk reduction options other than condoms.
- **Heterogeneity of the gay community.** Service providers noted the wide range of awareness and openness to new prevention strategies in the gay community. Some gay men were perceived as

having very basic knowledge and not being ready for, or open to, the complexities of biomedical aspects of HIV prevention. At the other end of the spectrum, service providers said they encountered gay men with sophisticated knowledge of HIV prevention, challenging service providers to keep up with the community.

- The service provision context. The risk reduction messages that service providers gave to their clients depended on the setting, duration and frequency of their contact with gay men. If they only saw a client in a brief one-time encounter such as in a bathhouse, or only had a brief exchange through online outreach on a cruising app, then some service providers erred on the side of caution in their risk reduction message, whereas if they were able to have repeated contact with a client over time, the messages could be more nuanced.
- **Correcting partial information.** Service providers found it challenging to help gay men correct and make sense of brief and often sensationalized snippets of information. Some service providers had the impression that gay men approached them to confirm information gleaned from sources such as news headlines, awareness campaigns or social media posts.
- Finding the right fit. Service providers discussed the scientific complexity of the multiple prevention options now available, the resulting complexity of prevention messages, their concerns with keeping up with the science, and the underlying value systems that often guided prevention messaging. They discussed the challenge of identifying who would benefit most from different prevention options.

- Avoiding paternalism. While some clients wanted clear directives, others resisted paternalistic messages and didn't want to be told what to do. Some service providers avoided overwhelming clients with too much information. Other service providers pointed out that many gay men had been adopting different non-condom strategies for a long time, sometimes in reaction to conventional prevention messaging.
- Acknowledging the role of (dis)trust. Service providers acknowledged the challenges gay men face when trying to decide whether or not they should trust other gay men, particularly what they said around sexual encounters (e.g., claims of a negative or undetectable serostatus, testing frequency and test results, use of condoms, use of PrEP, being monogamous). As a result, some of the service providers said that they often actively encouraged their clients to be distrustful.

What are the implications for service providers?

Service providers described the many roles that they played and strategies they used in helping gay men navigate new HIV prevention information:

• Equip clients to assess their own risk tolerance. An important part of service providers' risk counselling process is helping the client decide what level of risk they are comfortable with, as well as helping them think through risk reduction or management strategies. A key role played by service providers was equipping a client with enough information to make a judgment call for himself, balancing what he knows about HIV risk, transmission and prevention, with what he desires and values.

- Help gay men navigate information. Community discourse is building around the role of biomedical information as an integral part of a comprehensive approach to HIV prevention, sometimes without adequate input or guidance from service providers. These are the very service providers who are most trusted when it comes to HIV prevention information. An important role for service providers is to communicate in clear, sex-positive and user-friendly ways the key messages of what we now know works for HIV risk reduction.
- •Support and nurture leaders in the gay community. Some gay men are acting as peer educators, albeit sometimes reluctantly. In general, we found that gay men who had connections to the HIV sector, who were in serodiscordant relationships and/or were living with HIV, were the most knowledgeable about PrEP and undetectable viral load. PrEP users and gay men who have an UVL are often acting as key opinion leaders, shifting the conversations, one hook-up profile or chat conversation at a time. As service providers, we can support key opinion leaders and (sometimes reluctant) peer educators by getting easily accessible information into the very (virtual or physical) venues in which gay men are meeting and interacting.
- •Don't forget about the bigger picture. Too often, prevention approaches such as PrEP and undetectability are framed as standalone biomedical tools without recognizing their broader influences and impacts. Biomedical prevention strategies such as PrEP and undetectable viral load are having some important benefits in terms of reducing HIV-related fear and stigma, breaking down serodivides (the divisions between people who are HIV negative

and HIV positive), allowing gay men and serodiscordant couples to have the kind of sex they desire, and generating renewed conversations around HIV prevention in gay communities.

- Start where he's at. Whether an individual chooses to rely on one or more prevention strategies will depend on not only his understanding, but also his preferred sexual practices, his relationship with his sexual partners, his values around what it means to be a responsible person, and the extent to which he feels he can trust his sexual partners. For service providers, an important part of risk counselling and prevention education is to quickly gauge the knowledge levels, values and types of sexual relationships of their clients, and customize the messages accordingly.
- •Ground HIV prevention in the lived realities of gay men. In all risk counselling interactions with gay men, focus on situations, relationships and encounters that gay men are likely to experience in their lives and in their community. In our focus groups, we used mock hook-up and dating profiles, and dating and relationship scenarios to trigger discussions about biomedical approaches to prevention.

Our Overall Reflections

Gay men and their service providers are at the forefront of adopting new biomedical HIV prevention knowledge that expanded the range of available prevention tools beyond condoms. In the Resonance Project, we observed a wide range of responses to the emergence of new biomedical knowledge and tools.

Resonance among gay men

Among gay men levels of awareness about PrEP and undetectable viral load, and levels of confidence in their efficacy for reducing HIV risk, varied greatly. The ways in which gay men made sense of and took up biomedical concepts of HIV prevention depended greatly on contextual factors, including:

- their HIV status;
- their generational and personal experience of the HIV epidemic;
- their experience with condoms as a long-established prevention option;
- their geographical location and the types of information and attitudes circulating within their social networks;
- their relationship with, and levels of trust in, their sexual partners;
- where and how they met their sexual partners;
- their self-efficacy and the degree to which they actively sought out new information;
- their sense of what constituted responsible behaviours for "good gay citizens"; and
- their level of trust in biomedical research, "big pharma," media, community-based HIV/AIDS organizations and healthcare professionals.

Resonance among service providers

We saw that service providers brought their own personal perceptions, knowledge and attitudes towards biomedical prevention technologies. Their own value systems were very evident throughout the focus groups and interviews, and it was easy to recognize the ways in which their interpretations and perceptions shaped the information they provided to gay community members. Not surprisingly, sharing information about biomedical approaches to prevention did not happen

 $((\mathsf{resonance\,project}\mid\mathsf{community\,report}))$

in a vacuum. For service providers, it was not a straightforward transmission of facts, but rather a constantly shifting exchange between individuals, institutions, cultures and structures, all of which was affected by a range of factors, including:

- social and legal contextual factors of stigma and criminalization, and the desire of service providers to mitigate their impact in the community;
- socioeconomic considerations of access and affordability;
- alliance with or contradiction to conventional condom use messages;
- where interventions took place and for how long;
- assessments of individual and community levels of knowledge,
 values and anxiety around HIV and biomedical prevention options;
- •the degree to which formal guidance was in place and consensus existed among peers working in HIV prevention and gay men's health; and
- the level of organizational support for the integration of new and emerging biomedical HIV prevention information.

Resonance among gay service providers

Service providers who were themselves gay men recognized the growing dissonance between the conventional HIV prevention messages they conveyed to clients through their work and the newer biomedical HIV prevention information they incorporated in their own personal decision-making. In a context where the ground was shifting and in the absence of consensus or formal guidance, gay service providers were some of the earliest and most visible adopters of new HIV prevention information.

Resonance in the HIV prevention field

The Resonance Project has shown us the many complex ways in which biomedical approaches to prevention were introduced and incorporated into gay men's lives. Biomedical concepts and tools—such as PrEP and undetectable viral load—exist within a social, political, economic and cultural context. These biomedical approaches are laid on top of dynamics that already have a lot of influence on the HIV response: health systems; community understandings of safe sex; HIV stigma, homophobia and moralism about sexual behaviour; and health literacy disparities.

In the time since the data was collected for the Resonance Project, the science has become more definitive (regarding the preventive efficacy of PrEP, for example), and the consensus in the sector is stronger, making it easier for service providers to be clear in our messaging. These data capture a transitional time when the science was changing and a consensus had not yet developed within the sector about what can be confidently said about the new prevention strategies.

We hope that the outcomes of this research project will help HIV prevention stakeholders to identify how they could be integrating recent and emerging biomedical knowledge of HIV into current prevention programs and policies in Canada in ways that are best supported by, and supportive of, communities of people most at risk for HIV. By focusing on gay men as early adopters of biomedical information, we have gained an understanding about knowledge exchange and uptake, and the effect of biomedical information on sexual practices and understandings of risk. Hopefully, this understanding can also provide guidance for effective prevention messages and program planning with other vulnerable populations in the Canadian context.

INTRODUCTION

One of the biggest drivers of change to Canada's HIV epidemic over the coming decade will be how much biomedical approaches to HIV prevention are integrated into our programming, how individuals and communities think and feel about these approaches, and how they incorporate them into their practices.

In the last 10 years, biomedical research around HIV testing, transmission and prevention has produced dramatic new ideas and possibilities. We now know much more about the biological factors that change HIV risk, such as viral load, acute HIV infection, sexually transmitted infections, inflammation and antiretroviral drugs (ARVs). Research on per-act HIV transmission risks show that there are significant differences between different types of sexual activities. At the same time, new testing technologies have been developed that can provide results faster and detect HIV earlier.

Advancements in the biomedical knowledge of HIV have led to the development of powerful new HIV prevention interventions, such as pre-exposure prophylaxis (PrEP) and leveraging the impact of treatment on prevention. These strategies have been added to non-occupational post-exposure prophylaxis (PEP) and behavioural strategies to reduce the risk of HIV transmission, such as serosorting and strategic positioning.

ACRONYMS	
ARV	antiretroviral
CBR	community-based research
GMSH	Gay Men's Sexual Health Alliance
HIM	Health Initiative for Men
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
UVL	undetectable viral load

All told, there is a plethora of new and steadily emerging biomedical information about HIV risk, transmission and prevention. Individuals who are most at risk of HIV and their service providers must now navigate complex, sometimes contradictory, and nuanced information.

The Resonance Project research team saw the need for a robust social science agenda to understand how biomedical knowledge of HIV is entering people's discourses, prevention strategies and folk wisdoms.¹ We wanted to understand the cultural resonance of biomedical knowledge of HIV, the role of service providers and institutions in creating popular understandings of HIV prevention technologies, how it makes personal calculations of risk more complex, and how those complexities could influence personal agency (the capacity of individuals to act and make free choices).

```
((( acute infection ))) ((( seropositioning )))

((( cure ))) Biomedical Aspects ((( PEP )))

((( PrEP ))) of HIV Risk ((( testing )))

((( serosorting ))) ((( undetectable )))

((( treatment as prevention )))
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^{1.} Adam, B. D. (2011). Epistemic fault lines in biomedical and social approaches to HIV prevention. *Journal of the International AIDS Society, 14* (Suppl 2), 1-9.

WHAT DID WE SET OUT TO KNOW?

The Resonance Project was undertaken in order to understand the ways that gay men decipher biomedical prevention information that they may encounter through various sources, and to explore if and how they integrate this information into their sexual practices and decisions.

The objectives of the Resonance Project were to critically examine:

- how gay men are taking up biomedical knowledge of HIV
- how biomedical knowledge of HIV has resonance for their everyday lives
- the discourses men use to make sense of risk, and inform their sexual decision-making and practices, and
- the roles and responsibilities of institutions and service providers in shaping these discourses.

A note on the term "gay men"

We are using the term "gay men" to include all men who engage with other men romantically or sexually regardless of their gender identity (i.e., cis men or trans men) or sexual orientation (i.e., gay, heterosexual, bisexual, queer, two-spirit, pansexual).

The research questions were:

- 1. In what ways do gay and bisexual men living in Canada—individually and as communities—make sense of, incorporate into their understanding, and modify their behaviours based on, biomedical knowledge of HIV?
- 2. How are community-based organizations and service providers succeeding and struggling in integrating new biomedical knowledge of HIV within their existing (and evolving) social, structural and behavioural efforts?
- 3. What key elements—main messages, precautions and caveats
 —must be incorporated into communication about biomedical
 knowledge of HIV to be sensitive to the lived realities of gay and
 bisexual men and their communities?

HOW DID WE CONDUCT THE STUDY?

Who was on the research team?

As a community-based research (CBR) project, the Resonance Project reflected gay men's "folk wisdom" throughout the research process and ensured that their perspectives and interpretations informed each phase of the study.

The research team included gay men, gay men's health service providers, educators from community-based organizations, biomedical prevention experts, public health experts, researchers, and representatives of the collaborating organizations. The research team provided advice on the development of research tools, participant recruitment, data collection, data analysis, interpretation and knowledge exchange.

The Resonance Project Research Team is made up of the following individuals and organizations:

& CATIE	Ed Jackson (Principal Investigator), James Wilton*, Len Tooley* Melisa Dickie** Michael Kwag** Tim Rogers **			
University Windsor THE ONTARIO HIV TREATMENT NETWORK	Barry Adam (Principal Investigator)			
CANADIAN BOCIÉTÉ CANADIANNE SOCIETY DU SIDA	Kim Thomas			
Coalition on AIDS Coalition Coalition on AIDS Coalition Interagence side and Development	Shayna Buhler			
CPHA • ACSP	Greg Penney			
SanPatten AND ASSOCIATES	San Patten (Research Coordinator), Marc-André LeBlanc (Moderator and KTE Coordinator)			
HEALTH INITIATIVE FOR MEN	Wayne Robert*, Jody Jollimore*, Greg Oudman**, Joshua Edward**			
REZO:	Robert Rousseau*, Gabriel Girard, Roberto Ortiz**			
Owen McEwen, Daniel Pugh*				
* No longer with the	organization.** Joined part-way through the project			
30%	Funding Support: Community-Based Research			

Funding Support: Community-Based Research Operational Grant (2013-2016)

Who were the focus group and interview participants?

The Resonance Project gathered perspectives of gay men and service providers who work in gay men's health through focus groups. We conducted a total of 15 focus groups: four in each city (Vancouver, Toronto, Montreal) with gay men, and one in each city with service providers.

Based on our previous research and experience working with gay men, we identified four kinds of gay men that would provide the richest and most complete picture of how biomedical HIV knowledge is entering the lives of gay men. We made sure to hear from gay men who are the most active consumers of, or most in need of accurate understandings of, biomedical knowledge of HIV.

Table 1 summarizes the inclusion criteria for the focus groups with gay men and service providers.

In addition to the focus groups, we conducted individual telephone interviews with four gay men who were aged 25 years or less and/or identified their ethnocultural background as non-Caucasian; eight healthcare professionals (nurses and physicians) working in a clinic or public health setting; and eight service providers who during the focus groups had identified themselves as gay men.

TABLE 1: INCLUSION CRITERIA FOR FOCUS GROUPS *			
Gay men connected to HIV organizations	 Attended a workshop, training or conference on HIV in the past year 		
Gay men in	• HIV negative or HIV positive		
serodiscordant relationships	 Currently in relationship of more than 6 months 		
	 Partner's HIV status is different than theirs 		
Sexually active HIV-positive gay men	• Has ever received a positive HIV test result		
	 Has had sex with >1 man in past 3 months 		
HIV-negative gay men at "high risk"	 Has never received a positive HIV test result 		
	 Has been tested for HIV more than twice in last year and/or has used recreational drugs in past 3 months 		
	 Has had sex with >1 man in past 3 months 		
Service providers	 Service providers who provide sexual health, counselling and HIV prevention services to gay men 		

^{*} For the gay men, all participants had to be at least 18 years old, to identify as cisgender or transgender men, and to have been sexually active with men in the last six months.

Table 2: number of gay men and service providers who participated in focus groups and interviews across the three cities (Montreal, Toronto and Vancouver)

TABLE 2: TOTAL NUMBER OF PARTICIPANTS IN FOCUS GROUPS AND INTERVIEWS								
		GAY MEN				SERVICE	SERVICE PROVIDERS	
CITY	FG1	FG2	FG3	FG4	Interview	FGSP	Interview	
Vancouver	8	6	5	12	3	7	3	
Toronto	11	5	8	9	0	6	7	
Montreal	10	2	5	5	1	9	6	
Total	29	13	18	26	4	22	16	
Total # of unique individuals	Gay Men: 86 Service Providers: 30							

Figure 1: demographic characteristics of the gay men who participated in our study

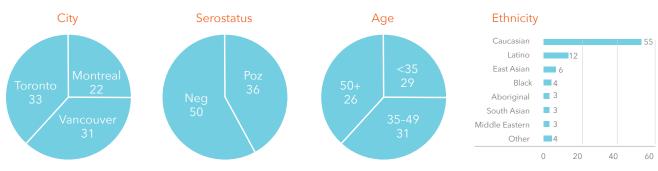
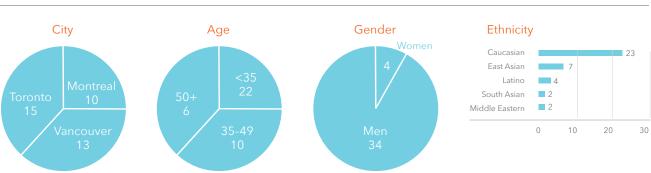


Figure 2: demographic characteristics of the service providers who participated in our study



How did we recruit gay men?

The local partners—HIM in Vancouver, REZO in Montreal and GMSH in Toronto— recruited gay men for the focus groups in ways that fit best for the local gay scene. Each of the local partners developed their own recruitment materials (see Figure 3). The recruitment posters and ads were posted in various physical and virtual spaces:

- community venues: social clubs, gay men's health clinics, at community meetings and events, bars, bathhouses, and outside subway stations
- virtual spaces: websites, social media and hook-up apps

Interested participants called a toll-free number to receive background information on the project, complete the questionnaire to make sure they were eligible, and provide their contact information. Gay men who participated in a focus group received a \$40 honorarium. Those who were interviewed received \$20. Service providers did not receive an honorarium.





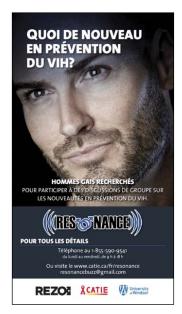


Figure 3: participant recruitment posters from Vancouver, Toronto and Montreal

How did we conduct the focus groups?

The research team collaboratively developed the focus group guide. Rather than directly ask the focus group participants about their knowledge levels and how they know what they know about biomedical aspects of HIV, we used culturally appropriate and indirect means of exploring perceptions and understanding:

- Mock online profiles from common hook-up sites and apps
- · Dating, relationship and hook-up scenarios
- Actual headlines from mass media and community organization newsletter articles related to biomedical HIV prevention

A brief survey was administered prior to the start of each focus group to capture demographic information about the gay men and service providers.

The focus group guides and materials, and interview guides are included in Appendix A.

How did we do the data analysis?

The focus groups and interviews were audio recorded and transcribed verbatim. Using a process of interpretive description², we repeatedly read the data to confirm, test, explore and expand on the key concepts and patterns, emerging themes, symbolic examples from the data, and connections to other themes.

The next section details our findings, with quotes taken from the focus groups and interviews as examples of what the gay men and service providers said. The quotes are ascribed with identifiers according to the following code:

IDENTIFIER CODES FOR QUOTES				
Gay men: 4 identifiers	Service providers: 4 identifiers			
1 HIV status: Neg or Pos	1 SP (service provider)			
2 Age group: <35, 35-49 or 50+	2 Age group: <35, 35-49 or 50+			
3 City: MTL (Montreal), TO (Toronto) or VAN (Vancouver)	3 Work setting: CBO (community-based HIV organization), GMHO (gay men's health organization), PH (public health), CLIN (clinic), PSYC (psychology or counselling), RES (research)			
4 Type of focus group: 1, 2, 3 or 4	4 City: MTL (Montreal), TO (Toronto) or VAN (Vancouver)			

2. Thorne, S. (2008). Interpretive Description. Walnut Creek: Left Coast Press.

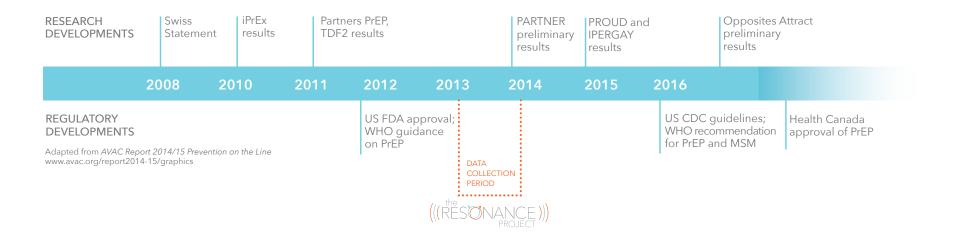
A note about our timing

It's important to note that our data collection occurred in late 2013 and early 2014. This was the period after major PrEP trials such as iPrEx (which demonstrated the efficacy of PrEP in men who have sex with men (MSM) and transwomen) and the Partners PrEP and the TDF2 studies (which demonstrated efficacy in heterosexual couples), but before IPERGAY and PROUD—which both provided robust findings for the efficacy of PrEP for MSM.

Figure 4: Resonance data collection in the context of biomedical prevention research and regulatory developments

With respect to Treatment as Prevention, the Resonance Project was conducted well after the Swiss Statement and the HPTNo52 study results, which focused on the preventive effect of HIV treatment among heterosexual couples, but before the preliminary results from the PARTNER and Opposites Attract studies—which provided evidence for gay men.

Thus, as depicted in Figure 4, the Resonance findings should be considered as a snapshot in time, with the discourse expressed by the gay men and their service providers reflecting the state of knowledge about HIV research at the time of our data collection.



WHAT WE HEARD FROM GAY MEN AND THEIR SERVICE PROVIDERS ABOUT INFORMATION SOURCES

Gay men highlighted the difficulty they have in identifying reliable sources of information, especially in a context where this information is voluminous, complex and often contradictory. For some, this led to distrust. For others, it led to a refusal to pay attention to new information, relying instead on what they already know.

One of the key challenges for service providers was trying to correct misinformation or partial information that men glean from news snippets.

Inconsistent information in the public domain

Many gay men described the information presented to them as excessive, inaccessible and/or inconsistent. Many gay men were particularly sceptical and critical of media coverage of HIV prevention research, which they considered to be inaccurate, dishonest, sensationalist and contradictory. As a result, some gay men felt that they might as well just wait for the confusion around new biomedical prevention options to pass, rather than take a risk and then discover the risk was greater (or less) than they had understood. In some cases, gay men actively avoided any new information related to HIV prevention.

There are so many mixed messages. I mean one day there's a pill that prevents HIV and then the next headline says that it failed... They say that with coffee as well; one day caffeine is great for you and it extends your life and then the next day if you're drinking two cups a day it's shortening your life and it's going to give you heart disease. *Pos*, 50+, VAN1

They'll come out with all these clinical trials and CATIE comes out with so much information on HIV, you can't read it all. You really can't. But then the next newsletter sort of contradicts everything that was in the previous one or the one before that. You know? As far as media goes, they are the worst to read for scientific information. They manipulate it. They twist it. They throw their own curve to it. Neg, 50+, TO4

Conspiracy of big pharma

Several participants expressed considerable distrust of the pharmaceutical industry and of the medical-research establishment. They provided examples of contradictory information and breach of public trust (e.g., tainted blood supply, toxicity of early antiretroviral drugs) and made reference to conspiracy theories linked to profit motives of the pharmaceutical industry. Service providers described

observing this distrust among gay men. Additionally, when service provides tried to correct misinformation with some clients, they were sometimes perceived as being part of the conspiracy.

Obviously everything in this world is money driven, period. So you'd be delusional to think that these guys are doing this stuff out of the goodness of their heart. I equate it to iPhones. There's a new iPhone every three months. There's a new drug every six months. *Pos*, 35-49, TO3

I find a lot in the media, they'll advertise a drug. If you've taken this drug in the last two years, you get to sue their ass now. So really you don't know what you're taking. You don't know what this stuff is going to do to you in 10 years. *Neg*, 35-49, TO4

Withheld information

Some gay men expressed frustration at the lack of evolution in HIV prevention messages, with its persistent emphasis on condom use. They acknowledged that messages around condom use are simpler, but perceived that some information about risk reduction strategies other than condoms was being withheld from them, considered taboo, or forbidden by public health.

I'm sure that public health educators are tearing their hair out because this complicates messages. It's better when it's more simple and if you can instil fear in people and tell them 'don't have condomless sex, it's death.' Neg, <35, VAN4

There has been information about it going around for a few years now and at first I was sceptical and wondering 'Is that a lie? You can't find anything written about it almost anywhere else. Is this information boycotted? Is it censored? 'It came from Switzerland. They were saying that 'for people who have an undetectable viral load and take their meds regularly, the risk of transmission is almost nil. 'Well, this information was well kept. We were wondering how can we even know if it's true? No one is passing it on. Where is this coming from? Is this reliable? Neg, 35-49, MTL4

Finding trusted sources and correcting misinformation

Despite the scepticism expressed by many gay men, some of them identified trusted sources, which were typically healthcare professionals or people working in the HIV field.

It would take a nurse or doctor to tell me you don't actually need to worry; you're at super, super super low risk. My friends had told me that. But it took a nurse and doctor to tell me that before I actually realized that: 'oh OK I was at super low risk and I'm fine.' Neg, <35, VAN1

Service providers had the impression that gay men approached them to confirm information that they had gleaned from elsewhere (news snippets, awareness campaigns, social media posts), and to reassure them about their understanding of that information. Some service providers explained that they found it challenging to help gay men correct and make sense of these brief and often sensationalized snippets.

Sometimes all they catch is just headlines or just a comment that a friend posts and that's enough for him to know what the article is about. I find that many guys are just being educated by one sentence and that's how misinformation becomes. *SP*, <35, *CBO*, *TO*

They're merging their basic knowledge with whatever the media just said, which is usually sensationalized ridiculously so... That's when you get the complicated questions because it's a mixture of like misinformation on the basic sense and then trying to match it with what they're hearing. Sometimes I'm like, I need to have an hour conversation with you. *SP, VAN*

Synthesizing a personal strategy

Even when facing a vast and complex array of information sources and opinions, many gay men described making their own autonomous decisions after reviewing information that they could understand and that they deemed credible. Some of the men noted that they had a prevention strategy that worked for them to reduce anxiety and to rationalize their personal balance of risk avoidance, pleasure seeking and intimacy in a way that incorporated the information they trusted.

When you read 'the US FDA approves HIV prevention pill' I'm like how could I have been in such a news bubble that I didn't read something about this? I'm now intrigued and I want to take time and be like well let's find out when this happened, what happened with this. But in the meantime—condoms. By default it's what's worked for me so far. Hopefully it'll always keep working. Neg, <35, VAN4

WHAT WE HEARD FROM GAY MEN AND THEIR SERVICE PROVIDERS ABOUT PrFP

Even though we didn't measure knowledge levels among participants, we nevertheless observed significant differences in knowledge levels about PrEP. Some men had never heard about it, while others were already taking PrEP.

Participants expressed concerns about a range of issues, including cost, efficacy, side effects and ethics. They also expressed a range of judgments about PrEP and those who use PrEP. Some of the judgments we heard were rooted in how the men experienced the HIV crisis and their experiences around antiretroviral drugs (ARVs) and condoms. Some of the participants vacillated between thinking about PrEP users (including themselves) as reckless sluts, while others described them as well informed and responsible. Sometimes PrEP users were described as both at the same time: responsible sluts.

There were also discussions about the impact of PrEP on the kinds of sex that gay men desired, and the liberating potential of PrEP in allowing for condomless sex with reduced anxiety.

Service providers described the struggles they faced when trying to integrate PrEP into their work.

PrEP awareness and concerns

Service providers appeared to be overwhelmingly supportive of PrEP and interested in promoting its use. While they described overall awareness among gay men as low, they noted that interest tended to be high among those who are PrEP-aware. According to service providers, awareness tended to be limited to a certain subset of well-informed gay men, who tended to be in serodiscordant relationships, connected to the HIV sector and/or of higher socio-economic status.

PrEP, yeah I'm still not hearing a lot of buzz about PrEP. People who are super informed read all the stuff on Positive Lite and The Body and get all the blog feeds and stuff. But that's a pretty small number. SP, 35-49, CBO, TO

So it's like very affluent and also well-informed people who have access and can advocate for themselves with doctors. *SP*, 35-49, *CBO*, *TO*

Indeed in our focus groups, many of the gay men had never heard of PrEP, or knew very little about it. As a result, confusion between PEP and PrEP was fairly common. Experience with ARVs—either as a positive person, being in a relationship with a positive person, or being linked to an HIV organization—seemed to have an impact on

awareness and views about PrEP. Ironically, among the four types of focus groups, those who were least aware of PrEP were those who would most benefit from it—the HIV negative men at high risk.

In the quotes below, we can see the range in levels of awareness about PrEP-from an HIV negative participant in Vancouver who had barely heard of PrEP before coming to the discussion group, to a positive guy in Toronto who could explain PrEP to his peers in simple terms.

I honestly had no... like I knew about there being some sort of drug but I wasn't too much aware of it to be honest with you. Neg, <35, VAN4

If you take one pill a day, the same thing as HIV medication, there's a good chance that if you are engaging in unsafe activity, that you will remain negative by taking these medications. So that's what PrEP is. *Pos*, 35-49, TO1

Participants raised several concerns over accessibility, efficacy, side effects and the ethics of PrEP.

I'd be taking on a lot of risk by taking the drugs. Once it's been out maybe 10 years, I might consider it then when all the effects are known. But right now it's just too new. I don't want to be one of the guinea pigs. Neg, 35-49, VAN2

If you're using condoms I think PrEP would be ridiculous to use. I think condoms are way safe enough to stop transmission and PrEP would be just overkill. Why would you put your liver through that much toxicity over the years, chemicals, if you're using condoms? *Pos*, 35-49, VAN3

Community discourse is building

Service providers in all three cities noted that community discourse around PrEP was building among gay men. Service providers reported that gay men were hearing about PrEP through social networks, online sexual and social networking sites, gay media, or through service providers. As community dialogue was building around PrEP, service providers felt the need to proactively participate in the discourse.

I think a main source of information is other guys...it's a very mobile population. When they travel to the States for example where PrEP has much more of a high profile than it does in Canada, they hear about it. Online apps like Grindr, Scruff and all the rest of it are opportunities for people to have conversations. It's through these communities, networks. *SP*, 35-49, *RES*, *TO*

We can't ignore the fact that PrEP is now a topic in the community...The longer we wait to let people know about PrEP and educate people about PrEP, the more challenge we'll have. SP, <35, CBO, TO

PrEP and risk calculation

For some gay men—both positive and negative—PrEP provides sufficient reassurance to have condomless sex, while others remain committed to condom use regardless of PrEP's effectiveness. The participants also wondered: Are guys on PrEP safer sexual partners than others? Can I trust that a sexual partner is really on PrEP?

A miracle pill not to protect yourself, exposing yourself to risk of infection... This makes no sense to me. Neg, <35, MTL4

But nobody is saying 100%. So I'm very suspicious of all this stuff. Neg, 50+, VAN1

I thought about it briefly and decided it wasn't really for me and didn't consider it anymore because with [my positive partner] I already feel safe enough and with anybody other than him I'm using a condom anyway. Neg, 35-49, VAN2

I've heard about people taking it. But I personally never encountered one that I would have sex with. I would feel more comfortable but I would still push for the person to use the condom as well. *Pos*, 50+, TO3

PrEP and the sex we desire

Participants questioned PrEP's role in the type of sex gay men want. Two conflicting tropes circulated through the narratives of gay men in all the focus groups. For some participants, PrEP is introduced into a context where gay men are already pursuing the type of sex they desire, allowing them to do so with lowered risk of HIV. For others PrEP provides a false sense of security in the pursuit of condomless sex, and is helping to precipitate it. Is PrEP a license to throw caution to the wind or is it a sign of the good gay citizen calculating risk and responding rationally and methodically to the threat of HIV infection? Especially for men who find condoms an impediment to sexual satisfaction, PrEP promises enhanced sexual pleasure. Below is a quote from a positive guy in Toronto and from a Vancouver service provider:

PrEP I mean that's... like I respect the guy... he's doing what he can while still enjoying sex cause a lot of guys, they don't enjoy sex when there's condoms involved. That's just a reality right. They'll lose their hard on. They just don't enjoy it. We're only here for a short time. [laughter] We've got to have some fun in that time somewhere along the line. *Pos*, 35-49, TO2

I think there's an entire culture of bareback...people who are participating regularly in barebacking and unapologetically doing that. They're saying 'well, I've used condoms for 20 years and I'm exhausted. I'm tired of it and now I'm taking back my liberty' and they're using PrEP as a point of pride. SP, 35-49, PSYC, VAN

PrEP users: responsible/sluts

Participants alternatively describe PrEP users as sluts and barebackers who think they are invincible on the one hand, and as responsible, thoughtful and knowledgeable individuals who take care of their health on the other. Sometimes they described them as both—responsible sluts. When participants talk about PrEP users as sluts, they sometimes refer to other guys, but they are also sometimes talking about themselves—either as current PrEP users in a couple of cases, or while imagining themselves as potential PrEP users. It often has a mix of judgement and irony, targeted both to others and to themselves.

If PrEP is available to anyone who wants to take it, does that mean you've got a bunch of guys who think they're totally invincible and they're going to go fuck their brains out? ... I wish that we had PrEP for my personal situation. *Pos*, <35, *VAN2*

 $((\mathsf{resonance\,project}\mid\mathsf{community\,report}))$

It means that they want the possibility of unprotected sex, a bit like me. S-L-U-T. *Pos*, 50+, *VAN2*

We're pill takers because we like to fuck... Well maybe you're better off not taking medication and respecting your sexual health. *Pos*, <35, *MTL*3

I know he's negative and on PrEP and tested every three months. That's like everything a bottom could wish for. Neg, <35, VAN1

PrEP judgment and stigma

Service providers observe high levels of judgement, slut-shaming and stigma towards those who might choose to use PrEP. Some attributed this judgment to the strong dogma of condom use that has been reinforced since the early days of the HIV epidemic.

All those criticisms are the exact same thing that was said when the birth control came on the market. When the pill came out it was like oh my God, you're all a bunch of sluts; it just means you're going to be sluttier. That's sort of the same thing. SP, 35-49, PH, VAN

PEP is 'oops I made a mistake' but then PrEP is 'I am planning to be bad.' SP, <35, PSYC, VAN

Lack of consensus and guidance

Service providers themselves are struggling to know what to say about PrEP in the absence of consensus and guidance.

There's no standard...it's not like there's a health unit out there or Health Canada saying this is their guideline. It's still kind of a Wild Wild West. *SP*, <35, *PH*, *TO*

People who work in the field are fighting amongst each other, squabbling about what percent effectiveness we can really take home from these trials. Gay guys are witnessing these types of disagreements...and from the standpoint of the average gay guy that's just not good enough. We need to be doing a better job of creating some kind of consensus. *SP*, <35, *PSYC*, *VAN*

WHAT WE HEARD FROM GAY MEN AND THEIR SERVICE PROVIDERS ABOUT UNDETECTABLE VIRAL LOAD

The HIV-positive participants generally viewed undetectable viral load in positive terms. For many, it reduced anxiety about transmission and could reduce stigma. For some, undetectability was even the basis of a new identity, which they distinguished from being just HIV positive. It could also contribute to a feeling of sexual liberation and to better sex.

However, some HIV-positive participants and many HIV-negative participants expressed considerable caution about relying solely on undetectable viral load as a means of reducing HIV transmission risk.

Among service providers, we noted a lack of consensus about the role of undetectable viral load as part of risk reduction strategies.

Undetectable viral load awareness and concerns

While we did not measure gay men's level of awareness about undetectable viral load (UVL) or their level of confidence in its ability to reduce the risk of HIV transmission, these levels of awareness and confidence seemed to vary greatly. Those gay men in the focus groups who were living with HIV, knowingly interacted with positive men or were connected to HIV organizations seemed to have greater knowledge and confidence levels in the concept of undetectability

as a risk reduction strategy. These knowledge and confidence levels also seemed to vary according to geographic location. The most commonly cited caveats regarding undetectability and its impact on the risk of transmission included: frequency of viral load tests; re-infection with different strains; the impact of other infections; viral blips; adherence to treatment; and the applicability of research focused on heterosexuals to gay men.

In the Village everyone knows what it means to be undetectable. In outlying regions when I say that I'm poz undetectable, I get three question marks. *Pos*, <35, *MTL1*

Until I moved here I was still operating on the data from 20 years ago when raw was forbidden, period. I had to go do a lot of research before I could convince myself that it was an OK thing to do...I went to the web and looked up everything I could and spoke to some health professionals...They all said the same thing; having sex with somebody that is known to have low viral load is safer than having sex with a stranger with a condom. I couldn't believe that they were all saying the same thing. Wow! So I started having unprotected sex with him [poz partner]. I'm always the top. That's the stipulation. Neg, 35-49, VAN2

Undetectable viral load and risk calculation

In general, HIV-positive participants expressed more confidence in the idea that an UVL sufficiently lowers the risk of transmission than HIV-negative participants. However, a few participants had opposing views to that of their peers. Having an HIV-positive partner had been particularly instructive for some negative men around risk management. Many gay men emphasized that while it might lower the risk, some risk remains. For some gay men—both positive and negative—UVL provided sufficient reassurance to have condomless sex, while for others it did not. Gay men were divided: Are undetectable men safer sexual partners than others? Some gay men wondered: Can I trust that a sexual partner is really undetectable?

- You also can't lose sight of the fact that it's a crapshoot. You might get away with it once. You might get away with it twice but then one day you might wake up and get that phone call. Neg, 50+, TO1
- I don't know. If you've been with somebody for 5 years and you've barebacked the whole time, and they're still negative, that raises a lot of questions. *Pos*, <35, *TO1*

A lot of negative guys are seeking out undetectable positive partners... Saying undetectable is the same as negative, I think it's actually better, because a negative person's status is only as good as their last test. *Pos*, 50+, *VAN1*

Undetectable, a lot of people think 'oh I'm never going to get infected' or 'I'm never going to infect anybody else.' So therefore, get rid of the condoms now... But there's still that less than 0.05% that you can. *Pos*, *50*+, *TO3*

Undetectable as identity: "The new negative"

Many HIV-positive men espoused the idea of undetectability as an identity (as opposed to "poz" or "positive") as a way to signify that they were healthy and posed a lower risk of transmission. They felt this helped reduce stigma. However, some positive and negative participants questioned the impact of identifying as undetectable in a context where the concept was not well understood in the community.

I wear my undetectability like a badge of honour. I'm very proud to be undetectable. *Pos*, 50+, VAN3

It takes the emphasis off the illness and puts it on my health. HIV positive has such baggage attached to it and undetectable doesn't really have that baggage. *Pos*, *35-49*, *VAN3*

Just to say undetectable, most people who are positive they know what that means and they know that they are in a healthy phase, in a healthier phase. *Pos*, 35-49, TO1

Concerns about over-confidence in undetectability

Some service providers described how some gay men used the term as a "magic phrase" to convince their sexual partners to have condomless sex. They expressed scepticism about gay men's ability to understand undetectable viral load accurately or appropriately. Some service providers described gay men as being overly confident in undetectability, and as engaging in "risky" or "unprotected" sex when they chose to have condomless sex on the basis of undetectability as the sole risk reduction method.

They just take it as a license sometimes to just go with it, to proceed either in risky behaviour or unprotected sex. Do they have a complete understanding? Not always. So basically it's just a two-second conversation 'oh he said he had undetectable viral load, we don't need to use a condom.' They're not looking at what does an undetectable viral load mean, at what time and how do STIs and other things impact the spikes in viral loads. *SP*, 50+, *PH*, *TO*

The focus of HIV/AIDS prevention is bringing us back to a point where we can have condomless sex without conversations, without concerns, without consequences. It's just mindboggling. We have had guys who have come in who have serosorted based on a partner who's undetectable. *SP*, 35-49, *PH*, *TO*

Positive men as educators

Service providers had the impression that negative gay men were learning about undetectability from positive men. Gay men living with HIV confirmed this; they felt that they often had to educate their sexual partners about the meaning and implications of undetectability.

Positive guys, usually they're more knowledgeable about those things. Negative guys, it's not even on their radar. The only bridging of that is the negative guy who knows positive guys or has friends who are positive or is having sex with positive guys. That's where that knowledge transfer is happening. SP, <35, GMHO, VAN

I don't always want to explain what PrEP is and Truvada and HIV and undetectable to some guy I just want to suck my dick [group laughter]. Straight up. *Pos*, 35-49, TO1

Impact on stigma reduction

Some service providers described undetectability as reducing levels of stigma and self-stigma related to HIV and infectivity. They also described how some gay men saw sexual partners with UVL as more desirable and safer than partners who claimed to be negative. They discussed the tension between messages that destigmatized positive men and messages that accurately reflected the state of evidence around undetectability and transmissibility. This tension was often described as being emotional versus rational.

The undetectable thing is a bit of a hope for them that they aren't that huge risk. They're not this source of HIV, they can have a relationship and their partner doesn't have to be positive. I think that's really liberating for positive guys, this idea that I don't have to feel like this viral source. *SP*, 35-49, *PH*, *VAN*

It's this delicate dance because you do want to talk about what undetectable and treatment does for people and how it affects peoples' health. But you also don't want to increase stigma against people who aren't on treatment. It's this delicate dance of trying to reduce stigma while also explaining likelihoods of transmission. *SP*, 35-49, CBO, TO

Divide among service providers

Service providers demonstrated their own varying levels of confidence in the efficacy of undetectability, and a few admitted that their own levels of knowledge on this topic were not as complete as they would like. Some service providers erred on the side of caution by advising gay men of all the uncertainties of UVL, while others described such messages as overly conservative. Some service providers acknowledged a divide among their colleagues, characterizing some who touted the risk reduction possibilities of UVL as being irresponsible.

It frustrates me to no end. I do believe that some doctors are being irresponsible when they're advising people who are undetectable that they don't need to use condoms. Most patients don't have the capacity or medical knowledge or are in a psychological position to take that information in a way that is accurate. Doctors giving that advice so freely doesn't take into account all the complexities. *SP*, 35-49, CBO, TO

There's a huge flame war on my Facebook...it's a big division and it's where logic just disappears down an emotional void. People are attached to condoms, they're attached to safe sex or they're attached to HIV status or they want to de-stigmatize. Most attachments are very powerful and they really divide the education messages. *SP*, 50+, *PSYC*, *VAN*

WHAT WE HEARD FROM GAY MEN AND THEIR SERVICE PROVIDERS ABOUT RISK CALCULATION

Participants described how they formulated personal strategies for HIV risk reduction that worked for them, based on balancing their knowledge and fears/anxieties. In general, HIV-positive men felt an extra burden of responsibility for risk reduction. How gay men understood risk, and how service providers helped gay men to assess their risk, depended on the nature of the relationship and the type of sexual encounter. Service providers had the impression that gay men sought reassurance, often after a sexual encounter.

Personal rules and strategies for managing risk

Several gay men described the rules and strategies they had devised for managing risk, and how they made an informed choice about the level of risk they were willing to take according to circumstances. Some referred to the influence of their closest peers within their social circle in terms of setting the norms for risk tolerance. Some participants pointed out that there was risk in any sexual activity, that some of that risk was due to chance, and that there was a great deal of subjectivity in how individuals perceived and mitigated risk. As part of their risk calculations, gay men often compared HIV prevention strategies (condoms, serosorting, seropositioning, PrEP, undetectability) to each other, weighing the pros and cons and relative efficacy of those strategies. Some described the challenge and frustration of having so many mixed messages about HIV risk.

I don't think [if someone was on PrEP] would change my opinion either way. I'd still insist on playing safely whether they were on it or not. It would be non-data to me. *Neg*, 35-49, VAN2

As a young man...I'd get testing on a regular basis. The tests get back a negative result and then I kind of put everything that I've done into the category: 'well that was reasonably safe' and carry on. Neg, 50+, VAN2

Discourse: analogies, code words and numbers

Several types of discourse circulated in the focus groups: 1) making sense of various prevention strategies by comparing HIV risk to everyday experiences of risk such as driving a car, getting on a plane, stepping out of the house or winning the lottery; 2) deciphering, critiquing or defining code words commonly used in hookup sites and apps, such as "clean," "DDF," "undetectable," "PNP," the "+" symbol, and "UB2"; and 3) discussing risk and effectiveness of various prevention strategies in terms of numbers and percentages.

A couple years back growing up on my little island, I used Craigslist and I didn't know the internet lingo and I didn't know the jargons that they used. So 'undetectable' back in my earlier days, I may have mistaken that for oh I'm on DL. No one can tell I'm gay. [group laughter] ... I still don't even know what PNP stands for. Neg, <35, TO1

Well we're talking about acceptable risks right. I would say the risk is acceptable. If you put it in line with, for example, someone like me getting behind the wheel of a car, it's probably far less dangerous than that. Pos, 50+, VAN2

Negotiating risk in the heat of the moment

Gay men discussed many factors at play in risk negotiation, often weighed "in the heat of the moment": balancing emotional factors (fear and worry, desire and intimacy, horniness and impulses) with rational decision-making, and risk calculation; negotiating whether or not sex occurs, condom use and positioning with their sex partners, based on discussions of HIV/STI status, testing patterns and drug use; figuring out their partners' HIV status, the awkwardness of asking the questions, and the extent to which their answers could be trusted. Some men pointed out that not everyone is on an equal playing field when it comes to HIV prevention. The ability to protect oneself and one's partner is dependent upon factors like self-esteem, self-efficacy, sexual positioning, power dynamics, whether options truly are available, and broader structural issues like the legal context of criminalization.

I think I already know what my preference would be in the encounter; like you know big guy, I think I want him to top me. That's probably going through my head and then it's what's the risk, what am I willing to tolerate in terms of risk with this guy. So that's when the decision would be is it undetectable and bareback versus condom...I guess it is possible, but rare, that the negotiation of position comes up after the undetectable conversation.

Neg, 50+, VAN2

Influence of relationship status

Several gay men and service providers described how risk management strategies and acceptable levels of risk vary based on partner type (regular or long-term; occasional; one-time/anonymous), relationship status (open/closed, dating, seroconcordant/discordant) and how men met (online; in saunas, parks, bars). For others, their strategies remained immutable, regardless of the partner or their relationship status. Some gay men specifically addressed the risks of anonymous sex, particularly in relation to not knowing the partner's HIV status, and the constraints around negotiating risk. According to some participants, one of the benefits of meeting through online hookup sites was that some negotiation and information sharing happened upfront (e.g., preferences re top/bottom, HIV status, viral load, etc).

But in terms of this situation, it's the emotional bond that makes it a little bit harder to think about transmission within the relationship. Today what we both do external to the relationship, it's almost it doesn't matter as much, as long as we kind of protect each other. And quite frankly I like condomless sex. But with him, because of the love and the bond that we share, I can't see myself shaking a condom. I think I would do everything I could. *Pos*, 35-49, TO2

Risk elasticity

Service providers noted that tolerance for risk varied by person, and that there was often a mismatch between a given level of risk and the level of worry felt by gay men. As a result, service providers described the paradox of trying to instill a greater sense of risk in some clients while trying to quell a sense of fear in others, often for the same behaviour. Service providers discussed the phenomenon of gay men having "flexible" perceptions of risk, or "stretching" their risk practices to fit an expanding repertoire of behaviours and prevention strategies.

With the presence of PEP and PrEP, gay men can stretch their risk...So in my head, are we seeing risk like a rubber band that we can stretch as far as possible until it...? SP, 35-49, CBO, TO

Bottom line, you have to be comfortable having sex with people. You have to be comfortable taking a certain amount of risk when you have sex. It's an interesting challenge. People want absolutes... So you have to figure out how can you do this to be comfortable so that it doesn't cause you great anxiety. It's amazing because some people are taking huge risk and they seem to have no anxiety around it where there are other people that have no risk or very small risk and have huge anxiety around it. It's really interesting to kind of deal with those two extremes. SP, 35-49, PH, VAN

Extra burden of responsibility on positive gay men

Some gay men living with HIV described the paradoxical feeling of liberation in learning of their HIV status, and realizing that they no longer had to be preoccupied with the risk of becoming HIV positive. They also talked about serosorting for other HIV-positive men, and their strong fears around passing HIV to their partners.

I'm actually motivated now to take my medications and adhere to them because I don't want to be anything other than undetectable because my partner is HIV negative. I'd like to keep it that way. That's a relationship. That's not just sex. So I mean when negotiating sex and negotiating your relationship, it's two totally separate things. *Pos*, *35-49*, *TO1*

Seeking reassurance, after the fact

Service providers explained that they helped gay men to understand the risks associated with certain sexual practices, but that gay men often sought this advice after a risky behaviour had already occurred. They noted that questions were often driven by the need for reassurance, and that discussions about HIV were generally avoided unless the clients were driven by fear to raise the issue.

I just got a question from a client. 'How safe I am if I have sex with someone positive and using a condom?' Immediately I thought like 'oh my God this is another dumb question' because as a service provider you get so sick and tired of being asked. This is basic HIV 101. It's like 'yeah, it's safe.' And I realize what he was asking wasn't the safety. There is that stigma of HIV-positive people. He's just afraid of having sex behind that question. *SP*, 35-49, CBO, TO

WHAT WE HEARD FROM SERVICE PROVIDERS ABOUT RISK COUNSELLING CHALLENGES AND STRATEGIES

Service providers highlighted several challenges they faced as well as some of the strategies they used to incorporate new biomedical information in their work with gay men. These challenges included: staying on top of new information; determining how to convey this information in ways that are accessible; the lack of consensus around certain topics; and their desire to offer a variety of viewpoints. Some service providers said they often erred on the side of caution in their messaging—which translated into condom use promotion—although other service providers were critical of this approach. Many service providers described how they had to develop approaches that took into account the community's diversity, as well as the variety of contexts within which they did their work.

Challenge of staying updated

Some of the service providers reflected on the challenges of having the time to read, interpret and distill research findings, and translate them into simple lay terms in ways that clients/patients will understand. Some of the service providers noted the high expectation on them to have "all the answers" despite their own knowledge limitations. Service providers also felt challenged when clients asked for their personal opinion or judgment about prevention strategies. A minority of service providers felt that the messages were relatively straight-forward and not all that difficult to communicate to patients/ clients.

I think as service providers we need to acknowledge our limitations as well... It's scary that they place a lot of authority on us...It's hard for us to admit we have that power over our clients...If we are positioning ourselves as the experts, then we need to know what we're talking about. SP, 35-49, CBO, TO

There's a bit of a paternalistic tinge to it but I think most gay men are not ready to digest this information. It's not possible for a lot of gay guys to read the peer review papers and to draw conclusions from it. But I think it's really important that people who work in the field to try and stay on top of this stuff. SP, <35, PSYC, VAN

Dealing with complexity

Service providers discussed the multiple prevention options that were now available, their scientific complexity, the resulting complexity of prevention messages, their concerns with keeping up with the science, and the underlying value systems that often guided prevention messaging.

It doesn't say this is right or wrong. It just says this is new information, it's interesting, it could be very exciting and here are some questions that we're trying to figure out about what it means. Just get it out there right away so that we can be a part of

framing what guys in the community, how they're interpreting it. Again, we don't have the answers and we certainly don't want to endorse or not endorse something. *SP*, 35-49, CBO, TO

Service providers believed that some gay men were overwhelmed by the growing range of available options, and instead avoided these new strategies.

Now that there's so much to consider it makes it more complex... It's very confusing for the average guy. *SP,* <35, *GMHO, MTL*

They noted that many gay men have long adopted a diverse range of strategies beyond condoms, sometimes in reaction to conventional condom messaging.

Gay men have known for a long time that there's more than one way of preventing HIV... There have been many cultures and communities of gay men who have adopted lots of different ways of preventing HIV that fall outside of the official way. *SP*, <35, *PSYC*, *VAN*

Some service providers mentioned that they noticed more openness among young men.

I think younger guys have been more willing to adopt and embrace newer paradigms around prevention and more readily accept that you can have safer condomless sex. *SP*, <35, *PSYC*, *VAN*

Consensus versus multiple interpretations

The service providers expressed a contradiction: on one hand wanting to have consensus and to be able to provide a definitive statement, while on the other hand wanting to be able to provide a variety of viewpoints and interpretations of the science. The lack of consensus led to conflicting interpretations, messages and advice.

So many of us are still squabbling, fighting over things that should have been figured out years and years and years ago. We have some cleaning house to do as a community, as people who work in HIV prevention in gay men's health. *SP*, <35, *PSYC*, *VAN*

There's just a real lack of consensus on a lot of new biomedical reasoning. A lot of the research in the last five to ten years has thrown a lot of different potentially innovative and interesting ideas about HIV prevention but there's very diffused and uneven uptake of those things by public health which is traditionally a very conservative institution. *SP*, <35, *PH*, *VAN*

Providing a balanced answer

Service providers noted the challenge of providing advice when there was conflicting information, no definitive answer could be given, chance played a role, and the only truly correct answer about risk was "it depends." They saw their role as building enough knowledge and skills in clients in order to instill self-efficacy, and remove a reliance on chance. Several noted that they owed clients a balanced answer about risk, and not necessarily just their own professional or organizational perspective.

When people ask for your opinion that's where they're trying to justify maybe an internal belief...Sometimes it's best for people to form their own opinion first. I want to encourage them to hear about both sides of the argument and not really give my opinion. *SP*, <35, *GMHO*, *VAN*

It can feel really frustrating as an educator...trying to help them make their own decisions about what risks they want to take when every answer is 'it depends.' *SP*, 35-49, *CBO*, *TO*

You also have to be very cautious as a healthcare provider—what is their motivation for asking? Are they asking you for permission? Are they asking you as an expert? Are they asking you for information? Are they asking you because something might have happened? What is their subjective position that they're coming to you with this seeking of information? *SP*, 35-49, *PSYC*, *VAN*

Scepticism and erring on the side of caution

"Erring on the side of caution" was probably the phrase we heard most frequently during the service provider focus groups. Some service providers tended to give the most conservative messages possible (i.e., condom use only), but also acknowledged that being overly simplistic or conservative in HIV prevention messages could frustrate or alienate clients who knew of risk reduction options other than condoms. Some of the service providers noted that it could be difficult to express their scepticism around biomedical information without being construed as stigmatizing towards people living with HIV.

We have a really disproportionately skeptical orientation towards things other than condoms and we're really married to this idea of condoms. *SP,* <35, *CBO, VAN*

I think erring on the side of caution; it also is kind of like dehumanizing in that you're sort of telling someone that their desires and their decisions don't matter based on this set of ideals and ideology. *SP*, <35, *GMHO*, *VAN*

I want to support new technologies, and we will get excited when we should, but I'm not changing our practices or suggesting this information when we just don't have enough data. We have no idea what the toxicities will be over 30 years...It becomes divisive, we're either seen as holding information back, or being irresponsible and too loose and free with promoting the meds. *SP*, 35-49, CBO, TO

Heterogeneity of awareness and receptivity within the gay community

Service providers noted the heterogeneity of the gay community, with some gay men having very basic knowledge and not being ready for, or open to, the complexities of biomedical aspects of HIV prevention. At the other end of the spectrum were gay men with quite sophisticated knowledge of HIV prevention, which led service providers to feel that it was a challenge to keep up with community discourse.

I have people that know a lot and there are those that don't know nothing. I know people that think that they can re-use condoms. Otherwise I have people who are serodiscordant and they are on PrEP. SP, <35, CBO, TO

There's a lot of paternalism in health promotion and to some extent some segments of the population that we work with, that's what they want. They're craving someone to provide some kind of direction in this really complicated and messy world. But there's a whole other segment of the population that we work with that has an intense hatred of being patronized, of being told what is the right way of doing something. *SP*, <35, *PH*, *VAN*

The service provision context

Service providers described how the context of contacts with clients had an impact on the extent to which they could do harm reduction counselling. If a risk calculation conversation were a one-off, some service providers would err on the side of caution, whereas sustained conversations over time could be more nuanced.

As opposed to a Towel Talk that can last anywhere from like 30 seconds to 10 minutes, some people you see on a regular basis...We have a counselling session of 30 minutes, so it can go a lot more in-depth in regards to various different harm reduction strategies and helping them integrate them into their lives. SP, <35, GMHO, MTL

WHAT WE HEARD FROM GAY MEN AND THEIR SERVICE PROVIDERS ABOUT TRUST AND DECEPTION

Gay men discussed whether or not they felt they could trust other gay men around sexual encounters, particularly in regards to serostatus (when a sex partner stated he was HIV negative or had undetectable viral load), testing frequency and test results, use of condoms, use of PrEP and being monogamous. They also wondered whether some gay men deliberately lied or sought to deceive, particularly in the online dating scene.

Trust regarding serostatus, testing, PrEP, condoms, monogamy

Sometimes participants distinguished PrEP and undetectable viral load as strategies that are distinct from condoms because unlike the first two, condoms were used directly during the sexual encounter and they could be seen. The third quote comes from a participant who called into question all three—serostatus, testing and PrEP.

You see it sometimes on the sites. 'Neg as of' last December. OK, six months have passed. Why bother telling me that you were negative six months ago? How am I supposed to know now? Pos, <35, MTL3

If you're positive, you're positive. That's the clearer one. But when it comes to undetectable and negative, it's not as clear. You don't know you're still undetectable. You don't know you're still negative... *Pos*, 35-49, TO2

It's the fact that he specifies that he's negative, on PrEP, and tested every three months... Why would I take that as a guarantee of my own sexual health as a bottom? *Pos*, <35, *MTL3*

However, as we see in the next quotes, even condom use raised questions of trust. Some of the gay men described encounters in which they questioned whether or not the sexual partner was keeping the condom on (or even if he had tampered with the condom).

Let's say they are topping you, you didn't check the condom or something. He could open the condom or tear it before and put it on because he's into barebacking right? Neg, <35, TO4

He was positive but he told me he was negative. I was wearing a rubber but we were having drunk sex. But he was holding the penis and as my penis was going in and out, the condom was coming off. He's done this to 10 other guys and he infected 10 of us. *Pos*, 35-49, TO1

Below is an exchange between HIV-positive and HIV-negative men. We can see here that trust was an important factor in calculating risk, in addition to the biomedical information that they had to consider.

- I was in a relationship for more than a year. We had gone for our tests. We weren't using condoms anymore and my boyfriend cheated on me. He got it and gave it to me... But who's going to get tested every three months when you're in a relationship... Pos, <35, MTL1

Q: When you're in a couple, are you going to use a condom every time?

- Yes, me yes. Neg, 35-49, MTL1
- Well, bravo! [sarcastic, group laughter] Neg, <35, MTL1
- Because you just don't know. He could be lying. Neg, 35-49, MTL1
- It seems to me that after so much time as a couple, it could be perceived as a lack of trust. *Pos*, <35, *MTL1*
- But we have to accept that we're men... Neg, 35-49, MTL1

Deliberate deception

In discussing the dating profiles, many of the gay men made reference to (dis)honesty in the ads. Some of the gay men had the impression that online dating sites and apps were not conducive to honesty among potential sexual partners. This theme was also evident among service providers, as well as a generally pronounced sense of distrust.

There's a lot of insincerity online. Neg, 35-49, TO4

- Fidelity doesn't exist. Pos, 50+, MTL3
- Even less so in the gay world. Pos 50+, MTL3

- How many times do you lie to get sex? Neg, 35-49, TO2
- All the time... just kidding [laughter]. Pos, 35-49, TO2
- No, yeah, seriously. People tell small lies, half lies, lies of omission, different levels of lies to get laid. It happens everywhere, not just gay people but everywhere. *Neg*, 35-49, TO2

I'm not quite as much of a romantic as you are. You still have to behave all the time in your own best interest. I'm sorry, that's what's called survival. Neg, 50+, VAN1

Encouraging (healthy) distrust

Service providers discussed whether or not they felt gay men should trust other gay men, particularly what they said around sexual encounters (e.g., negative or undetectable serostatus, testing frequency and test results, use of condoms, being monogamous).

We're not like condom assholes or ignoring all the relationship nuances. But we say: 'when you're ready to give your partner your passport or your credit card, have a conversation about condom use and get tested.' It's not that difficult right. We really need to educate men to determine the difference between intimacy and love and trust and condomless sex. *SP*, 35-49, CLIN, TO

Some of the service providers said that they often actively encouraged their clients to be distrustful, stating that some gay men deliberately lied, and that it was an inherent part of being gay and/or being a man.

- _ Just the spectacular lying that goes on in the gay community. SP, 50+, PSYC, VAN
- I think that sometimes being gay facilitates a certain need to be a bit of a different person, putting on different masks, in a sense

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of creating different personas. I think that gay men can certainly become quite adept at making those personas and lying to themselves or lying to others. Deception becomes in a sense a masculine trait if you will. *SP*, 35-49, *PSYC*, *VAN*

Some of the service providers described being "shocked" and "scared" at how "naïve" gay men were, stating that they engaged in "wishful thinking" and made decisions about risk based on very partial information. Service providers generally expressed and encouraged greater trust in someone's claim of being HIV positive and/or undetectable than HIV negative, encouraging clients to be mindful of the risks of acute infection.

Negative's the last year's unknown... Negative is an assumption that people make. *SP*, 35-49, *CBO*, *TO*

The thing that scares me is that people will choose a risk based on just that tiny little piece of information that they've gathered that isn't really part of a whole picture. *SP*, 35-49, CLIN, VAN

On a dating site the extent of the inquiry that's directed towards me about my HIV status is usually half a sentence 'are you clean, are you negative, are you tested?'... People really want to get laid and they don't want to put too many things in the way of that. But they also want to deal with their anxiety. But they deal with it in a very minimal way that relies on my word or their word. It's shocking to me. It's really shocking... after all this time, how naïve that is. *SP*, 50+, *PSYC*, *VAN*

WHAT WE HEARD FROM GAY MEN AND THEIR SERVICE PROVIDERS ABOUT RESPONSIBILITY

Biomedical approaches to HIV prevention have renewed conversations about the responsibility for HIV risk reduction. Both gay men and service providers discussed the burden placed on the gay community for HIV prevention, and how biomedical strategies both entrench and change norms around risk reduction. Both gay men and service providers described what they thought constituted responsible and irresponsible behaviours for gay citizens. They discussed the tension between the idea of shared responsibility for prevention and that everyone needed to look after their own health. Some of the gay men noted the role they played as peer educators, sometimes reluctantly, and the extra burden for prevention placed on positive men.

Community burden

Some of the gay men discussed the sense of betrayal they felt when other gay men (often those they perceived as being younger) were dismissive of HIV risks and didn't take adequate steps to protect themselves from a disease that devastated the gay community in its early years.

Some service providers noted this collective experience of trauma.

Some of the participants—both gay men and service providers—noted the burden of blame, shame and responsibility, coupled with homophobia, carried by the gay community for HIV prevention. In the quotes below, we can sense the feeling of unjust community burden.

I get upset...because it shows a lack of concern...Having been weaned in community through the AIDS epidemic, having lost two partners to AIDS, volunteering my time... to see somebody putting themself at risk by having anonymous sex, looking for somebody to penetrate them and cum in their ass without any protection... *Pos*, 50+, VAN1

The gays have to put on a condom and if they don't they're irresponsible and promiscuous... If this were a situation that the general population were dealing with, the science would be way further than it is today. *Pos*, <35, *VAN2*

An entire culture of people frequenting hook-up sites specifically geared to bareback sex and... unapologetically doing that. I think that is the generational trauma... They're saying 'I've used condoms for 20 years and I'm exhausted... Now I'm taking back my liberty' and they're using it as a point of pride. SP, 35-49, PSYC, VAN

Good citizenship—Judging (ir)responsibility

Participants described what they saw as correct, acceptable behaviours and the duty of good, responsible citizens (wearing condoms, achieving undetectability, getting tested regularly, disclosing to partners, being informed), versus men they perceived as being irresponsible or having a defective character.

We can see in the quotes below that the norms around responsible behaviours was often internalized, not just an expectation placed upon others. And it was reinforced between men of the same serostatus, not just across the serodivide.

I used to spend a lot of time online and doing drugs and that's why I seroconverted. I didn't really look into the research behind HIV. I didn't really look into anything for a number of years after I seroconverted. I just continued to behave irresponsibly and continued to do what I wanted. *Pos.*, <35, VAN2

[Presented with a scenario of a new couple getting tested together before having condomless sex]

- I think that's terrific. Pos, 50+, VAN1
- How responsible of them, great. Neg, <35, VAN1
- I think these are two volunteers at the HIM clinic. [group laughter] Well-informed. *Pos, 50+, VAN1*
- Why isn't he taking the meds? Everybody's taking the meds now. What is it about him that he's not doing it? ... A lot of people that I know that use a lot of drugs... don't take the meds... I'd just wonder what's going on there. *Pos, 35-49, VAN3*
- It just makes it seem like they're not taking their health seriously...It doesn't make sense. Pos, 50+, VAN3

In the quotes below, we can see that what many men perceived as irresponsible behaviour—whether it was seeking out a positive guy as a sexual partner, not knowing one's HIV status or being ignorant about HIV—was seen as offensive, not to be tolerated, a sign of not having a conscience or the result of having suffered some trauma in the past.

[Presented with a mock hook-up ad from squirt.org]

- He's a hustler. He's seeking a positive guy. TO4
- He says seeking... bi, bear, jocks, truckers, positive guys. Neg, 35-49, TO4
- He probably doesn't know what he wants. He's probably confused. Neg, <35, TO4
- A bad person. Neg, 35-49, TO4
- Or probably has run into some trauma in the past. He just feels that sex actually gives him that satisfaction or something like that. I'm not sure. Neg, <35, TO4
- I think most people just don't give a fuck that have it because I know certain people that have it and they just don't care. It's like they don't have a conscience, you know. Neg, 35-49, TO4

I used to be very tolerant of people's ignorance about HIV, but I'm becoming less and less tolerant. *Pos*, 35-49, *MTL2*

- I'm uncomfortable with somebody who doesn't know their status. *Pos*, 35-49, TO3
- And doesn't care to know. Don't care is pretty offensive. It's pretty offensive. *Pos, TO3*

According to some service providers, despite some gay men taking steps to reduce their risk (for example through PrEP), some of these decisions were perceived as being irresponsible.

It's funny that PrEP looks like such a responsible option for those who can afford it... well-informed people who have access and can advocate for themselves with doctors. But in the media reports, and the way it's talked about by a lot of service providers, it's presented as the irresponsible choice, like 'disco dosing.' When it actually can be such a responsible decision for people. SP, 35-49, CBO, TO

This service provider is describing how the tension between responsible and irresponsible behaviours played out in the community, and how it might have influenced his work.

I don't want to be shamed into talking about my condomless sex...into thinking that my behaviour is reckless and irresponsible or delusional for thinking that what I'm doing is safe. I want to be supported in my practices because I believe that it's supported by evidence and research even though it's not being adopted and recognized by the institutions. I think that does lead to the emergence of sub cultures and sexual cultures that are resistant to public health and community but where these things are being discussed and adopted as indigenous kind of practices. *SP*, <35, *PH*, *VAN*

Here men (generally older) talk about how (generally younger) men had a different set of values. They questioned whether these younger men had a conscience and called them selfish. There were some dissenting voices in the focus groups, who explicitly called out some of the judgmental attitudes they were hearing.

Even though I'm undetectable, I would never take the risk. It's very upsetting... It's all bareback, fuck me anyway, you're undetectable, no rubber... And it's not guys my age who ask for it. It's guys who are 20 or 23. What's their problem? Are they looking for STIs? Do these guys have no conscience? They're saying 'who cares if you have AIDS, fuck me anyway.'

Pos, 50+, MTL1

- There's no love like before... It's like they've set intimacy aside... It's like we older guys are looking for it, but with the newbies it's just sex, sex sex, no fidelity, then see you later... Sex, fucking, drugs. *Pos, 50+, MTL3*
- -There's a lot of selfishness. Pos, <35, MTL3

What surprises me about the discussion is how much judgment there is. Neg, <35, MTL1

Shared responsibility?

Some of the gay men noted that negotiation of risk reduction was something that must be shared and discussed as equal partners. Another perspective on shared responsibility was that each person should have the autonomy to decide for themselves what risks they're willing to accept, do their due diligence, look out for themselves and get educated.

Even if I'm undetectable, it's not my decision about having sex with condoms. There are two people in the room having sex. It's not only my decision. *Pos*, 50+, VAN3

- I have no problem using a condom... but if the guy doesn't mention it... *Pos*, <35, *MTL3*
- It's as much his concern as yours. He's as guilty as you are. It takes two. *Pos*, *50*+, *MTL3*

In the quotes below, the idea of individual responsibility is expressed differently. In one case, the sentiment was that the other person needed to look after himself. In the other case, an individual must place responsibility upon himself to do everything in his power to protect himself, and interestingly, in the context of a relationship.

I've done my due diligence. I told you I'm HIV-positive... How you digest my status, I don't care. I hate to sound selfish but everyone needs to be looking out for themselves. *Pos*, *50+*, *TO3*

In my doctor's opinion, theoretically it wouldn't even be necessary for me to be on PrEP because my partner is undetectable. But I'm the one who chooses to use it. I want the added safety... If it didn't work after six months, a year or two years, I wouldn't want to resent him for infecting me or to resent myself for not having done everything I could to protect myself to the best of my knowledge.

Neg, 35-49, MTL2

(Reluctant) peer educators

Participants described (willingly or reluctantly) taking on the role of peer educators or acting as a moral compass, in the face of their sexual partners' lack of awareness around basic or complex concepts related to risk, transmission and prevention.

'What's up with that? How is it transmitted?' Hey, listen, it's 2014, wake up! You can educate yourself on the Internet... There are documentaries that will explain everything to you... *Pos*, 50+, *MTL1*

When I get to the point where I have to explain to someone the risks and give them the sheet that my doctor gave me, all of my sexual fun is already gone and I'm in the educator mode.

Pos, 50+, VAN2

I don't always want to explain what PrEP is and Truvada and HIV and undetectable to some guy I just want to suck my dick [group laughter]. Straight up. *Pos*, 35-49, TO1

Extra burden on poz men

Some of the gay men living with HIV made special note of the elevated responsibility they shouldered for ensuring that they don't pass HIV to others. For some of the poz men, disclosing their HIV status was the full extent of their responsibility. The quotes below illustrate the extra burden that some positive men felt, but also a certain resentment.

I feel like a gatekeeper in a way... Now they're talking about undetectable viral loads. Still, I wouldn't want to put a negative guy at risk.

Pos, 50+, VAN2

If you're with a negative partner you're actually doubly careful and that's not necessarily a bad thing. But at my age I find it exhausting. *Pos*, 50+, VAN2

- I would never feel guilty. I have a friend who always says 'you know, we're murderers.' Well you can eat shit! I'm no murderer! If I were to kill somebody, I'd do it with a weapon, not my ass. You understand? Maybe you're a murderer because you've had it for 30 years. My friend has had it for 30 years. And he's always thought of himself as a murderer. Well you're fucked in the head! *Pos*, 50+, *MTL3*
- Yikes, okay, that's intense! Pos, <35, MTL3

WHAT WE HEARD FROM GAY SERVICE PROVIDERS ABOUT THEIR DUAL ROLE

Service providers working in HIV prevention and gay men's health —many of them gay men themselves—have privileged access to emerging information about HIV prevention. We explored how these gay service providers grappled with this new biomedical HIV prevention information, while occupying a "dual role" as service providers and as members of the very same community that they serve. The following themes emerged: the challenges of separating personal and professional lives; the impact of having access to new and emerging HIV prevention information on fear and risk-taking behaviours; how they conveyed this information differently to their clients vs. friends vs. sexual partners; and how insider subjectivity and reflexivity influenced their work.

Separating professional and personal lives

Gay service providers described the challenges of trying to "disconnect" from work, and to separate their personal and professional lives. They felt that they were, and should be, held to a higher standard of HIV risk reduction, a standard that was not just an expectation from community members, but also from other service providers.

I had sex with this guy, and then you cannot just like, no I'm not going to give out any information. SP, 35-49, CBO, TO
[Q: So next thing you know you're doing an intervention.]
-Yes. It's unintentional but I still do it anyway. I struggle with that for a few years of working in this field. SP, 35-49, CBO, TO

It's a small world. I can't go out in my own city without seeing one of my clients somewhere, turning on Grindr... In another city I can go crazy and be up on a stage twirling my shirt around and not give a fuck. I am and can be a professional but I can also be a gay man in his 20s living his life to the fullest. They cross lines a lot. *SP*, <35, *GMHO*, *MTL*

People hold us to a certain standard. Sometimes they forget that we too are just gay men that want to fuck. I mean I'm no saint. I'm not perfect when it comes to condom usage or 100% adherence... I can make mistakes. I can be under the influence. All the things that are factors for the people that I work with are factors for me as well... I hate being held up to this golden standard and then sometimes the disappointment people might have when this standard wasn't upheld. *SP*, <35, *GMHO*, *MTL*

We had a frontline worker who stood up at a conference and said 'I'm positive, I party and I bareback.' A lot of people were applauding as opposed to confronting it at all. It was just the reaction that really freaked me out. This is somebody who was doing outreach work at an ASO. They were very, very cavalier about it... But then everybody is kind of silent for whatever reason to not say, 'well let's talk about that; what you just said might be OK for you but as a worker is it OK to give those messages?' I mean what I do in my personal life is my personal life. But what I have to do in my professional life is my professional life. I have to be very careful. I'm accountable to a higher whatever right because of our position here. *SP*, 50+, *CLIN*, *TO*

Impact on fear and behaviours

For some gay service providers, stress and fear increased as they were initially exposed to more information. However, their growing understanding of HIV risk eventually eased that fear. Many of the gay service providers noticed that working in the HIV sector led to an increase in what they used to consider risk behaviours, but believed that these were now more "calculated" risks, more grounded in facts than "paranoia," and about which they felt more comfortable.

In the beginning I was more panicky. Getting notices from public health about a rise in... LGV [Lymphogranuloma Venereum] or things like that. It's a lot of information to absorb and I was young in the community... Later on I think it had the opposite effect. There's not much that impresses anymore. OK. It's like that, what else?... it's about finding balance between safety/health/information and pleasure. SP, <35, GMHO, MTL

Knowledge is power. I just feel more safe because I know that I'm fully aware of most of the consequences of my actions. SP, <35, GMHO, VAN

I'm much more relaxed about the issue of risk... At the least I would say that I take more risks, but in reality it's just that I calculate a bit more. *SP*, <35, *GMHO*, *MTL*

Some gay service providers described their sex lives as getting worse, and some as improving, as a result of their work.

I used to have a lot of fuck buddies and then when I started doing [HIV work] I lost them all... I think that was the anxiety and the fear of sex. I had no interest in sex and I viewed sex as lethal. Yeah, a deadly thing. *SP*, 35-49, *CBO*, *TO*

I like to think that my own personal and sexual life is enriched because of the work that I do. I can make a lot more informed decisions. SP, <35, GMHO, MTL

Before... I always had a belief that I probably prefer not to sleep with someone who is known HIV positive... Since working in the field that belief has completely been squashed. I don't choose my sexual partners based on their HIV status anymore. SP, <35, GMHO, VAN

Talking to clients versus friends versus sexual partners

Gay service providers generally found that the factual information they provided regarding HIV risk remained the same, regardless of whether they were talking to clients, friends or sexual partners. However, they were more likely to give more nuanced information and personal opinions to friends. Some participants lamented that they treated everyone the same, saying they had difficulty disconnecting their professional and personal lives. Finally, some gay service providers felt a responsibility to use their privileged access to information and professional credibility to challenge stigmatizing attitudes and to help other gay men in their community to make healthy decisions.

How PrEP works, it's the same regardless of whether you're talking to someone that you're working with or with a friend. SP, <35, GMHO, MTL

Unfortunately, I treat it the same way because I have trouble letting go...I'm equally as intense with everybody...my sexual partners, my friends and the people I meet at the clinic. *SP*, <35, *CLIN*, *MTL*

When it comes to clients, I will never tell them what to do. When it comes to my friends though... sometimes I will take that liberty of being like 'listen you should do this'... When it comes to people I am working with... I make sure they have the information they need to know to come to their own proper decisions. SP, <35, GMHO, MTL

With a client there's an ethical and legal element, so I tell myself I need to protect myself and not express my opinion too much. SP, <35, CLIN, MTL

To a client I might say something like 'there are conflicting reports.' To a friend or a partner I probably would be a bit more on the advocate side and say well the evidence is quite strong that treatment has a very strong effect on transmission. SP, <35, PSYC, VAN

Insider subjectivity

Gay service providers described bringing insider perspectives to their HIV prevention work, sometimes directly referring to a practice of reflexivity as they described the role that their own life experiences played in the kinds of judgments they made and advice they provided to their clients.

There's been a few committees and stuff where I'm told 'you need to be an objective gay man.' I'm like well no, that's not actually my job. My job is to be a subjective gay man doing this job. I think that's definitely very important. SP, <35, PSYC, VAN

We made promises to ourselves, 'I'll never do this again. If my test comes back negative I promise to whatever God, I will never bareback again.' And then guess what. You go back into the same cycle. [laughter] We can laugh at it now because we're slightly smarter maybe... But that's a good learning process as well. It's important to go through that stage. So that you don't become complacent, that you just become separate from the work that you do. *SP*, 35-49, CBO, TO

APPENDIX A FOCUS GROUP AND INTERVIEW GUIDES

Focus Group Guide for Gay Men

Preamble

- Resonance project background: research team members and organizations, objectives, and desired outcomes.
- Review consent form
- Completion of brief intake survey to collect demographic information
- Introductions

Part 1 - Warm-up question. 15 minutes.

- 1. What are some of the ways that gay men in this community meet other guys?
- a. Prompt if needed: How does that differ if it's meeting guys to socialize, or for possible dates, or for sex?

Part 2 - Vignettes: profile, hook-up, dating (for sero-disc. use LTR instead of dating). 60 minutes minimum.

I'm going to show you a few images and brief scenarios, and ask you to comment on them. [Show one image/scenario at a time, then ask the following questions.]

Online profile

- 2. What comes to mind when you see this profile?
- 3. What questions does it raise for you about the risk of HIV transmission?

Prompts as needed:

- a. What do you think this guy is communicating about himself in his profile?
- b. What do you think he's looking for?
- c. Is there anything that you don't understand, or that strikes you as maybe a contradiction?

Hook-up scenario

- 4. What comes to mind when you read this?
- 5. What questions does it raise for you about the risk of HIV transmission?

Prompts as needed:

- a. If you were Chris / Franck / Paul / Guillermo in this scenario, how would you react?
- b. How worried would you be about the risk of HIV transmission? Why? Why not? How did you come to that conclusion; what is your reasoning?
- c. What are the things in this scenario that would make it more likely that you'd worry? Less likely?

Dating scenario - for FG1, 3 and 4

- 6. What comes to mind when you read this?
- 7. What questions does it raise for you about the risk of HIV transmission?

Prompts as needed:

- a. If you were Robert / Joseph in this scenario, how would you react?
- b. How worried would you be about the risk of HIV transmission? Why? Why not? How did you come to that conclusion; what is your reasoning?
- c. What are the things in this scenario that would make it more likely that you'd worry? Less likely?

LTR scenario - for FG2

- 8. What comes to mind when you see or read this?
- 9. What questions does it raise for you about HIV risk?

Prompts as needed:

- a. If you were David / Thomas in this scenario, how would you react?
- b. How worried would you be about the risk of HIV transmission? Why? Why not? How did you come to that conclusion; what is your reasoning?
- c. What are the things in this scenario that would make it more likely that you'd worry? Less likely?

Part 3 - Specific biomedical topics, using headlines and targeted questions as needed, if the topics have not come up already

There has been a great deal of new scientific information in the last few years about HIV risk, transmission and prevention. Maybe you've heard of some of them. I'm going to pass around headlines from actual articles. I'd be curious to hear what you think about these.

[Circulate headlines as needed (TasP, PrEP, testing, cure), asking the following questions after each.]

- 10. Have you seen headlines like this before? When you see this list of news headlines, what do you think they're talking about?
- 11. Do you take the information referred to in these headlines into account when you make decisions about sex? If so, how? If not, why not?
- 12. What questions do these articles leave you with—what isn't answered that you might want to know?

[Prompts as needed, if the following topics have not already come up.] Have you heard of the following term or idea? [Read one at a time as needed]

- PEP or post-exposure prophylaxis
- the idea that HIV can be passed on more easily right after you're first infected (acute or early HIV infection)
- choosing who will top and who will bottom based on things like the HIV status of both sexual partners.
- the idea of only having sex without condoms if both people have the same HIV status
- research into vaccines that can reduce the risk of becoming infected with HIV
- 13. What are you hearing about these topics? Where are you learning about this?
- 14. Do you take this into account in decisions about your own sexual activities? How?

Part 4 - Closing. 15 minutes.

- Thank participants
- Reminder re: confidentiality
- Sign-up for receiving project report
- Hand out information sheets with more information regarding biomedical prevention strategies and weblinks, and contact information for local organizations

Meeting in a sauna

Chris and Paul have both been playing around at a local sauna for a couple of years. They have noticed each other before, but haven't played together yet. One night, when Paul sees Chris on his own in the sauna, he mentions he has a private room. They go back to Paul's room. There is no discussion of HIV status between them as they drop their towels and get on the cot, fool around, and eventually start to fuck. Paul bottoms, Chris tops. They don't use condoms. After the sex, Paul says something about being undetectable. A few days later Chris realizes that Paul is HIV-positive and wonders if he should get PEP and how soon he can get tested.

Meeting at a community event

Franck offers Guillermo a lift back home. Guillermo invites Franck up to his place for a drink. Three minutes after they are in the apartment, they know they both want some hot bare sex. When Franck asks "are you clean?", Guillermo says yes and that he's using a new HIV prevention strategy called PrEP where he takes an HIV pill every day and it prevents HIV infection. Franck has heard about PrEP but doesn't know much about it.

Dating

Robert and Joseph hooked up at a mutual friend's birthday party a couple of weeks ago. They hit it off and are on their third date, and things have been going well. They are very attracted to each other. By the end of the evening, they end up at Robert's place and it looks like things might be moving to the bedroom. They've been having sex and have used a condom every time. Robert tells Joseph he wants to do it bare and that he was just tested a month ago. He suggests they both go for rapid testing. Joseph agrees. A week later they go to the clinic together and the test results are negative, so the guys decide to fuck bare.

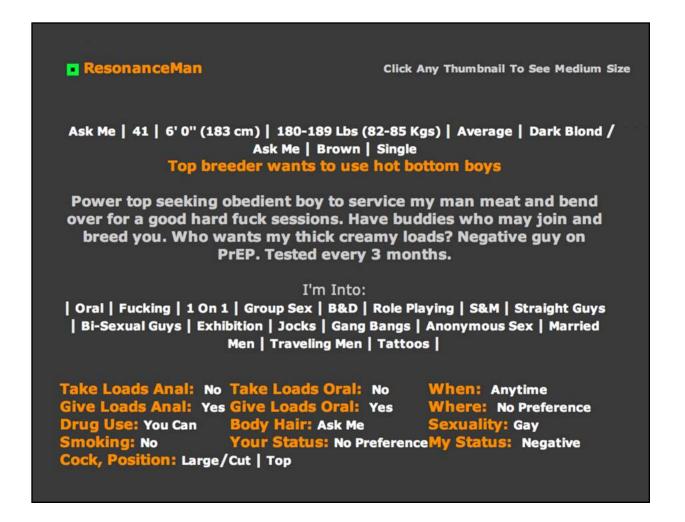
Long-term relationship

David and Thomas have been seeing each other for several months. They call each other boyfriends and have an open relationship and it has started getting serious. Thomas has been poz for 4 years and on treatment for 3 years, and he has an undetectable viral load. David's last HIV test was negative. They've both been wondering about whether they still need to use condoms within the relationship, and whether David should start to use PrEP. The sex is hot and they have lots of it. David only wants to start PrEP if it means that he and Thomas can have condomless sex. David says that he is very comfortable dropping the condoms because Thomas has been undetectable for years, plus he'd be on PrEP. But for Thomas the possibility of infecting his partner weighs heavily.

Mock Hook-Up Profile 1



BBRT (Bareback Realtime) profile



Craigslist ad

CL > vancouver, BC > vancouver > personals > casual encounters

Reply to: craigslist reply address will appear here

Posted: 2013-06-04, 2:52PM PDT

TIGHT horny cumdump for HUNG Top - m4m - 33 (dt area)

In shape discreet masc bottom guy here in a jockstrap ready to take a Massive cum-filled Cock.

Anonymous scene. Hosting right now

Undetectable. NO PNP/STD & DRUG-FREE. UB2

8+ Dudes Only. Uncut+++ I wanna feel ur skin sliding on your cockhead when you fuck me. Big Shooters+++

- · Location: dt area
- · it's NOT ok to contact this poster with services or other commercial interests

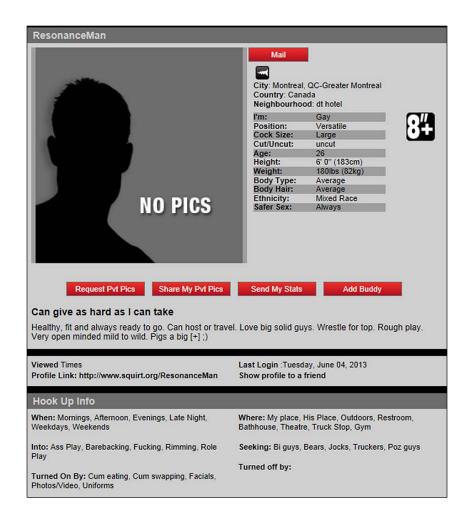
Posted: 2013-06-04, 2:52PM PDT

email to a friend

Mock Hook-Up Profile 3



Squirt profile



Headlines regarding treatment as prevention:

Early HIV therapy sharply curbs transmission

Treatment is prevention: HPTN 052 study shows 96% reduction in transmission when HIV-positive partner starts treatment early

HIV study hailed as biggest 2011 breakthrough: Findings indicated antiretroviral drugs can dramatically halt HIV transmission

Clinical trial showing drugs as effective as condoms at preventing HIV is declared breakthrough of 2011

UK experts: successful treatment is "as effective as consistent condom use" in reducing HIV transmission

Challenges of treatment as prevention for gay men: Nearly all participants in the HPTN 052 study were heterosexuals

Headlines regarding PrEP:

Daily pill helps prevent HIV infection in men: Study first to show pills prevent HIV in uninfected people, 70 per cent protection rate

Daily pill greatly lowers aids risk, study finds

Two studies show pills can prevent HIV infection

U.S. FDA approves HIV-prevention pill

Lack of success terminates study in Africa of AIDS prevention in women: Daily pill did not work

AIDS prevention pill has its critics: Researchers concerned medication could lead to false sense of security among high-risk populations

PrEP: PK modeling of daily TDF/FTC (Truvada) provides close to 100% protection against HIV

Headlines regarding rapid HIV tests and home tests:

Rapid point-of-care HIV tests approved for use in Canada

Offering rapid point-of-care tests would increase uptake of HIV testing

Rapid point-of-care test as accurate as standard test, but still same window period

FDA approves 1st rapid take-home HIV test

Will gay men use over-the-counter rapid HIV tests to screen sexual partners?

HIV home tests – how will they be used?

Headlines regarding a cure for HIV:

Baby born HIV-positive apparently cured, say scientists: 'About as close to a cure' as science has seen, says doctor

Fast HIV treatment a step towards 'functional cure': French researchers find 14 patients achieve 'long-term infection control'

More HIV 'cured': first a baby, now 14 adults

A cure for HIV is now a realistic possibility

Misleading news reports suggest HIV cure is near

After Berlin Man, two reported cured of HIV in Kenya

Focus Group Guide for Service Providers

Preamble

Resonance project background: research team members and organizations, objectives, and desired outcomes.

Review consent form

Completion of brief intake survey to collect demographic information

Introductions

Questions

- 1. What kinds of information around HIV risk, transmission and prevention are gay men asking for or are interested in?
- 2. What are some of the difficult questions gay men are asking and that you have a hard time answering?

There has been a great deal of new scientific information in the last few years about HIV risk, transmission and prevention. Maybe you've heard some of the following terms and ideas.

- viral load, undetectable viral load
- treatment as prevention, or the impact that giving HIV-positive people HIV medication has on the risk that HIV will be transmitted
- PrEP or pre-exposure prophylaxis
- PEP or post-exposure prophylaxis
- the idea that HIV can be passed on more easily right after you're first infected (acute or early HIV infection)
- seroadaptive behaviours, seropositioning and serosorting—which includes things like deciding who will top and who will bottom based on the status of both sexual partners, and the idea of only having sex without condoms if both people have the same HIV status.

- new and emerging testing options like home-based testing and rapid testing
- examples of people who have been cured of HIV, and research into cures
- research into vaccines that can reduce the risk of becoming infected with HIV
- 3. What are you hearing from gay men about these issues?
- 4. Where do you think gay men are getting their information from? What would you say about how reliable those sources are?
- 5. Do you think gay men are applying this information to their sex lives, and in their decisions about risk? How so?
- 6. What are good ways for this information to be provided to gay men in your community?
- a. What kinds of strategies do you use to communicate new information about HIV and sexual health to gay men in your community? Campaigns? Booklets? Educational sessions? In-person counselling?
- 7. What are the constraints or supports that you encounter with respect to your organization (funding, policies, attitudes, training, etc.)?
- a. What helps you and makes you more comfortable communicating this kind of information?
- b. What kind of support do you feel you need within your organization to start talking more about new information and prevention strategies?
- c. Where do you look for reliable information on HIV risk, transmission and prevention?
- d. Are you able to find the information you need to feel confident about answering these questions from gay men in your community?
- e. What topics have you found most difficult to find information about?

Interview Guide for Gay Men

- 1. Can you tell me a little bit about yourself? Where do you live, what do you do, where did you grow up, etc?
- 2. Where do you go for HIV information? What are some of the sources you use for information on HIV and risk of transmission?
- 3. What are the main messages you're hearing these days about HIV and risk of transmission?
- 4. Can you tell me a little bit about what you think risk is in terms of sex and HIV?
- a. What are risky things?
- b. How do you decide what amount of risk you are comfortable with?
- 5. Can you tell me about a time when you had to educate someone you were having sex with about HIV?
- a. What did you tell them?
- b. How did it affect the sexual encounter?

There has been a great deal of new scientific information in the last few years about HIV risk, transmission and prevention. Maybe you've heard some of the following terms and ideas.

- viral load, undetectable viral load
- treatment as prevention, or giving HIV-positive people HIV medication to control the virus, making it less likely that HIV will be transmitted

- PrEP or pre-exposure prophylaxis
- PEP or post-exposure prophylaxis
- the idea that HIV can be passed on more easily right after you're first infected (acute or early HIV infection)
- choosing who will top and who will bottom based on things like the status of both sexual partners.
- the idea of only having sex without condoms if both people have the same HIV status
- new and emerging testing options like home-based testing and rapid testing
- examples of people who have been cured of HIV, and research into cures
- research into vaccines that can reduce the risk of becoming infected with HIV
- 6. Do you feel like any of this new and emerging information about HIV risk, transmission and prevention is having an impact on your sex life and prevention strategies? How?
- 7. What strategies are you using to manage risk?

Interview Guide for Clinical/Public Health Service Providers

- 1. Please tell me about the work you do in gay men's sexual health.
- 2. What kinds of information around HIV risk, transmission and prevention are gay men asking for or are interested in?
- 3. What are some of the difficult questions gay men are asking and that you have a hard time answering?
- There has been a great deal of new scientific information in the last few years about HIV risk, transmission and prevention. Maybe you've heard some of the following terms and ideas.
- viral load, undetectable viral load
- treatment as prevention, or the impact that giving HIVpositive people HIV medication has on the risk that HIV will be transmitted
- PrEP or pre-exposure prophylaxis
- PEP or post-exposure prophylaxis
- the idea that HIV can be passed on more easily right after you're first infected (acute or early HIV infection)
- seroadaptive behaviours, seropositioning and serosorting which includes things like deciding who will top and who will bottom based on the status of both sexual partners, and the idea of only having sex without condoms if both people have the same HIV status.
- new and emerging testing options like home-based testing and rapid testing
- examples of people who have been cured of HIV, and research into cures
- research into vaccines that can reduce the risk of becoming infected with HIV

- 4. What are you hearing from gay men about these issues?
- 5. Where do you think gay men are getting their information from? What would you say about how reliable those sources are?
- 6. How do you think gay men are applying this information to their sex lives, and in their decisions about risk? How so?
- 7. What information do you provide about how to keep abreast of the new and emerging information on HIV transmission, risk and prevention?
- 8. Where do you go to find (or what sources do you find most reliable in looking for) reliable information on these topics?
- 9. What excites or concerns you about providing information on new and emerging knowledge about HIV transmission, risk and prevention?
 - a. What helps you and makes you more comfortable communicating this kind of information
 - b. What information do you need, and from whom, in order to feel comfortable talking to clients about something new related to HIV and HIV transmission?

Interview Guide for Gay Service Providers

- 1. Please tell me about the work you do in gay men's sexual health.
- 2. What kinds of information around HIV transmission, risk and prevention are gay men asking for or are interested in?
- 3. Do you think gay men are applying this information to their sex lives, and in their decisions about risk? How so?
- 4. What are some of the difficult questions gay men are asking and that you have a hard time answering?
 - a. Why do you find those questions so difficult?
- 5. Is there a difference in the way you talk about HIV or sexual health information with your friends/sexual partners versus with your clients? How so?
- 6. How has the information that you learn through your work influenced your personal decision making around HIV risk and prevention?