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Individual Responsibility Concerning HIV Transmission Among MSM: A Comparative Study of the Effectiveness of NGO Intervention Policies and Their Practical Applications Within the United Kingdom, Australia, and the Netherlands

Martha Kienbaum
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**Individual Responsibility
Concerning HIV Transmission Among MSM:**

A comparative study of the effectiveness of NGO intervention policies and their practical applications within the United Kingdom, Australia, and the Netherlands

“We need to break the silence, banish the stigma and
discrimination and ensure total inclusiveness
within the struggle against AIDS.”
Nelson Mandela

Martha Kienbaum
Fall 2006
School for International Training
Amsterdam
Project Advisor: Tobias Dörfler
Academic Advisor: Ginni Fleck

Abstract

This study investigates the complexities involved in utilizing the terms of individual responsibility for the construction of HIV prevention campaigns that target men who have sex with men. Four health workers in the Netherlands were interviewed about their personal opinions regarding HIV intervention, and these interviews were analyzed qualitatively for their points of comparison and contrast. Then, campaign materials from organizations in the United Kingdom and Australia were analyzed for their use of the language of responsibility, their portrayal of MSM, their balance between promoting disclosure and communication, their focus on individual groups within the MSM community, and their overall deployment of either a liberal or normalistic approach to prevention. Results include the reality that even when the problems are made known through research, it is very difficult to create effective and realistic methodologies for intervention. One theme that arose from this study is that prevention campaigns need to provide a general message to MSM concerning communication, testing, and responsibility before any tailored messages are expressed. Additionally, it became clear that fear, stigma, and assumption-making are important targets for ‘responsible’ prevention work in the Netherlands.

Key Words: HIV/AIDS, male, sexuality, policy, health care

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Table of Contents

I.	Introduction_____	3
II.	Literature Background and Theory_____	5
III.	Methodology_____	12
IV.	Interview Analysis_____	16
V.	Campaign Analysis	
	United Kingdom_____	27
	Australia_____	35
VI.	Conclusions and Recommendations_____	41
VII.	Works Cited_____	45
VIII.	Works Referenced_____	49
IX.	Appendix A	
	Initial Letter to Interviewees_____	50
	Interview Guide_____	52
	Prefaces to Email Questionnaires_____	53
	Transcription of Interview I_____	54
	Transcription of Interview II_____	63
	Transcription of Interview III_____	71
	Transcription of Interview IV_____	80
X.	Appendix B	
	example I: “Responsibility” poster (sauna), GMFA, U.K.	
	example 2: “Think Again” photo poster (kiss), THT/CHAPS, U.K.	
	example 3: “Think Again” photo poster (bed), PLWHA, Australia	
	example 4: “Think Again” graphic poster, PLWHA, Australia	
	example 5: “Sensations” photo poster, ACON, Australia	
	example 6: “Mates” photo poster, ACON, Australia	
	examples 7 & 8: “Staying Negative” posters, VAC/GMHC, Australia	

Introduction

My academic intention is to research how different non-governmental organization (NGO) campaigns that target men who have sex with men (MSM) employ the terms of individual responsibility for HIV/AIDS prevention. This study includes a special focus on existing programs in the United Kingdom and Australia, as compared with the developing programs in the Netherlands. More specifically, I look into what varies among the campaigns' strategies depending on their direction toward HIV negative (hiv-) MSM as opposed to HIV positive (hiv+) MSM; I also analyze how these differences are reflected in campaign paraphernalia and literature, in order to evaluate how each campaign is effective and/or fails to reach its intended goals. Then, as a final task, I provide my informed opinion on which approach seems the most effective for MSM in the Netherlands.

The significance of my research is to produce and gather together comparative materials that can be used to guide Schorerstichting's policy planning for 2007. The Schorer foundation receives government-subsidized funding from the Ministry of Health to address the MSM community in the Netherlands. Since about 50% of those people treated each year for HIV/AIDS are men who contracted the virus through sex with other men, both relational and intercultural research is imperative for Schorer's enduring, local utility. I researched campaigns in the United Kingdom and Australia because these countries have taken more steps in integrating responsibility within their prevention interventions; therefore, I felt that the most effective comparison would result from interviews with Dutch health workers and an analysis of foreign campaigns materials.

In this paper, there is presented detailed background information about the politics of language in terms of HIV transmission campaigns that target MSM. Additionally, there is information about the conceptual theory of responsibility as it has been understood through the development of the AIDS movement since the 1980s. This is followed by the description of accumulated campaign materials, which are then analyzed through comparison with interviews conducted in the Netherlands. Finally, my opinion is presented as conclusion. Included in appendices are the letters written in preface to my interviews, the interview questions I used as a guide, some visual examples of the campaign materials I analyzed, and literal transcripts of the interviews themselves.

My interest in this subject began with a long-term concern for the complex state of public health, especially in terms of the global AIDS epidemic; specifically, I have been motivated by a deep sensitivity toward the issues surrounding sexual health education and outreach. It is my hope that the challenge of having worked with these issues will eventually serve to benefit the Dutch MSM community and policymakers in the Netherlands in some way in the future.

Literature Background and Theory

Overall in the Netherlands, in 2005, 12,059 people were registered and in treatment for HIV/AIDS, including 9,524 men (cf. de Wolf, 2006). 68.6 percent of this majority of men reported having contracted the virus through sex with other men; furthermore, 73.7 percent of these men were of native Dutch origin (cf. de Wolf, 2006). Alarming, “the majority of new HIV diagnoses are in MSM” (de Wolf, 2006). While the average of MSM who have ever been tested for HIV has continuously risen over the

last years, from 42 percent in 2000 to 60 percent in 2006 (cf. Hospers, 2000, 2006), the Netherlands still has one of the lowest testing averages for MSM in the western world (cf. Mikolajczak, 2003). Additionally, before the introduction of effective viral treatment options in 1996, the official health policy in the Netherlands was to not encourage, and otherwise to discourage, HIV testing for the general population (cf. Kok, 1999).

Most health workers will admit that there will always be (and have always been) men engaging in unprotected sex; however, their ultimate goals are to persistently encourage men “to realize under which conditions this option is safe” (-----, 1998) and, equally, to educate men about how to monitor themselves and react appropriately when the conditions are unsafe. As one theorist has stated, “personal rationalizations around sexual risks are worldwide phenomena” (Blakenship, 1998), affecting everyone who chooses to be sexual, including, but not limited to, MSM.

In reality, HIV/AIDS killed people before it became appropriate to look to the future of the virus; therefore, only now does prevention have the time, along with the necessary funding in the Netherlands, to tackle the real social issues associated with HIV at the local and, increasingly, individual level. Currently, two of the greatest barriers to effective prevention interventions that target MSM are “prevention fatigue” and “disinhibition” (DiPietro, 2006). MSM who are close to the gay community that first suffered from the epidemic are understandably tired of the issue; on the other hand, MSM who remain distant from this community often misjudge the severity of HIV’s consequences. Moreover, it has been argued that fewer “visible reminders of the deadly consequences of AIDS” (-----, 2002) have led to the increasing apathy of young MSM. In

society as well, I assume that systematic and standardized homophobia and heterosexism only make matters worse.

It is common sense that HIV testing, condom use and counseling are among the most effective methods for preventing HIV transmission (cf. Marks, 1999). However, the issue becomes extremely complicated within the MSM community. For example, testing for HIV includes the possible challenges of both “establishing one’s positive HIV status...[and then] coping with a positive result” (Keogh, 2006). Also, because HIV was first stigmatized as the “gay disease”, men who either identify as ‘gay’ or men who have sex with other men bear the brunt of the virus’s social implications. Since the introduction of HAART (highly active antiretroviral therapy) in 1996, it is a fact that there are now more men living with HIV who can potentially transmit the virus (cf. DiPietro, 2006). Whether or not this fact has an effect on unsafe sex rates among MSM, the issue creates more discrimination and resentment in society, which needs to be tackled by prevention campaigns. In my opinion, for MSM, a lot of the associated stigma is neither based on reality nor on the sexual identities of those who are living with HIV; rather, social scape-goating and the widespread lack of person-sensitive education leave space available for discrimination. On one level, I understand the stigma surrounding HIV and MSM as extending only as far as the virus remains a mystery.

I believe that it is therefore necessary for organizations that target MSM to remain vigilantly aware of the community’s unique history. For me, inciting men who have sex with men, including those who don’t identify as gay, to practice individual responsibility is an integral and fragile tenet of any ‘responsible’ intervention. However, it is very difficult to gather first-hand reactions from MSM about the best ways to frame

responsibility; sexual object-choice and personal health are both socially guarded and personally sensitive areas for interrogation. Simply asking a man who has sex with men to analyze a campaign's employment of 'disclosure' tactics is, simultaneously, to force him to disclose his privacy in a public forum.

The category of MSM has its own historical context, which explains its widespread, modern implications. MSM are an otherwise marginalized group in most societies. Thereby, the term 'MSM' was first put into discourse as a neutral substitute for 'gay' or 'homosexual', terms which are "too charged with stigma and political connotations" (DiPietro, 2006). Overall in the Netherlands, "public reactions to people with HIV/AIDS seem to be moderately positive" (Bos, 2001); thus, the biggest challenges for prevention in Holland appear to be centered within the MSM community itself.

Individual responsibility is a terribly complicated concept. Within HIV/AIDS prevention, a discourse full of contrasts and contradictions has compounded the general issue of public health. In my studies, it has been easiest to understand responsibility in four steps: open communication, disclosure or nondisclosure, consent and agreement, and the final resolve to stick to one decision. I believe that once sex is something worth talking about openly, the first step toward safe sex has been mastered. Disclosure, although "not a preventive behaviour in itself" (Kok, 1999), is treated as an important method for promoting negotiated safety between partners, especially those who could be sero-discordant. Disclosure is more about "the right to know" (Serovich, 2003) for all involved parties; therefore, it has been framed as something that can benefit the other, over and above the self.

Since “what constitutes being ‘safe’ is highly subjective” (Keogh, 2006), it is most important to negotiate safety by taking the others person’s assumptions and goals into account. The proven limitations of self-interest motivations in sexual health promotion have given rise to this theory of “other-sensitive motivation” (Nimmons, 1999), which expresses itself through men’s “felt ethical, moral, altruistic, social responsibility, or spiritual imperatives” (Nimmons, 1999). However, only when the benefits of disclosure outweigh its personal costs can honesty about HIV status be construed as a personal, rather than moral, duty.

There is often little incentive for HIV positive men to disclose their status to casual partners. Disclosure is a risk in every instance by attaching “certain moral attributes (good or bad) both to the person who imparts the information and the person who receives it” (Keogh, 2006). In some cases, simply “using a condom can disclose HIV-positive status...without saying it” (Interviewee in Serovich, 2003). Often, the man who receives the disclosure mishandles the information, rewarding the original honesty with fear, disgust, and rejection; this common issue of avoidance has even been described as “AIDS apartheid” (Shernoff, 2001).

Thus, some MSM become part of the stigmatizing general population, which is quick to label any HIV positive sexuality as “inappropriate, irresponsible, or even criminal” (DiPietro, 2006). The HIV negative man assumes that it is up to the HIV positive man to protect him, and the HIV positive man further becomes the ‘other’ (cf. Keogh, 2006). It is no surprise, then, that for some HIV positive men, responsibility can act as a “barrier to intimacy” (Keogh, 1998), especially when individuals “establish themselves as moral actors by comparing their own actions with those of seemingly

immoral actors” (Keogh, 2006). Therefore, and most importantly in this respect, HIV prevention should never be an “anti-sex movement” (Blakenship, 1998); sex itself has been shown to “boost the immune system” (Blakenship, 1998). I believe that HIV status needs to be treated as just one aspect of ‘gay’ diversity for MSM. It is too often assumed that HIV positive people obtain the virus through promiscuous or ‘irresponsible’ acts, which they are then likely to repeat in the future. However, it is proven that, in general, neither “ignorance, nor obstinacy, nor irresponsibility” (Adam, 2005) is what causes men to practice unsafe sex.

Some theorists are content with the idea that “health promoters can provide information that might supplement decisions around sexual practice but have little impact on determining decision making around those practices” (Grierson, 2006). Other theorists believe that the key to success is supporting “men in engaging their own processes and clarifying their own values in deciding what is right for them” (Wright, 1998). The latter, liberal approach to prevention disseminates critical information in order to empower men to decide for themselves how to engage their awareness of the facts in bed. Adverse to this noninterventionist method, there co-exists a normative or moralistic approach to prevention, which utilizes scare tactics in an attempt to force MSM into the reality of their social and sexual situation. This discourse highlights “the source of infection...[as] the body of a gay man who is infected” (Keogh, 1998), and is apt to incite responsibility as either the greater duty of the HIV positive man or as the shared responsibility of the partnership. However, it has been shown that “AIDS-related fears are not sufficient to motivate the adoption of safe-sex practices” (Bell, 1999). For me, a balance between these two approaches seems optimal.

Within prevention strategies, there is a vast difference between targeting HIV positive men and HIV negative men. Not only are these two groups separated by the polar extremes of viral status, they are also implicated in different ways by society. Both the social and institutional differentiation between positive and negative “is necessary in order to negotiate not only sexual risk, but social and emotional interaction” (Keogh, 2006). As most health literature about MSM makes evident, “no prevention intervention can be divorced from its context, because HIV prevention always involves questions of culture, behaviour and identity” (Cairns, 2006). An examination of “the ways in which men’s perceptions of their social surroundings influence how they experience and negotiate sexual risk” (Keogh, 2006) should constitute the first goal of any intervention. Distinct within the MSM community, HIV positive men share the unique experience of coping with their status as well as bearing the brunt of disclosure pressure. Therefore, intentionally focusing materials away from HIV positive MSM, in an attempt to control the stigmatization of positives as *the* guilty party, only furthers the widespread “depersonalization” (Keogh, 1998) of the positive community. Acting on the fear of “victim blaming” (Kok, 1999) is, equally, to assume that an HIV positive status makes the individual into a victim of circumstances or fate.

Each person involved in the sex act will naturally assume certain things about the nature of responsibility and risk. It has been found that “the major determinants of safe and risk-taking behaviour are...similar for HIV-positive and HIV-negative people” (Kok, 1999). Recent studies have also proven that “personal norms (i.e., feelings of personal responsibility)...[are] the most proximal determinant of intended condom use with both steady and casual sex partners” (van Kesteren, 2005). However, HIV positive men and

HIV negative men develop different practical strategies for reducing transmission risk, as well as for negotiating sexual encounters. For me, this implies that HIV negative men should be addressed as a unique group, rather than through the terms of shared responsibility; they require training about how to respond in specific situations, and they need to understand the complication of any partner's open communication. Additionally, I believe that the message to remain negative, which can be provided through older, HIV negative role models, may be more effective than providing information about the drawbacks of becoming positive.

Overall, it appears as if interventions need to “address the social and psychological processes that give rise to risky behaviour patterns in HIV-infected men” (Marks, 2001). This strategy would not abandon disclosure or responsibility; it could simply make clear the complex environments in which disclosure becomes an issue, and could offer HIV positive men sensitivity tools with which to negotiate their private sexuality. For HIV positive MSM, intersecting the implications of responsibility with facts about the prevalence of unsafe sex has also been shown to be ineffective. Thus, targeting HIV positive MSM with a long-term perspective and through long-term goals is one method of effectively reducing the language of stigmatization that plagues so much of what is written about the virus (cf. Kok, 1999). Just as both men in a partnership desire active engagement in the sex act with each other, shouldn't both men actively engage with the possibility of HIV being present in the act? An overarching message promoting equal health opportunity, coupled with a message addressing equal risk management responsibility, could be the key to success.

HIV should not and cannot remain “a disembodied threat to a community” (Keogh, 1998), for both at-risk people and those who presume themselves to be safe. HIV prevention for MSM has to embrace the individual experience in its “traditionally disempowered or marginalized” (Keogh, 2006) context in order to succeed in the future. In my opinion, this is the reason why responsibility is so important for current HIV/AIDS campaigns; it is crucial for risk reduction that men accept “the presence of HIV risk in their lives” (Keogh, 2006). The failure to recognize personal proximity to HIV creates space for a “prohibitive social norm” (Keogh, 2006) of secrecy and denial to operate in favor of HIV negative as well as apathetic MSM. Furthermore, this process of denial can work to prevent open communication at the most critical moments. Information regarding the complexity of disclosure, taking into account the diversity of experience and emotion surrounding the issue, is also necessary for an effective HIV intervention (cf. Courtenay-Quirk, 2003). Defined simply, responsibility can imply the authority to make independent decisions; therefore, responsibility can be framed as both a ‘positive’ and affirming “form of active coping” (Kok, 1999) within the MSM community. Overall, it constitutes just one part of the overall strategy and skill that each of us have to construct for our own survival, as well as for the ongoing maintenance of our health and happiness.

Methodology

For me, it was of foremost importance to employ both first and second-hand research in a complete analysis of HIV prevention directed at MSM. By doing so, I was able to properly explore the complex interplay between the intentions and results of each campaign. First, I outlined the theoretical background and intervention goals of the

campaigns in the United Kingdom and Australia through online research and analysis of used NGO materials, without lingering on legal policy surrounding transmission. By comparing intention with my own knowledge and sensitivity, I constructed an idea of each campaign's effectiveness. Beyond this, I gathered first-hand accounts through interviews in English with four health workers in the Netherlands to investigate the specific complexities of promoting responsibility for Dutch MSM. Along the way, I made a conscious decision to complete the literature background and theory section of my paper before starting the interviews, so as not to be swayed in my language by another individuals' opinions. I used the Literature Background and Theory section to ground my ideas in some working definitions, and this process produced more specific research questions, which then better enabled me to conduct and analyze the interviews.

Since I was not in direct contact with the target group of MSM, I didn't expect to encounter difficulties in the interview process. I gained consent from my interviewees by phone calls and emails after identifying them through their involvement with the work of various NGOs. I contacted NGOs in the United Kingdom, the Netherlands and Australia, including Terrence Higgins Trust, Gay Men Fight AIDS, Schorerstichting, HIV Vereniging Nederland, AIDS Fonds, AIDS Council of New South Wales, People Living with HIV/AIDS, and the Victorian AIDS Council / Gay Men's Health Center. Overall, I was able to assume that my subjects were comfortable with the language of my interrogation.

The subjects of my study were never asked to step outside the boundaries of their pre-determined professional positions. However, I hoped to incite self-critique concerning the aims, successes and downfalls associated with the practical construction

and application of intervention campaigns. After I contacted twelve people in the United Kingdom and Australia, only three consented to filling out an email questionnaire, and one went on vacation before he could complete it. I continued to search for alternate email addresses online as well as other people who may have been interested in my topic. At one point, I called Terrence Higgins Trust in the United Kingdom in order to request another participant. After speaking to a secretary there who promised to help, I received an email from her five days later explaining that no one else felt qualified to address my questions about MSM responsibility.

In the end, neither Rod Watson from Terrence Higgins Trust nor Dean Murphy from VAC/GMHC returned a completed questionnaire. However frustrating it was to exert hours of effort in order to obtain personal reflection from organizations in the United Kingdom and Australia, I don't believe that these individuals' opinions would have had a great effect on my analysis. I believe strongly that it would have been both problematic and difficult to draw conclusions about prevention and health care policies in these countries based solely on one person's typed answers.

Fortunately, I was free to honestly introduce myself from the beginning, alongside my complex intentions for critique, through Schorerstichting. Since Schorer directly recruited me at the School for International Training in Amsterdam, I had the trust and respect of an established and successful governmental foundation on my side. The head of the STI/HIV department at Schorer, Minus Altenburg, signed off an introduction written by my advisor, Tobias Dörfler, for my original interview participation request, which informed my subjects of their rights to refuse cooperation as well as to receive a copy of the paper after it was completed. Joyce van Galen Last at Schorer then forwarded

all my emails through her official email account, to give more weight to my message. I retained copies of my subjects' emails of consent, and requested permission to use their names in my analysis when I sent them the questionnaire. Schorer has agreed to make available the results of my study.

While some of my subjects might have considered me to be under-qualified as an undergraduate American student, I was able to frame my questions with comprehensive research so that my real interest and serious intentions were clearly evident. However, I also remained vigilante in monitoring their responses for any oversimplification or silence, and I was politely determined to push for the full disclosure of otherwise complex and difficult issues. On another hand, my subjects might have found that the interview gave them a chance to reflect broadly on their work, while being allowed to include their personal feelings and opinions in an objective way. Hopefully, the fact that I am a non-heteronormative woman attempting to understand the MSM community was not implicated in my professional communications. All of my interviewees in Amsterdam seemed nervous at first about speaking in their second language, but I was able to conduct the interviews in a manageable and understanding way. Thereby, they each relaxed quickly and seemed intrigued by my line of questioning. In analyzing the interviews, I decided to paraphrase a lot of the responses that I integrated into the paper, only directly citing the transcripts when I had to. Each of the paraphrased statements is cited, so as to lead the reader to a specific transcript for more information.

In the end, this methodology produced an extensive essay fore-grounded by Schorer's request for the exhaustive comparison of 'as much information as possible'. Since a lot of my process was the simple collection of information, and most of my

analysis took place at the level of a common, humanistic language, my analytical conclusions should appear logical and founded. Overall, the only drawbacks to any conclusive opinions were my distance from the communities at hand, my determination not to judge any statement as absolute, and my commitment to not assume that I knew too much to be truth.

Interview Analysis

Over the course of a few weeks, I completed four interviews with policy makers and health workers in Amsterdam. I found that each interview quickly became an hour-long conversation about HIV prevention, MSM, and responsibility, and each interviewee provided me with a whole new language to engage in my process of analysis. After initial research into the subject, I had developed my own informed opinions about prevention, some of which were challenged by the personal and professional experiences of these native Dutch health workers. Other opinions of mine were affirmed and, at the same time, put into a more specific context based on the history of prevention efforts in the Netherlands.

I interviewed two employees from Schorerstichting, Bouko Bakker and Minus Altenburg, whose views and ideals for the progress of the foundation's policies differed at times. Due to their specific positions within the organization, Bakker's responses drew upon more experience with policy literature and theory, while Altenburg's answers incited more experience with the MSM community itself. My next interviewee, Antony Oomen, who works for AIDS Fonds, had different opinions based on his experiences with the legal and policy-based side of HIV prevention. AIDS Fonds does not carry out

interventions itself, but translates official policies for general audiences and funds other outreach organizations in the Netherlands, including Schorer. Lastly, my interviewee Robert Witlox's responses specifically represented the HIV positive community, based on his advocacy, education, and outreach work at HIV Vereniging, a patient organization that serves two thousand of the twelve thousand people living with HIV in the Netherlands (cf. Witlox).

All of my subjects agreed that responsibility is an increasingly important and most probably effective tenet for modern prevention campaigns. Responsibility was spoken about generally as an important goal for the individual, a complex issue that is nearly impossible to define, and an effective method for translating knowledge into behavior. Definitions ranged from "appreciating...who you are and what your life is about" (Oomen) and "keep[ing] healthy and...[not] hurt[ing] others" (Bakker), to the fact that care of the self implies care of the other along with the ideal that more emphasis should be put on taking care of the relation, above and beyond protecting the self (cf. Altenburg). It was agreed, however, that responsibility is complex, situational and relational, furthermore presupposing its increased difficulty within casual situations and for HIV positive men. Including responsibility in prevention, therefore, was best framed by encouragement rather than enforcement (cf. Oomen); the first step is then to talk about responsibility, while the second step is to facilitate the real act of taking responsibility (cf. Bakker). Additionally, it was highlighted that opinions about how to engage in a sense of personal responsibility differ widely within the MSM community, but the issue of responsibility typically becomes alive immediately when a person finds out their positive status (cf. Witlox).

To benefit my subjects' comprehension of the questions, I expressed my personal framework for defining responsibility within the course of each interview (cf. Literature Background and Theory). After tackling responsibility in general, I first asked them to express their honest opinions about the difficulties of promoting open communication among male sexual partners. All of them spoke of the fear of rejection that plagues openness, as well as the lack of a social norm for open communication in the Dutch gay scene. Also, relations between two men, especially those taking place within the guarded subculture of darkrooms, were defined as more "clumsy" (Witlox) in terms of communication than relations between individuals of other sexual identities (cf. Witlox). Since sexual relations between men exist in a diverse range of practices, communication doesn't always benefit the specific goals of a sexual situation (cf. Witlox). More specifically and frustratingly, it was also expressed that some men just don't find health to be that important (cf. Bakker), and others simply "wish to avoid confrontation with internal questions about responsibility" (Witlox).

One interviewee highlighted the fact that communication skills have been proven to directly enhance the safety of sex, and that fewer tools for spoken sexual negotiation leads directly to high-risk situations (cf. Oomen). Therefore, it is absolutely essential for prevention interventions to promote communication, especially because some MSM believe that they would rather have good sex than protect themselves from HIV by talking about risk reduction before every act (cf. Bakker). But how to effectively promote open communication? It was suggested that both positive and negative men need to be informed about the fact that communication is not the reason most relations split up (cf. Altenburg). Promoting communication should equally promote the value of each person's

life, by intimating the fact that two or more people's life-long health is in the balance when sex is enacted (cf. Bakker). In what I see as the relatively pragmatic and private Dutch culture, community support systems for communication are also needed in order to firmly establish new social norms, and to reassure MSM that openness is neither dangerous nor un-sexy.

Included within the theme of communication, I incited my interviewees to speak about the complications of disclosure between MSM. Most of them agreed that disclosure is not necessary for risk-reduction and that there are a lot of problems with promoting disclosure, especially in terms of HIV positive men. However, a lack of communication in the context of sex was generally labeled as the overwhelming problem for MSM. The greatest reason for not promoting disclosure seems to be the negative reactions to sero-positive disclosure that commonly hinder HIV positive men's willingness to be open. For disclosure to be included in a campaign, communication has to come first in order for it to be in any way beneficial (cf. Altenburg). Additionally, one interviewee expressed the opinion that disclosure is not helpful based on the fact that people should always protect themselves, regardless of what they know about the other (cf. Oomen). Yet I believe it is overly optimistic to assume that people are always going to protect themselves, even when they are educated about risk.

However, as negotiated safety between men has become more of a common practice, and as individuals are searching for ways to enjoy sex within the context of health, disclosure has become a tool for certain populations, especially those that engage in sero-sorting. More and more, individuals are looking for safe outlets to disclose HIV status, including on the Internet (cf. Witlox); therefore, for some people disclosure is an

active way to get what they want while engaging their individual responsibility. One interviewee labeled disclosure as an important method for health promotion, equal to and coupled with HIV testing (cf. Bakker). On its own, however, disclosure was outlined as both useless and potentially harmful; furthermore, the question was importantly emphasized as to what kinds of information a disclosure actually provides (cf. Witlox). Disclosing an HIV negative status is realistically very different from disclosing an HIV positive status. Would an HIV negative disclosure justify unsafe sex and an HIV positive disclosure thereby provide more trust in that individual's risk-reduction strategy? To me, this implies that an exclusive focus on disclosure within the MSM community, along with its associated pressure for HIV positive men, serves to support the unproductive practice of assumption, which shrouds each sex act wherein communication is either not open or is actively ignored.

Since motivation and a final resolve are key in terms of personal responsibility, I asked my interviewees to choose between a campaign for HIV negative men that uses the terms 'stay negative' and one which employs the tactic 'don't become positive'. My first interviewee at Schorer rejected both options in exchange for the general message of keeping yourself healthy; he labeled my options as too negative, because the general goal of health has been shown more often to positively effect behavior. At my suggestion, he agreed that HIV negative role modeling is an increasingly important tactic within prevention; however, for Dutch MSM, outing themselves as either positive or negative, in order to become proud role models, has proven very difficult due to the atmosphere of privacy. My second interviewee at Schorer expressed a great deal of inspiration in the staying negative campaign in Australia, and therefore believes that the foundation needs

to integrate the ‘stay negative’ message into its developing behavioral interventions. He also believes that the motivational aspect of responsibility has not been given enough attention in past interventions. This step would include a general message about the importance of health, as well as resist the stigmatization implicit in a ‘don’t become positive’ campaign, through the means of a tailored ‘negative’ intervention. It is evident within the contrast of these two men’s opinions that policy decisions are never easy, nor are they the true consensus of personal values within a structured organization. The goals might be the same, but the methodology of follow-through is inherently more complex than the problems at hand.

Another interviewee resisted directly answering my question and instead brought up the importance for prevention work of “reinforcing the behavior you want to see...besides punishing the behavior you don’t want to see” (Witlox). In his opinion, the message ‘stay healthy’ or ‘remain negative’ is too common sense to actually transfer into behavior; more detailed and tailored prevention messages need to be created in order to reward the ongoing practice of risk-reduction for both positive and negative MSM. This approach, for him, would not be “about ‘this should be the standards for you’ in behavioral outcomes, but more [about] ‘where can you find little room for improvement in the things you define for yourself...where do you want to reach’” (Witlox). Therefore, the ideal for HIV negatives would be “individual, motivational, behavioral-like interventions, or individual support-like interventions” (Witlox); therein, the fact that a majority of gay men *are* protecting themselves at all times could serve as the norm and inspire the minority to change their habits. My last interviewee was similarly suspect of both options, provided that ‘don’t become positive’ is stigmatizing and ‘remain negative’

seems to imply “a conservative attitude...[for instance] ‘stay the way you are’...[provides] a false sense of safety” (Oomen), by failing to encourage ongoing risk reduction.

After discussing the contradictions present in the messages ‘stay negative’ and ‘don’t become positive’, I asked my interviewees to further differentiate between addressing disclosure to HIV positive MSM and addressing disclosure to HIV negative MSM. This question brought about more personal opinion responses surrounding the nature of HIV prevention in itself. For Robert Witlox, targeting positive and negative men separately is only one part of the total intervention. He stressed how it is only logical that positive men will create different strategies for risk reduction than negative men, and therefore they need both differentiated and more specific information about health in order to make informed decisions regarding their responsibility. For him, a mass media campaign cannot do this successfully; it takes a local focus and tailored, individual messages about realistic norms, apart from policy goals that tend to be unattainable, within a specific ‘MSM’ community, to truly affect behavioral patterns. Additionally, he recommended focusing education and counseling on the ongoing and ever-changing moments of personal confrontation with the virus, so that everyone can feel free to be open about their natural, human reactions of fear surrounding the issue of HIV transmission (cf. Witlox).

Both my interviewees at Schorer agreed that there was a practical need to differentiate between positive men and negative men in prevention interventions and health campaigns, but that this divide should only extend as far as policy goals. Like my interviewee from the advocacy organization, they believe that positives already feel more

pressure regarding responsibility, and therefore have different expectations for health interventions (cf. Altenburg, Bakker, Witlox). Both men also emphasized the difference between targeting younger MSM and targeting older MSM, because of these groups' histories and differing proximities to HIV. For sex and communication, however, they believe that the message should be the same, characterized specifically by self-regulation and self-protection through individual responsibility (cf. Altenburg). The first step toward this message would be to create a greater need to talk about HIV status within the MSM community, even if men therein are already practicing safe sex, while concurrently differentiating between tailored messages and general messages (cf. Bakker). Moreover, the social distinctions of positive and negative need to be fought in intervention education with the message that HIV status applies equally to everyone (cf. Bakker).

My last interviewee addressed his personal desire to remove any "meaningful distinction between HIV positive and HIV negative" (Oomen) on a social and philosophical level. However, he was still willing to recognize that reality insistently differentiates between these populations. For him, making a divide within the MSM community simultaneously constructs the desire of some negatives to belong to the 'other' group and convert, as well as it creates a stigma for positives surrounding the fact that they used to belong to the other category and can never do so again (cf. Oomen).

In order to encourage my subjects to confront the contradictions of specifying one or the other target group in HIV prevention, I asked them each to choose either a responsibility campaign for negatives or a responsibility campaign for positives through the terms of effectiveness. Three of my four subjects responded with targeting negatives, while all four of them recognized the difficulty of making the choice. One subject,

however, resisted the question by stating that campaigns should always first target both groups before tailoring their goals and information via HIV status (cf. Altenburg). Another interviewee stressed the fact that there should be no taboos in the discussion of HIV; for him, using the fact that “each HIV infection starts with an HIV positive person” (Oomen) should not be resisted solely because it is too realistic or drastic. My last interviewee spoke about the necessity of targeting negative MSM because “people who think they are negative but are actually positive and running around with...sky-high viral load[s]...[are] the motor in the epidemic” (Witlox). He also believes that the discovery of a positive HIV status has a great behavioral effect on MSM by automatically invoking responsibility in daily decision-making, which negative or untested MSM don’t understand (cf. Witlox).

Lastly, I asked the participants of my interview to talk about a possible balance between the more normative or moralistic approach to prevention and the liberal approach that disseminates information without any prescription for action. I wanted each of them to assert the differences between encouraging a responsibility to know and promoting a responsibility to act for MSM. All of the interviewees were in consensus that the most effective state of prevention is somewhere between these two extremes. However, each of them had distinctive reasoning for their opinions. My subjects from Schorer agreed that information is the first step in prevention, but that without advice concerning how to use the facts, health education isn’t effective in HIV prevention. One of them saw a conflict for health workers in reconciling policies with the target group itself; he emphasized that health promotion should start with the people who need to be reached, rather than with general policy guidelines (cf. Altenburg). The other interviewee

saw the solution as “giving a lot of information...tailored information...but the messages should be, could be more collectively in a moral way: ‘it’s normal to take care for yourself and each other’” (Witlox). The greatest justification I encountered for spreading information among MSM about responsibility, and attaching some norm to the facts, is that “in Western societies...most new infections are among very well informed men” (Oomen). Probably, Oomen is referring here to statistics concerning how men over forty and fifty years old have very high rates of HIV transmission; even though these men tend to be well educated and middle class individuals, they are often tired of prevention. One of my subjects further expressed frustration about how “there was this one group of people who made the switch in the Eighties or Nineties, or even now, who become sexually active and for whom it is even no discussion that the condom should not be used...and then there is this whole group of people who are tempted or are in this confusion state [regarding safe sex practices]” (Oomen). None of the interviewees believed that moralistic or norm-setting advice could be effectively separated from the liberal distribution of information, nor vice versa.

In the end, due to the diversity of working and personal experiences shared by the four men I interviewed, I received productively varied responses to my opinion-based questions. One interviewee believed that, overall, that there is a lack of treatment for the whole person in current sexual health platforms; therefore, the main goal should be to “go back...to the common beliefs or the common task” (Witlox) of the gay community, which protected itself as a whole before the introduction of HAART in 1996. For him, “repeating what people *should* [do] is not really...what’s helping” (Witlox). In fact, he sees the future of prevention centered around medical science, because chemical

interventions, like administering PEP and allowing at-risk groups to choose their own chemical timeframe for HIV medications, would allow sexuality to be more naturally expressed, as it is not in itself an area “overloaded with rationality and communication” (Witlox).

For another interviewee, “promoting...[a gay community] and building that and having an open and visible and hearable dialogue on these issues, and to come to an understanding...[about] what is wrong with people’s lives that they are so willing to take huge risks in their lives” (Oomen) is the biggest challenge for modern HIV prevention interventions. Yet another subject highlighted the fact that more MSM are now asking themselves ““don’t we go too far with our sexual liberties...isn’t there some border?”” (Bakker). In his case, when the target population is asking about responsibility and demanding more public voices on the subject, it is natural and reactive for prevention to respond with both information and advice, which are then equally supplemented by the empowerment of every individual’s free choice. My final interviewee agreed that there is a strong movement today of individuals who are seeking more responsibility in all aspects of life (cf. Altenburg). For him, more personal contact between outreach workers, including members of the MSM or gay community in the Netherlands, and the target population is the means to effective modern HIV prevention. Overall, recognition of the problems at hand was more comparable than the specification of realistic solutions to these problems; for me, this mirrors the particular complexities of the MSM community and sexual health promotion in general. We know what is going on in the MSM community and what tangible problems need to be addressed, but there is an ongoing and

exhaustive debate surrounding how to best tackle the real application of any modern HIV intervention.

Campaign Analysis: the United Kingdom

Before I started to review campaign materials produced in the United Kingdom that target MSM for HIV prevention, I was under the impression that the U.K. operated under a more liberal policy for intervention. However, the history of criminal prosecution of HIV positives surrounding HIV transmission in the United Kingdom is based on an ideal of 50:50 responsibility (www.avert.org). Additionally, I learned on the Terrence Higgins Trust website (www.tht.org.au) that 30,000 gay men have tested HIV positive in the last twenty years in the U.K., that thirty percent of those living with HIV/AIDS in the U.K. are unaware of their positive status, and that the two groups most affected by HIV are MSM and individuals of Sub-Saharan origin. Therefore, it appears as if HIV prevention for men who have sex with men is an issue of great importance in the United Kingdom, like it is the Netherlands.

The first organization that I researched in the United Kingdom is Gay Men Fight AIDS (GMFA). On their website (www.gmfa.org.uk), there is extensive information regarding responsibility, communication and disclosure. The information first establishes the widespread problem of men making incorrect assumptions about their partners, that HIV positive men feel HIV negative men are in charge of their own prevention and HIV negative men feel that it is only fair for HIV positives to disclose their status knowledge. However, the website is quick to assert that “it’s up to every individual to take responsibility”. For HIV positive men, GMFA justifies personal responsibility in terms of

the altruistic protection for HIV negative partners; whereas for HIV negatives, they explain responsibility in terms of simple self-protection. For those who do not know their HIV status, the website then emphasizes that their responsibility is to prevent behavior from putting either the self or the other in risky situations.

The website information continues by highlighting the fact that both HIV positive and HIV negative men are taking part in unsafe sex, and that this is the motor behind the epidemic. After collecting their own data, the foundation states, “almost 40% of men living with HIV won’t say that they’re positive before sex”; however, disclosure is never directly addressed by prescriptive advice or in plain terms. After giving statistics on low rates of disclosure, GMFA asserts that “most gay men’s expectation of disclosure is unrealistic” and, therefore, that “ALL gay men should take responsibility for keeping the sex they have safe, to protect themselves, their partners and to prevent the spread of HIV in the gay community”. The website further provides excerpts from interviews with gay men about responsibility, in which the responses have been edited to appear overwhelmingly contradictory and hopeless about the benefits of disclosure. Whereas I appreciate GMFA’s lack of pressure on disclosure due to my opinion that open communication is of utmost importance, I think it might be exaggerated to assume that some HIV positive men don’t find relief and community through disclosure.

After describing the laws surrounding HIV transmission, there is one small section on the website about the “hassle” of communicating HIV status. This tiny piece of the total web address informs gay men that it is up to them how to deal with communication; yet, it also poses the question to HIV positives, “would you have been so carefree with the bloke who gave you HIV if you knew his status at the time?” After this,

GMFA recognizes the reality that disclosure sometimes leads to rejection by stating “you should remember that just because you are +ve doesn’t mean a guy won’t have sex with you...lots of –ve guys have no problem in shagging a +ve guy!” Directly next to this statement is a small image of a man wearing a t-shirt that reads ‘I’m + and I’m keeping it to myself’.

Overall, it seems as if GMFA is dedicated to a collective message of responsibility for every man who has sex with men; however, when they tailor this message down to focus on either positive or negative men, the equality and fairness of their original intention becomes slightly skewed. Through analyzing just their web information, I can see how the differentiation between positive and negative men is necessary, but how information and advice should not be addressed to positives through the same language that is employed for negatives. Responsibility, when GMFA targets HIV negatives, only incites methods of safe sex based on an equal-opportunity suspicion for any partner. Responsibility, when GMFA targets HIV positives, includes the normalization of care for the other (because the other could *still* be negative) and sets a standard for communication that is not expected from negatives. GMFA never addresses how negatives have the equal power to communicate and disclose before the act, along with their effective power to ask a partner about his status as long as they know how to handle the disclosure. The website offers no tools for gay men to train themselves in reacting appropriately to communication, partly because communication is downplayed for HIV negative men; therefore, GMFA seems to be favoring HIV negatives in its objectives for prevention, while singling out positives as the sites of infection .

One of the poster campaigns organized by GMFA directly employs the term ‘responsibility’ (cf. appendix B, example 1). It includes four posters with the same message and different images, including two men in bed, two men at a bar, two men using web cameras, and two men in a sauna together. Each image is divided down the middle of the page, with one side labeled as ‘HIV negative men’ and the other labeled as ‘HIV positive men’, while the men in the photos make eye contact across the divide; yet, the word ‘responsibility’ is bold across the center of the page, shared by each side of the image. On the HIV positive side, the message implicates responsibility as solely that of protecting the partner, while on the HIV negative half, the message is that responsibility is to protect the self. What cannot be addressed through these divisive means is that some HIV positive men may find that the responsibility to protect themselves is a better means of motivation for condom-use or communication, because of the serious repercussions of infecting someone else as well as the threats of superinfection and STIs. On another hand, some HIV negative men may engage altruistic motivations to protect themselves, in order to preserve their health to benefit family, friends, or a lover.

GMFA also provides online access to two pamphlets or guides, one addressed toward HIV negative men, called “Keep It Up: a gay man’s guide to staying negative”, and another directed toward both HIV positive and HIV negative men, named “How can you tell?”. “Keep It Up” is a reality-check meant to remind HIV negatives both that they are not immune to the virus and that living with HIV is “no picnic”. However, it only provides motivation through the terms of ‘don’t become positive’, rather than inciting men to ‘remain negative’. “How can you tell?” is separated into two distinct sections, one for HIV negative MSM and one for HIV positive MSM. The HIV negative guide first

outlines why a positive partner will not disclose his status, what to do if a positive partner does disclose, and finally what the reasons are for negative men to resist communication. The HIV positive guide, on the other hand, outlines the reasons why a negative partner will not communicate, what to do if a partner discloses as either positive or negative, and finally why positive men keep their status to themselves. While both guides are foregrounded by the advice to “assume nothing” and to recognize in more detail both the difficulties and importance of equal communication, it is evident that GMFA continues to divide their advice by status, putting more pressure on positive men to responsibly protect their partners and more pressure on negative men to defend themselves from the fact that positive men have difficulty disclosing.

The other foundation in the United Kingdom that I focused my research on is Terrence Higgins Trust (THT), which is closely affiliated with both Community HIV and AIDS Prevention Strategy (CHAPS) and Vive La Difference, an organization for sero-discordant male couples. The section of the THT website (www.tht.org.uk) that targets gay men and MSM actively employs a more liberal viewpoint on prevention, by providing informed opinions about both the benefits and drawbacks of disclosure, testing and open communication. For disclosure, THT highlights the power of context in every moment of choice; yet the language of the information frames ‘telling’ HIV status as a “good idea” that is “difficult”, rather than a bad idea under certain circumstances. Concerning testing, the website asserts that “you shouldn’t feel under pressure to have an HIV test from other people”, but that *not* testing can potentially damage your health and your future, especially if you happen to be HIV positive and not know it. Finally, THT advises that self-regulation, above and beyond self-protection, is the most effective

method for risk-reduction, as well as for better sex; they state “you should also learn to be aware of your own behaviour and how this puts you at risk...starting a dialogue is the first step: over time you’ll learn negotiation skills that will make it easier”. Overall, I believe that communication is the central tenet of THT’s promotion for negotiating and maintaining sexual safety. The intention of their online information is not to attempt to tailor messages for either positives or negatives, but, rather, to give a general overview of the issues at hand alongside their best advice for dealing with the daily confrontation of HIV/AIDS.

In my opinion, as the largest HIV health organization in the U.K., Terrence Higgins Trust has to be as professional and politically correct as possible, in order to reach out to the extensive groups affected by the virus. Thereby, THT uses CHAPS, which focuses solely on MSM, along with Vive La Difference, to develop its more confrontational interventions. On Vive La Difference’s website (<http://together.chapsonline.org.uk/Home/>), it is stated in more colloquial terms that, “it’s far easier to fuck without a condom than to talk to each other in a very deep, honest way...unprotected fucking isn’t the only kind of intimacy”; the information further demands that gay men ask themselves “what is it about certain sexual acts that are important to you...and why?”. By providing personal testimonies of sero-discordant couples, Vive La Difference is able to address the target population in terms of ‘we’, tailoring their messages in order to make their advice more realistic and specific to life circumstances. The site seems to assume that sero-discordant couples are interested in their joint self-protection, and are already educated about the practical means of safe sex.

One campaign developed by THT and CHAPS, called “Infection Situations”, employs a similarly direct tone in targeting MSM. “Infection Situations” attempts to break the taboo for HIV positive men’s conversion stories by using five men’s personal histories, in order to emphasize the ordinariness of a majority of transmission conditions. CHAPS specifies the taboo of positive story-telling as one reason that MSM find it difficult to bring their knowledge into bed and, therefore, as a reason that MSM are able to ignore, or dismiss through assumption-making, the diverse realities of some high-risk situations. CHAPS further highlights how positive men rarely see their conversion as something that had to do with their individual role in sexual responsibility; thereby, positives are more apt to blame their partner or the lack of communication for their HIV conversion, rather than the situation itself.

Another poster campaign developed by CHAPS and THT deals more generally with responsibility and the assumptions that resist open communication between partners and, therefore, continue to benefit HIV transmission. The campaign, called “Think Again”, utilizes six different images of men’s faces in close, intimate proximity to each other (cf. appendix B, example 2). Over each man’s forehead is a different statement meant to represent the thoughts of the individual during the moment of sexual choice. The statements range from “he’d freak if I tell him about the guy last week” coupled with “he’d tell me if he’d had unprotected sex with another guy”, to “will he react badly if I tell him I have HIV?” coupled with “he would have used a condom if he had HIV”. The overarching message is that, however exciting the images are, there are judgments at work here that can possibly instate danger within each couple’s interaction. I find this poster campaign to be highly effective because of its simplicity, the fact that it demands

attention based on the image, and furthermore because it challenges the assumptions that any viewer makes upon first glance. After comprehending the messages, the reader has to reconcile whether or not they have thought the same thing, or whether or not these men's thoughts induce nervousness or self-reflection. In that case, I believe that the campaign has done its job.

However, "Think Again", like the campaigns created by GMFA, implies a distinct separation between positive and negative men. In some cases, like that of GMFA's "Responsibility" posters, this division implicates positives more in HIV prevention than HIV negative men or even those who have never tested; HIV positive men have to protect others in order to protect themselves from social judgment. With GMFA's campaigns, I believe the divide is stigmatizing and unrealistic. Within the "Think Again" poster campaign, although, the division is meant to make a statement and challenge the viewer, rather than pass judgment on the responsibility of either the positive or the negative man. The lack of communication that leads up to each of the images in "Think Again" is what is on trial for CHAPS and THT. On one level, I believe that GMFA's general message of responsibility should be directed more toward the general MSM population; this way they can tailor their goals, like inciting positive men to act on altruism, in a less stigmatizing way, rather than articulating it directly alongside their message to HIV negatives. Overall, I understand the materials that I collected from the United Kingdom as employing a less prescriptive and more liberal approach to HIV prevention intervention, even though their means of application could sometimes be counterproductive. THT, CHAPS, Vive La Difference and GMFA aim to provide important information and advise each man to decide for himself how to use the facts.

Campaign Analysis: Australia

Before I began to analyze campaign materials produced in Australia, I was under the impression that Australia utilizes a more moralistic or normative approach to HIV prevention interventions. I learned through online research that many of the issues that plague HIV intervention strategies are the same in Australia as they are in the Netherlands and the United Kingdom. According to information provided by VAC/GMHC (www.stayingnegative.org.au), over 85 percent of people who are HIV positive in Australia identify as men who have sex with men.

The first organization that I researched in Australia is People Living with HIV/AIDS (PLWHA). The online information provided by PLWHA (www.plwha.org.uk) talks at length about disclosure, highlighting the assumptions that many men make in the case of non-disclosure and the unfair expectations that are placed on HIV positive men to disclose their status to every partner. Safe sex is labeled as a “non-verbal form of disclosure”, while both the possible drawbacks and benefits for disclosing are listed in detail, including the fact that disclosure implies safer sex for both partners more often than it implies rejection and avoidance. In this way, disclosing either a positive or negative HIV status is framed as an opportunity to not only protect your partner, but also to allow him equal rights and power in protecting you through his increased knowledge about your experience with the act of intimacy.

PLWHA developed a campaign called “Think Again” (www.thinkagain.com.au), which recalls the campaign by the same named used in the United Kingdom. This campaign involves both a pamphlet and a poster series, which portrays a range of situations where disclosure of a positive status is at issue, including a few graphic designs

expressing the differences between an HIV positive man's assumptions and an HIV negative man's expectations. The pamphlet asserts that surveys of Australian MSM prove that "four in five negative men expect positive men to disclose before sex...[and] one in five positive men always disclose and one in two sometimes disclose". It goes on to tell the story of Ben and Bill who had to face disclosure and the fear that surrounds it for both positives and negatives; furthermore, this possibly fictitious story leads to the statement that "HIV is often only a small part of a much bigger picture...[but] it's worth remembering...for gay men...[that] HIV is still part of the picture". Overall, the pamphlet makes no dramatic distinction between the effects of an HIV positive man's assumptions concerning safe sex and an HIV negative man's expectations surrounding safe sex.

The "Think Again" poster campaign extends the same policy standard. Rather than labeling the thoughts of both men in the photo images (cf. appendix B, example 3), as THT and CHAPS did with their campaign in the United Kingdom, PLWHA labels the general situation with messages that don't clearly mark either man as HIV negative or positive, including "think he's negative just because he didn't tell you?", "think it's easy for someone to say they're HIV?" and "think he'll say he's HIV just because you think he should?". Each poster challenges a common assumption or expectation for either HIV positives or HIV negatives in a way that resists constructing a visual dichotomy for blame or responsibility. At the bottom of the graphic posters (cf. appendix B, example 4), there is a disclaimer that explains how assumptions directly lead to HIV transmission, listing specifically and equally "assumptions about whether he is positive or negative...[and] assumptions about whether he'll tell if he's positive". The responsibility of MSM implied

by this campaign is overwhelmingly the responsibility to avoid assumptions, rather than the responsibility to specifically disclose or communicate openly, even though these are both realistic methods for risk-reduction.

PLWHA also created a campaign along with the AIDS Council of New South Wales (ACON) called “The Words to Say It”. The campaign features a set of three pamphlets, focused on communication, disclosure, and sex and health. Although not exclusive to gay men or MSM, the pamphlets address the specific complexities of continuing a ‘normal’ life as an HIV positive individual, framing practical information with quotes and names of people who are HIV positive. The communication brochure tackles the issue through the probability that HIV positive people require more detailed information in order to negotiate sexual life. The disclosure brochure treats honesty as the key to “joint responsibility”, while concurrently regarding HIV stigma and discrimination as roadblocks to open communication. However much disclosure is a dangerous and sensitive topic for HIV positives, the information provided frames it as a necessary evil and an active way to fight discrimination, as well as something that needs ongoing management and personal monitoring. All the information is provided in a simple present tense, rather than in an imperative form that would appear more prescriptive. By focusing the intervention on HIV positive people of all sexual orientations without distinguishing between gay men and straight women, I believe that PLWHA has more effectively tailored their message, compared with attempts made in the United Kingdom, by promoting communication through the particular complexities of a positive status. It is as if PLWHA is asserting that HIV is equal opportunity for all people, but HIV indignity and HIV risk should not and do not have to be the same.

Next, I focused my analysis on ACON's poster campaigns, called "Mates" and "Sensations". Both of them feature images of MSM in intimate situations, and the most prominent captions are those establishing differing levels of emotional commitment, including playing, fucking, being in love, or just being together. Altogether, the message is that sexual partners are protecting themselves through various safe sex practices, regardless of their level of relationship. The "Sensations" posters (cf. appendix B, example 5) portray feelings like "my heart skips a beat", "shivers down my spine" and "tingling all over" to invite viewers to personally relate to the information. In small print at the bottom of each poster is a description of the dialogue that each partnership has engaged in order to stay safe while enjoying ideal sexual freedom, including "by being clear and honest about the sex we want to have inside and outside our relationship...we can give in to the moment". The "Mates" campaign employs a similar connection between sexual enjoyment and safety, by listing the specific methods used by the partnership to keep sex safe, including "using condoms and lube for fucking...being aware of PEP...[and] communicating about our feelings and concerns". Each poster in these two interventions captures an emotional or real sexual ideal for a general MSM population, while further specifying the prevention activities that lead up to the attractiveness of the image, and thereby establishing norms of sexual happiness that are based on risk-reduction.

Lastly, I concentrated on the progressive "Staying Negative" campaign monitored by the Victorian AIDS Council or Gay Men's Health Center in Australia (VAC/GMHC). Online information from VAC/GMHC (www.vicaids.asn.au, www.stayingnegative.org.au) is more normative than any other organization in my

analysis. The advice given includes the language of prescription more than choice, for example, “you should be using condoms”, “discussions you need to have with your partner about HIV status”, “no-one is immune to HIV” and “so when you’re fucking a guy...don’t assume that he’s going to reveal his HIV status to you”. On the other hand, the information is equally sensitive to situations in which strategic positioning and negotiated safety are optimal, or wherein the difficulty of talking for the first time about HIV can have a long-term effect on the trust in a relationship.

The “Staying Negative” campaign in itself is directed toward HIV negative MSM, and is one of the first of its kind to single out this population for prevention. It features the personal histories of a diverse group of men who have sex with men, who detail their experiences through stories about coming out, casual sex, depression, body image, violence and sexual assault, drugs, sex work, sero-discordant relationships, rejection, avoidance, stigma, and assumptions and expectations in the sex act. Besides this online tour through men’s lives, “Staying Negative” also includes a poster campaign (cf. appendix B, examples 7 and 8), which portrays and names happy and healthy Australian men, after which the number of years they have been negative is provided along with some practical reason for their continuous risk reduction. Some of the reasons given include “I know that trust isn’t always enough to protect yourself out there” and “I haven’t really had any worries about HIV because I know what I’m doing, basically”.

Overall, I believe that this campaign is attempting to set an HIV negative status as the norm within the gay community. Each man in the campaign is a willing role model for negatives and those who have yet to test; each model is actively exposing and disclosing his status through an incredibly public forum wherein his personal, sexual

secret is 'out'. As they express online, VAC/GMHC wants "not having HIV" to become a transmissible condition, and knowing your HIV negative status to otherwise become a "large club to join". However, when a healthy and happy HIV positive person comes across this website, it is only natural for them to feel stigmatized by the fact that they are indirectly judged as having nothing to share with the negative majority, which is 'succeeding' in resisting conversion. It is rare that a prevention campaign portrays HIV positive men in the same way that this campaign depicts HIV negative men, based on the fears of making HIV seem less complicating that it is, and thus increasing prevention apathy among the general population.

Overall, the campaigns in Australia appear more focused on constructing norms than on disseminating 'other'-sensitive information to the MSM community. In this way, I find their approach to be slightly more effective due to the fact that they differentiate between positive men and negative men less often for their general interventions, which promote context-based communication, the equal responsibility to avoid assumptions, and safe sex at all times. By encouraging a disregard for expectations without employing scare tactics for MSM, I believe that these interventions have achieved a better balance, compared to interventions in the United Kingdom, between the liberal approach and the normative approach to HIV prevention; this conclusion productively coincides with my literary and theoretical research into the MSM community's specific history of social involvement and health.

Conclusions and Recommendations

During the months that I worked on this project, the issues of HIV prevention were constantly on my mind. One night recently, I ended up at a local bar after working for an entire day analyzing my interviews, and I couldn't stop myself from engaging the environment in my mental and emotional conflict. I spoke freely and passionately about how frustrating it is that HIV is still an issue after so many years of social recognition and medical intervention, and how easy it is to feel angry about rising transmission rates in advanced western society. Before I knew it, several women and a few gay men joined in the conversation. While they agreed with me regarding the main issues of disclosure and communication for safe sex, they effectively reminded me that practical information is very different at the personal level. I left the bar slightly relieved from the weight and burden of knowledge that has been increasing throughout the whole research process.

However, it is still difficult for me to decide how to conclude the diverse opinions, methodologies and policies that I have outlined in the paper. I could reiterate the complexities of targeting MSM above and beyond gay men. I could just as easily detail the discourses and approaches that modern prevention interventions should avoid at all costs. But it is nearly impossible for me, from my position as a disconnected researcher, to construct a definite solution to HIV interventions among Dutch MSM. At this point, I have assumed a similar position on the subject as my interviewees from the Netherlands; I know the problem to be that MSM are the most affected by, rather than the most burdened or responsible for, the epidemic. But the best solution is illusive and each individual option for action has its own benefits and drawbacks based on its specific context.

First of all, I believe that targeting HIV positive men separately from HIV negative men is important. Yet, this approach will only be effective if it is made up of tailored messages for each group, under the guise of a general message for all at-risk groups. Since the virus survives by replication, I think it is only realistic that interventions make clear that everyone who is HIV positive contracted the virus somewhere. Therefore, a general message that promotes testing, communication and equal responsibility is optimal. To encourage personal responsibility, it is important to frame HIV as an equal opportunity virus, but not as an equal opportunity risk in transmission. This approach would tackle stigma in general without first singling out HIV positives based on their status and without assuming that HIV positive men always suffer from fear and discrimination.

Ideally, this methodology would find a balance between providing information that empowers men to choose their best strategy for negotiating safe sex and setting norms concerning the active avoidance of assumption-making and taboos. The biggest problem among MSM seems to be translating knowledge and feelings of intended responsibility into action and behavior. However, when the virus is spoken about freely in a multiplicity of discourses and contexts, the issue of bringing knowledge to bed is undermined.

Over time, HIV interventions have shifted from a common goal of health and safety for the community to an individual goal of self-protection and personal responsibility. In my opinion, this shift has been too drastic and has left MSM feeling forced into their self-regulation. More than relying on altruism or self-protection to motivate MSM, both options which clearly differentiate positives and negatives in often

moralizing ways, instituting more outlets for the social support of all MSM would encourage story-telling as well as informal spaces in which men could share their accumulated knowledge concerning their negotiation of a complex and diverse community. The men in these spaces would identify with each other through life circumstances rather than status or sexual identity; furthermore, strong support networks might either decrease or negate the difficulties that accompany the misinformed pressure to disclose.

For tailored messages targeting HIV positive MSM, it is of utmost importance to include information addressing the tangible promotion of satisfactory sex, above and beyond the promotion of risk-reduction strategies. This sex positive approach would remove the social denial of sexual practices among positives, and possibly increase the likelihood that these men would practice safe sex for more than altruistic, 'other'-sensitive reasons. If HIV positive men were labeled as 'managing' HIV, rather than simply 'living with' or 'surviving' the virus, the intervention could frame the individual as having come before the virus. If possible, a support network would involve HIV positives in developing outreach materials themselves, so that their personal needs could be met and their voices could reach a more accepting audience. Men with HIV need more confidence as a group in order to be motivated to care for themselves; pressure to disclose is not effective without a framework that recognizes the complexities of communication in general.

For tailored messages targeting HIV negative MSM, more attention should be placed on education dealing with appropriate responses to specific sexual situations, including a partner's disclosure or non-disclosure. However, it is also important for HIV

negative men to know about the realities, rather than the difficulties, of managing an HIV positive status. In this way, self-responsibility would involve the terms of altruistic protection of the other, and, equally, protecting the other through sensitivity training would become a method of practicing individual responsibility and safe sex. Additionally, HIV negative men need more role models who are healthy, have remained positive throughout their active sex lives, and are willing to talk in plain terms about their close calls and moments of weakness. By reinforcing the ongoing decision-making process that continuously transmits their HIV negative status, HIV negative MSM would gain more self-esteem concerning their negotiation of risk, instead of feeling guilty for remaining negative or as if their negative status is stigmatizing positives in itself.

For any intervention in the Netherlands to be successful, I believe that all the health organizations need to work together. HIV is more and more decentered in the lives of MSM these days, so much that a message from one foundation might not promote behavior as much as it would assert a one-sided point of view on HIV transmission. Overall, the issue of HIV prevention among Dutch MSM can be summarized as a problem of blame and fear; a general recognition of the practice of unsafe sex along with the diversity and complexities that are innate within the ever-changing MSM community could be the key to managing HIV transmission in the future.

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