Original Article

Reflecting on HIV disclosure laws in the context of unsafe sex and the harm-reduction strategy

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Abstract In this article, we locate two discourses regarding the incidences of bareback sex practices. First, there is the greater reliance on safe sex practices, including going beyond condemnation of risky behaviour. Second, there is a disciplinary discourse of law and punishment. In the first instance, there is the promotion of the use of alternative (non-invasive) sex practices and condom use. In the second, there are highly selective and punitive disclosure laws specifically directed at unprotected sexual activity and other forms of risky or illicit behaviours that involve the transference of blood or other secretions. We believe, however, that a heightened understanding of the motivations behind unsafe sex is necessary to promote the implementation of public health interventions that will be better adapted to the reality of this population. There is, then, an urgent need to begin reflecting on the type of preventive strategies needed. To this effect, the aim of the current article is to initiate some reflections as well as a dialogue on the compatibility between the practice of bareback sex and a health risk reduction approach.
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Introduction

Since the emergence of HIV infections, the gay community has participated in the battle against the virus. This fight has manifested itself in several ways, from

support of those living with HIV to peer prevention and education (Altman, 1984). Volunteers and activists in the gay community have developed the first education and prevention activities intended for men having sex with other men (MSM), as well as participated in the creation of the first community health agencies (Kobasa, 1990; Chambre, 1991). They have created a culture of safe sex within their communities. As such, a number of researchers have noted that the adoption of safe sex practices by the majority of MSM represents an example of successful behaviour modification (Stall *et al*, 1988).

However, recent data suggest that MSM continue to be at high risk for HIV and sexually transmitted infections (STI) related to unprotected sex with regular or anonymous partners (Centers for Disease Control (CDC) 2009). A report from the US CDC indicates that AIDS diagnoses are increasing in the United States for the first time in 10 years (Yee, 2003). An increase in the incidence of HIV within MSM in Germany has also been noted (Marcus *et al*, 2006), as well as in many countries in Europe and elsewhere (Sullivan *et al*, 2009; van Griensven *et al*, 2009), along with an increase in at-risk behaviours within MSM communities in other large cities, worldwide (Dean, 2009).

Part of the reason for this increase is that, for the last 5 years, there has been some resurgence in the popularity of 'bareback sex' in male homosexual communities in western countries (Scarce, 1999; Dean, 2009). Bareback sex, commonly defined as 'skin to skin sex' or 'raw sex', derives from bareback horse riding, or riding a horse without a saddle (Scarce, 1999). Bareback sex constitutes a sexual practice in which condom use is intentionally excluded from anal intercourse. The increasing popularity of this sexual practice is confounding health-care workers because it is practiced by people who are aware of (or should be aware of) the risks associated with sharing body fluids (Holmes and Warner, 2005). Public health institutions in North America and in many European countries are responding to these new findings in two important ways: (a) by intensifying prevention campaigns aimed at limiting risky behaviours in uninfected people and (b) by attempting to stop the transmission of HIV from already infected persons. Included in this last strategy are formal and institutional means to limit HIV transmission, such as disclosure laws and the use of incarceration (Tierney, 1992).

The purpose of disclosure laws is to obtain convictions of those with HIV who have unprotected sex, based on the defendant's knowledge of his serological status, the engagement in prohibited activity and the status of the partner's consent. Knowledge refers to the defendant's awareness of his status as a carrier of HIV. Knowledge is satisfied when a health department official tells a person that he is HIV positive. For example, in Missouri, an HIV-positive person is prohibited from biting another person; if the non-HIV person contracts HIV, the punishment increases to upwards of 30 years in prison. The sexual activities of

HIV-positive persons fall into different legal categories than other ill individuals. The law regulates their sex lives out of a concern for public health or safety in ways not attributed to those with other sexually transmitted diseases. To be sure, the possibility of death separates the difference between HIV and other STI, but it is important to note that the actual transmission of HIV, AIDS or AIDS-'causative elements' (McArthur, 2009, p. 717) is not the requirement for prosecution; it is engaging in sexual activity without taking precautions or in not informing the partner of his or her viral status. Sex is the issue, not transmission.

In this article, we approach the question of harm-reduction strategies for those with HIV/AIDS by analysing the various ways in which such strategies are implemented. We take an interdisciplinary approach, based partly on legal analyses of key cases dealing with the transmission of HIV/AIDS, partly on theoretical constructs such as discourse analysis (Foucault, 1972), and finally through a medical and health perspective, all in an attempt to understand the various ways in which harm-reduction strategies influence public policy and the meaning of subjectivity. The purpose of this multidisciplinary strategy is to comprehend the phenomena of harm-reduction strategies as broadly as possible, as it seems to us that focusing on only one method of explanation, be it strictly legal or medical, has serious limitations, principally regarding the power that reduction strategies have in influencing the meaning of homosexuality and in shaping the perception of dangerousness that all too easily follows that label.

Lessa (2006, p. 285) defines discourse as a system of thoughts 'composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak'. Starting with the premise that the subjects of harm reduction are constructed through a discourse that favours constancy, responsibility and intent to harm, we locate two discourses regarding the incidences of *bareback sex* practices. First, governmental and non-governmental institutions alike emphasise safe sex practices, but they also go beyond condemning risky behaviour – they seek, that is, to control the practice of homosexual sex itself. In this view, the discourse of safe sex contains within it the idea that homosexuality creates a sphere of danger because it contains the potential for diseases that lead to death. Second, there is a disciplinary discourse of law and punishment that has, increasingly over the years, taken into account the question of life itself (Rose, 2007). In the first instance, there is the promotion of the use of alternative (non-invasive) sex practices, harm-reduction strategies and condom use. But there is, also, within these positions, an underlying claim about the true nature of homosexuality and its relation to risk and danger. In the second, there are highly selective and punitive disclosure laws specifically directed at unprotected sexual activity

and other forms of risky or illicit behaviours that involve the transference of blood or other secretions. Here, too, the law makes certain assumptions about the dangerous nature of the subject it seeks to regulate. And although these are two distinct strategies (one largely non-governmental but not exclusively so, the other only a governmental objective), emanating from discrete institutional sources, we see these two strategies as linked because they are united in their biopolitical desire to discipline and punish marginal communities for the presumed greater good of societal preservation and normalisation.

Placing these discourses within a Foucauldian framework, the argument is advanced as follows. First, we locate the rise of such strategies within the biopolitical realm. Foucault sees biopower, or the rise of a power over life, in the concentration by governments of the seventeenth century to integrate the body 'into systems of efficient and economic controls' and the measurement of the body in terms of the imposition of '*regulatory controls*' (1990, 139; italics in original). Second, extending these ideas to our era and to the problem of harm reduction, we see the production of such controlling strategies regarding HIV/AIDS as circumscribed by the profound emphasis both governments and the general population now place on the surveillance of those deemed dangerous to the health and safety of the polity (O'Byrne and Holmes, 2009). Through the subtle recodings of behavioural requirements by non-governmental actors, made necessary by the limitations liberalism itself imposed on governmental power throughout the nineteenth and twentieth centuries, regulatory practices became embedded within individuals and groups, reducing the need for overt forms of punishment (Foucault, 1977). In this regard, the presence of HIV/AIDS has created a new way of thinking about citizenship based on a biological impetus – a recording of 'duties, rights, and expectations of human beings in relation to their sickness, and also to their life itself' (Rose, 2007, p. 6). We see evidence of this new development in both strategies mentioned above.

By focusing on the discursive unity of this two-pronged strategy – harm-reduction strategies and the laws governing HIV/AIDS disclosure – in the last section of this article we intend to reflect on the type of preventive strategies needed that are not part of a formalised understanding of law and institutions. We want, in other words, to highlight the importance of these strategies as they reveal, in the realm of health management, the merging of biological life with political life (Foucault, 1990, pp. 142–143). To this effect, another aim of this article is to initiate some reflections as well as a dialogue on the compatibility between the practice of *bareback sex* and a health risk reduction approach.

We begin with the notion that once sex was 'put into discourse' (Foucault, 1990, p. 11) in the nineteenth century, it became part of a process of normalisation and control that continues to this day. That is, without replacing the

traditional emphases on the formalities of law that previously governed the boundaries of sex, the discourse on sex entered the realm of biopower, the subtle language of control and discipline that avoids attachment to any particular institution or agent, and which produces a new meaning to life itself. Biopower therefore undermines (and complements) the understanding of sex previously rooted in natural differences and essential distinctions formed by law by moving beyond it, becoming both a 'subject and object of the conflicts of the political order' (Agamben, 1998, p. 8). In what follows, we describe how the language of sex continues to be part of the law, understood in a traditional manner (deviance equals punishment), and how it contains within it a disruptive power that surpasses the confines of juridical thinking and reaches toward a concept of sex more attuned to the analytics of power itself (Foucault, 1990, pp. 17–20).

Discipline and Punish: Disclosure Laws

'This is no different than pointing a gun at somebody and pulling the trigger', said then-Governor of South Dakota, Bill Janklow, about anyone who knowingly has unprotected sex after being diagnosed with HIV/AIDS (Whitfield, 2003, p. 125). On the afternoon of 23 April 2003, Nikko Briteramos answered a knock on his dorm room door. Briteramos was the star basketball player at Si Tanka University-Huron, a Native American-run university in South Dakota. Briteramos had had sex earlier with his girlfriend and had not used a condom. A month earlier, Briteramos had donated blood that revealed he was HIV positive. Briteramos refused to let the Health Department officials into his room, no doubt realizing that they would suspect him of knowingly infecting the young woman in his bed. Indeed, that is exactly what happened. In an interview with Health Department officials later that day, Briteramos admitted to having had unprotected sex and was arrested, making him South Dakota's first person to be arrested under a 2000 law that made it a felony to knowingly expose another person to HIV (Whitfield, 2003, p. 124).

Under South Dakota law, 'Any person who, knowing himself or herself to be infected with HIV, intentionally exposes another person to infection by engaging in sexual intercourse or other intimate physical contact with another person', among other possibilities spelled out by law, 'is guilty of criminal exposure to HIV. Criminal exposure to HIV is a Class 3 felony' (South Dakota Codified Laws. Title 22. 22-18-31). A grand jury indicted Briteramos on three counts of intentional exposure to HIV. Each count carried with it 15 years in prison and a US$15 000 fine (Whitfield, 2003, p. 125). However, because of a deal struck with prosecutors, Briteramos pleaded guilty to one count and was sentenced

to 120 days in the county jail, 5 years probation and 200 hours of community service as an AIDS awareness counsellor.

As the following graph shows, 28 states have laws on criminal exposure to HIV through sexual contact, Francis and Mialon (2008) (Table 1).

Like many countries throughout the world, most US states have laws against the spread of infection or disease. These laws, mostly passed to contain smallpox and other airborne viruses, date back to the early part of the twentieth century. Typical offenders are guilty of 'misdemeanours or minor felonies' (Burris *et al*, 2007, p. 481). Unlike the laws against the transmission of STI such as syphilis, however, HIV/AIDS disclosure laws add such terms as 'reckless endangerment', 'fraud' and 'aggravated assault' to the bill of indictments, and speak in terms of intentional murder (Leonard, 1999, p. 2; Whitehorn, 2000; *R.* v. *Cuerrier*, 1998 2 S.C.R. 371; *R.* v. *Williams*, 2003 2 S.C.R. 134). Moreover, words such as 'monster', 'viral terrorist' and 'AIDS predator' (POZ.com, 1998, p. 3; Parnet, 2009, p. 89) appear frequently in the press. In some instances, the fear of contamination has been so great that those with HIV/AIDS have been refused medical care, police protection and other administrative amenities (Schuster *et al*, 2005).

Whether because of irrational fears or through misunderstanding statistical risk, those with HIV/AIDS have effectively been banned from normal political life. In 2000, the magazine POZ found 101 'cases individuals of individuals prosecuted for spitting, biting, and for having consensual sex or for rape or assault while HIV positive' (Whitehorn, 2000). The existence of those who are HIV positive is circumscribed by laws created to deal with extreme situations and rooted in containing plague, but which have now become the normal means by which prosecutions are meted out. The exceptional case has redefined the normal meaning of intent to harm (Ayres and Baker, 2005, p. 635).

The transformation of the regulation of those with sexual diseases, from treatment and containment to social isolation and imprisonment, puts those with HIV/AIDS in a new existential category, defined more by the content of the carrier's character than by the presence of disease. The image of the HIV carrier has changed since the 1980s, but so too has the language used to describe the carrier. We no longer are dealing with innocent victims of a terrible disease, such as haemophiliacs, but with intentional murderers (Galletly and Pinkerton, 2004; Shevory, 2004). This transformation in the legal and social understanding of sex and disease is underlined by the changed character of politics in our time, which has increasingly constituted itself by exclusions.

We find, here, the work of Giorgio Agamben particularly salient. According to Agamben, under Roman law, *homo sacer* is one who is banned from political

Table 1: State laws on criminal exposure to HIV through sexual contact (2007)

State	*Year enacted*	*Penalty*	*Maximum sentence*	*Intent to infect*	*Knowing or unknowing*	*Exposure or transmission*	*Safer sex behaviors excluded*[d]	*Disclosure affirmative defense*
Alabama	1987	Misdemeanor	$500		Knowing	Exposure	Yes	
Arkansas	1989	Felony	30 years		Knowing	Exposure		Yes
California	1998	Felony	8 years	Yes	Knowing	Exposure	Yes	Yes
Florida	1986	Felony	5 years		Knowing	Exposure		Yes
Georgia	1988	Felony	10 years		Knowing	Exposure		Yes
Idaho	1988	Felony	15 years		Knowing	Exposure		Yes
Illinois	1989	Felony	7 years		Knowing	Exposure		Yes
Iowa	1998	Felony	25 years		Knowing	Exposure		Yes
Kansas	1992	Felony	1 year	Yes	Knowing	Exposure		
Louisiana[a]	1987	Felony	10 years		Knowing	Exposure		Yes
Maryland	1989	Misdemeanor	$2500	Yes	Knowing	Exposure		
Michigan	1988	Felony	1.5 years		Knowing	Exposure		Yes
Minnesota	1995	Misdemeanor	$1000		Knowing	Exposure	Yes	Yes
Missouri	1988	Felony	15 years		Knowing	Exposure		Yes
Montana	1967	Misdemeanor	$500		Knowing	Exposure		
Nevada	1993	Felony	10 years		Knowing	Exposure	Yes	Yes
New Jersey	1997	Felony	5 years		Knowing	Exposure		Yes
North Dakota[b]	1989	Felony	20 years		Knowing	Exposure		Yes
Ohio	2000	Felony	8 years		Knowing	Exposure		Yes
Oklahoma	1988	Felony	5 years	Yes	Knowing	Exposure	Yes	Yes
Rhode Island	1921	Misdemeanor	$100		Knowing	Exposure		
South Carolina	1988	Felony	10 years		Knowing	Exposure		Yes
South Dakota	2000	Felony	15 years	Yes	Knowing	Exposure		Yes
Tennessee	1994	Felony	15 years		Knowing	Exposure	Yes	Yes
Utah[c]	1981	Misdemeanor	$2500		Knowing	Transmission		
Virginia	2004	Misdemeanor	$2500		Knowing	Exposure		Yes
Washington	1986	Felony	10 years	Yes	Knowing	Exposure		
West Virginia	1921	Misdemeanor	$100		Knowing	Exposure		

[a]LA's statute uses the word 'intentionally' in a way that means 'knowingly'.
[b]ND's affirmative defense provision requires both informed consent and condom use.
[c]UT criminalizes the knowing introduction of an STD into 'any county, municipality or community'.
[d]These laws only apply to certain risky behaviors, but the statutory language referring to the behaviors varies considerably: 'probably or likely transmit' (AL), 'unprotected sex' (CA), 'likely to transmit' (NV), 'reasonably likely to result in the transfer' of body fluids into the bloodstream of another (OK), and 'significant risk of HIV transmission' (TN). In MN, condom use is an affirmative defense.
Note: This table does not include sentence enhancement statutes. Missing states do not have statutes. CO and NY have general STD laws, but the state public health agency and case law, respectively, exclude HIV. Year enacted is the year in which an HIV-specific statute was first adopted or, if the state does not have one, the year in which a general STD statute was adopted. Some of the misdemeanor offenses may involve incarceration in addition to or instead of the fine.

life, excluded from the enjoyments of civil liberty. *Homo sacer* can be killed with impunity but not sacrificed. The *homo sacer* is not an enemy of the state, and therefore still belongs to the state. But he is also not wholly inside the state, either, the way a common criminal might be. A *homo sacer* is more like a concentration camp inmate, neither in nor out. The presence of *homo sacer* in modernity, Agamben argues, forces a reconsideration of the meaning of life and the value of those who have chosen to violate the norms of society. 'The decisive activity of biopower in our time consists in the production not of life or death, but rather of a mutable and virtually infinite survival' (Agamben, 1999, p. 155). It now seems clear, following Agamben's work on biopower (itself an extension of Foucault's work on the subject), that HIV-positive men can be included in the category *homo sacer*. Having been stripped of their right to remain silent (transmission laws require the HIV positive to speak of their disease), and, at the same time, having lost their stake in civil society by social practices and laws that exclude, mark, stigmatise and incarcerate such persons, they have only their bodies to mark them as human. They have been reduced to bare life and are denied the possibility of 'a qualified life, a particular way of life' (Agamben, 1998, p. 1).

HIV/AIDS disclosure laws contain within them an existential component that is difficult to ignore. In Texas, for example, a homeless man was sentenced to 35 years in prison for spitting into the mouth and eye of a police officer, after telling the officer that he was HIV positive. The homeless man was charged with assault with a deadly weapon, despite the fact that the CDC have stated that 'contact with saliva, tears, or sweat has never been shown to result in transmission of HIV' (Kovach, 2008). In Florida, it is illegal for an HIV-positive person to bite a non-HIV-positive person, even if the non-HIV-positive person's serostatus is not changed as a result (Whitehorn, 2000). In Pennsylvania, Eric Perez is in prison for theft and aggravated assault. If Mr Perez had been HIV negative, he would have likely been sentenced to about two and a half years in prison. But because he is HIV positive, and he bit a security guard, who remains HIV negative, he was sentenced to 27 years in prison (Whitehorn, 2000). In a Texas case, the penis and bodily fluids of an HIV-positive man were considered deadly weapons sufficient to sustain a verdict of 'aggravated sexual assault' (Markus 1999, p. 852, n. 27). In Ohio, a court held that an HIV-positive man's saliva was a 'deadly weapon' as long as it contained blood. In this instance, an HIV-positive man spat in a police officer's face (Minahan, 2009, p. 94). And yet, 'Of more than 60 000 cases of AIDS reported to the Centers for Disease Control, none have implicated saliva as a likely cause of transmission' (Gostin, 1989, p. 1025). Also in Ohio, a judge sentenced an HIV-positive defendant to the maximum penalty allowed by law, 8 years for each count against him, because the defendant's unwitting partner, now called a 'victim',

was in fact 'sentenced to death', and that the defendant not only endangered the victim but the entire community (McArthur, 2009, p. 721).

Not surprisingly, given the outsized fear that HIV/AIDS causes, some US states regulate serostatus and not behaviour as such. For example, an HIV-positive person who uses a condom with an HIV-negative person can be found guilty of a felony under Missouri's and Ohio's respective disclosure laws. 'Condom use without serostatus disclosure will not "protect" the parties from conviction in Ohio' (Minahan, 2009, p. 102). Florida law specifically prohibits intercourse for those with HIV/AIDS (Wolf and Vezina, 2004, p. 850). And the US military prosecutes the possible transmission of HIV/AIDS to partners (whether suspecting, knowledgeable or ignorant) under the Uniform Code of Military Justice. In *U.S.* v. *Bygrave*, a military case, an HIV-positive man had unprotected sex with a female who knew of her partner's positive serostatus. The military charged the man with 'assault with a means likely to cause death' (Weiss, 2006, p. 399). The knowing partner, who remained HIV negative, was not prosecuted.

Such prosecutions are becoming more widespread, and not just in the United States, where more than half of the world's prosecutions for potential HIV transmission have taken place (Bernard, 2010). For the past decade, there has been a general uptick in reported HIV/AIDS cases throughout Europe, particularly in Central and Eastern Europe. But prosecutions of HIV transmission have been notable in Switzerland, Austria, Sweden, Denmark, Finland and the Netherlands, as the table below demonstrates.

Number of attempted prosecutions/country (*refers to number of convictions)

30 or over	Austria, Sweden, *Switzerland
20–30 10–19	Denmark, Finland, the Netherlands
5–9	Norway
1–4	Azerbaijan, Cyprus, Czech Republic, Estonia*, France*, Georgia, Germany*, Hungary, Italy*, Latvia, Portugal, Romania,* Slovakia*, United Kingdom
0	Armenia, Belgium, Bosnia and Herzegovina, Croatia, Iceland, Ireland, Liechtenstein, Lithuania, Malta, Moldova, Serbia and Montenegro, Turkey, Ukraine*
HIV transmission not criminalised	Albania, Bulgaria, Luxembourg, Slovenia, Republic of Macedonia
No data or not enough data received from the country	Andorra, Greece, Poland, Russia, San Marino, Spain

In the following countries, only actual transmission of HIV is punishable:

Only actual transmission punishable
Belgium, Bosnia and Herzegovina, Croatia, Czech Republic, Estonia, Finland, Hungary, Ireland, Latvia, Lithuania, Malta, Portugal, Romania, Serbia and Montenegro, Switzerland and the United Kingdom.

In the following countries, exposing another person to the risk of transmission is punishable:

Exposing another person to the risk of transmission also punishable
Armenia, Azerbaijan, Denmark, France, Georgia, Germany, Iceland, Liechtenstein, Moldova, the Netherlands, Norway, Poland, Russia, Slovakia, Sweden and Ukraine.

Source: Criminalisation of HIV Transmission in Europe.

What is happening here is more than a reorientation of language or an adjustment of the criminal justice apparatus to a new problem. These laws are not intended to be symbolic of a legislature's power to address the irrational concerns of an uneducated citizenry. Rather, the rise in disclosure laws is part of a strategy to reclassify danger by connecting the biological existence of homosexuals to a restrictive political agenda. These laws also go beyond deterrence as traditionally understood (Bedau, 1983). Outside the formalities of legal language, the life of the HIV-positive person is now managed by considerations of risk, through a paradigm of surveillance and security, where the values of social preservation reflect the burdens of individual responsibility, so that those with communicable diseases that can only be managed but not eradicated need to be set at a distance from those who are seemingly healthy. Doubt about the effectiveness of living with those who are HIV positive is the order of the day, not epistemological (or epidemiological) certainty regarding the transmission of the disease. Consequently, the polity is constituted by those it excludes, and the excluded form the basis for the polity's understanding of its survival. The positivity of the HIV person creates a limit attitude regarding the boundaries of liberalism's relation to tolerance. Yet exclusion is brought into the discourse of liberalism without criminal sanction because the HIV-positive person is the embodiment of the exception that formulates the rules upon which liberalism operates (Agamben, 1998, pp. 83–84). As it is always possible that blood could be tainted and machines could fail to diagnose a disease, modern society is confronted with the notion that the well-being of any individual is interconnected with the well-being of others (Feldman, 2000). Thus, the threat to health is 'collective' and 'international' (Ewald, 2002, p. 293), and the burden

of individual responsibility is greater, forcing the utmost precautions to be taken to ensure non-contamination (Ewald, 2002, p. 297).

As these laws further intrude into the realm of the private, a new discourse is emancipated (or an old one, sex, is further embedded into a discourse of power). 'Silence equals Death', formerly a slogan used by the HIV/AIDS community to criticise the silence of government officials in the face of the HIV/AIDS epidemic in the mid-1980s, is now a legal prohibition on those with HIV/AIDS. To be silent about one's serocondition is to provoke the police powers of the state. Confession is mandatory (*State* v. *Musser*, 721 N.W.2d 734, Iowa, 2006). This is not, however, a protected confession, as between a parishioner and his or her minister. If the HIV-positive person will not confess to the non-infected partner, the law will. Indeed, the confession must go all the way down, to every intimacy. The law in Michigan, for example, is not confined to sexual intercourse. It requires known HIV carriers to inform their partners of their status in sex acts that include: 'cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required' (Galletly and Pinkerton 2008, p. 577). At least 10 states make it a crime to fail to disclose one's HIV/AIDS status before engaging in sexual relations (Weiss, 2006, p. 392). California has one of the more lenient disclosure laws, criminalising 'undisclosed exposure to HIV only when the HIV-positive person engages in unprotected anal or vaginal sex with an uninformed partner and does so intending to infect the partner' (Galletly and Pinkerton, 2008, p. 577). But California also gives the judge sentencing discretion, which can result in long-term confinement (McArthur, 2009, p. 721).

As a consequence of the popularity of disclosure laws, coupled with the ever growing popularity in unsafe sex, there has been a rise in new research (Bolton *et al*, 1995; Scarce, 1999, Halkitis, 2001; Suarez and Miller, 2001), most of which has focused primarily on the demographic background of those with HIV/AIDS, but has not addressed the desires at play within this practice (Tremblay, 2003). Moreover, the epidemiological understanding of unsafe sexual practices does not take into account several sociocultural and psychological dimensions: How important is it for men and women to feel a man inside them without a condom? What are the symbolic dimensions associated with semen exchange? For the most part, research based on epidemiological theoretical frameworks overlooks the importance of desires operating in the action itself.

Health-care providers dealing with the detection and education of STI are therefore vested with paradoxical responsibilities: Supporting the preventative measures regarding safe sex, while respecting their patients' personal decisions and choices. Health-care professionals must support and convey the public

health message while defending individual choices and needs, as dictated by their professional ethics. But we believe that a heightened understanding of the motivations behind unsafe sex is necessary to promote the implementation of public health interventions that will be better adapted to the reality of this population.

As a consequence of the failure of public health professionals to understand this radical sexual freedom movement (Rofes, 1996; Crossley, 2002; Manserg *et al*, 2002), intervention strategies seem to be either improvised or far too targeted, rather than stemming from a precise and customised plan of action. This results from the dearth of knowledge on the subject within the existing literature, especially in scientific journals, which in turn results from the lack of empirical research. An exploratory research design helped us in better understanding this new sexual practice, which some authors believe is responsible for the recrudescence of STI and HIV.

In light of the existence of this sexual practice, qualified as radical by many, we believe that there is an urgent need to begin reflecting on the type of preventive strategies needed that move beyond law enforcement. To this effect, the final purpose of this article is to initiate a reflection as well as a dialogue on the compatibility between the practice of bareback sex and a health risk reduction approach.

Understanding Unsafe Sex

Concurrently with demographic, psychological or contextual factors often associated with at-risk behaviours linked with HIV infection, several emerging new factors can also be related to the rise in these behaviours (Elford, 2006). For example, the relationship between optimism linked to the success of antiviral treatments and the increase in at-risk sexual behaviours has received a lot of attention (Sullivan *et al*, 2007; Rowniak, 2009; Brennan *et al*, 2010).

But other factors should also be considered, such as the anti-HIV vaccine trials and the availability of post-exposition prophylaxis (Bartholow *et al*, 2005; Poynten *et al*, 2009), as well as the rise in the popularity of the Internet for looking for anonymous sex partners (Liau *et al*, 2006). Moreover, some non-scientific journal articles report that many individuals practice voluntary unprotected anal intercourse for various reasons: to increase sexual pleasure, to feel a true connection and intimacy with one's partner, to achieve sexual arousal at the thought of transgressing recommendations from public health organisations and HIV prevention campaigns, and finally to realise symbolic bonding through the exchange of semen between partners (Scarce, 1999;

Manserg *et al*, 2002). The literature also refers to a particular form of unsafe sex named bug chasing. This type of practice aims not only at having intentional unprotected anal intercourse but also at deliberately attempting to get infected (Gauthier and Forsyth, 1999).

Unsafe Sex within the Gay Community

Some authors have defined health promotion as a process whereby individuals and communities aim to increase control over their own health as well as other the factors, individual and environmental, that influence health (Rootman *et al*, 2000). This definition underlines the importance of context regarding health improvement. According to Green and Kreuter (1991), the local community is health promotion's 'center of gravity'. Their affirmation rests on a number of published works. Community participation is an essential element of every health promotion intervention (McQueen and Anderson, 2000). Consequently, health promotion interventions should be based on an ecological vision comprising action at the organisational, community and political level instead of exclusively targeting individual characteristics (Green *et al*, 1996; Stockols *et al*, 1996). If community participation is an important means to promote the integration of individuals in the community, community participation can also be considered as a form of 'protection' against HIV/AIDS infection (Ramirez-Valles, 2002). In effect, by means of their involvement with community agencies, individuals develop and maintain their identity while becoming aware of the risks and behaviours associated with HIV/AIDS. Moreover, it is through community involvement that they are able to adapt interventions to their cultural context.

To be sure, linking the question of sexual identity to the HIV/AIDS phenomena within a community is not without problems. As Yep *et al* (2002) have noted, gay men can be characterised according to their sexual practices ('vanilla', 'kinky', 'raunchy'), their sexual roles ('top', 'bottom', 'versatile'), their sexual types ('bear', 'daddy', 'surfer', 'cowboy') and more recently their serological status (seropositive or seronegative) and their sexual behaviours in the context of the serological status (safe sex only or unsafe sex). Moreover, if the social *homosexualisation* of HIV/AIDS favors the reemergence of homophobia (Altman, 1984), then the identification of seropositive individuals as transmission vectors will bring its share of stigmatisation that could go beyond social isolation, and include punishment for sexual practices, as we have demonstrated. This, in turn, could create divisions within the gay community and its supporters in the non-gay community, and further weaken any attempt to enhance community mobilisation in the fight against HIV.

To be sure, the existence and representation of multiple identities with the gay community is neither unusual (from the standpoint of democratic politics) nor can it be dismissed as the problems of a particular marginal community. Such fragmentation within the gay community is a fact of political life, as it is for all groups. Consequently, interventions within the gay community must begin by taking into account the specific needs of the diverse subgroups composing this community (Yep *et al*, 2002).

In light of the possible fragmentation of the gay community into numerous subcultures, we believe that HIV/AIDS prevention begins with local interventions, that is, preventive strategies adapted to the specific needs of these subcultures, where harm reduction plays a pivotal role.

Unsafe Sex and Harm Reduction – Future Perspectives

In the 1980s, the concept of 'harm reduction' emerged in Europe as a response to the issue of drug addiction (Brisson, 1997). Harm reduction refers to the 'reduction of harmful effects on health' or 'damage reduction'. Harm reduction is based on two fundamental principles: pragmatism and humanism, which are used as replacements for the idealism and moralism previously prevalent in matters pertaining to drugs (Brisson, 1997).

Transposed to sexuality, this approach, even if it leans towards abstinence, aims to decrease the relative risk of HIV transmission by advocating condom utilisation. Moreover, since the beginning of the epidemic, MSM have developed a number of complex risk management strategies to balance the duel between sexual desires and reduction in HIV/AIDS transmission (Van de Ven *et al*, 2002). For example, negotiated safety proposes that seronegative men limit their unprotected anal intercourse to those within their couple, be screened regularly for HIV to ensure seroconcordance within the couple, and practice safe sex with infrequent partners (Crawford *et al*, 2001). Other harm-reduction strategies are now brought forward as part of various forums (Scarce, 1999). These harm-reduction strategies have this particular commonality: condoms are basically absent from the prevention strategy. This radical perspective is not without problems, as it raises different stakes and debates.

Individuals can adopt different harm-reduction strategies regarding their serological status. According to Elford *et al* (2001), seronegative men reported having unprotected anal intercourse predominately with a regular partner having the same serological status in the context of a stable relationship; by contrast, seropositive men had a tendency to have more unprotected anal intercourse with infrequent partners, equally of same serological status. Conversely, sexual roles (passive and active, respectively referring to roles

at the time of anal penetration) can equally be considered in the context of a harm-reduction strategy (Van de Ven *et al*, 2002). As such, during sexual intercourse involving ejaculation inside a regular serodiscordant partner, the majority of seropositive men would be passive, whereas seronegative men would be active.

In September 2000, the United Kingdom's Community HIV and AIDS Prevention Strategy launched a campaign entitled Facts for Life, which included slogans never used before, such as: 'It's safer to fuck than get fucked', or 'Pulling out before coming is safer'. The purpose was to suggest risk reduction strategies in the absence of condom use during anal penetration (Devlin, 2001). In the summer of 2002, AIDES-Provence (France) began experimenting with different strategies in Marseille's gay bathhouse. The association distributed pamphlets with slogans such as: '*Tu baises sans capote? Mets au moins du gel!*' [Are you having sex without a condom? At least apply gel!], '*Sans capote, mieux vaut se retirer avant d'éjaculer*! [Without a condom, it's better to withdraw before coming!] or '*Plus vous gardez les liquides sexuels en bouche, plus le risque est grand*' [The more you keep sexual fluids in your mouth, the higher the risk]. For Christian Saout, president of AIDES, preventive actions can no longer merely repeat the phrase 'Always wear a condom'. This is ineffective for individuals who, for psychological reasons, social or affective constraints, or personal choices decide not to protect themselves, or to protect themselves only sometime. A strategy that could be useful with such individuals would be to have them better understand what causes them to take such risks and then to 'technically' understand how to reduce these risks. These individuals would then be able to take the first step towards further protection, a step adapted to their particular situation. Thus, AIDES proposes a scale that ranks sexual practices with their associated risks. This scale allows people to choose their risk level with full knowledge of the facts (Remaides, 2002). It is important to add that a harm-reduction strategy need not substitute customary prevention messages; rather, it complements them (Praï and Héraud, 2002).

These initiatives have raised a debate among actors involved in the fight against AIDS, particularly with Act Up Paris. According to them, AIDES is abandoning prevention to focus on information pertaining to contamination probabilities. According to Act Up Paris, the starting postulate (without a condom…) is a contaminating practice. If condom utilisation is evoked at the back of pamphlets proposing to reduce risks, condom utilisation is still included as part of the risk scale: 'the condom is the best way to protect oneself'. However, for Act Up, condom use does not represent the best way to protect oneself; rather, it is the only way (Act Up Paris, 2002). Beyond the debate, the basic objective of sexual risk reduction as intended by AIDES appears seminal: re-initiate the dialogue with individuals who do not or rarely wear condoms

without inciting others to renounce its protection (Praï and Héraud, 2002). The aim is to stop those who decide not to use condoms from feeling guilty (Lestrades, 2002), as this creates a serious risk of losing any chance to guide their behaviour towards greater harm reduction.

Although harm reduction is generally praised with respect to drug use or sexual practices, there are concerns about this approach. One of these concerns is the fear that harm reduction 'is a Trojan horse for the drug legalisation movement' (MacCoun, 1998, p. 1200). Also, whereas harm-reduction strategies have focused on harm to 'users', drug-related violence and other harms to *non-users* remain important (MacCoun, 1998). Finally, while the prevalence of drug use is known to be more measurable than harm reduction, the literature shows that harm-reduction programmes, with the exception of needle exchange, have not been rigorously evaluated. With respect to sex, we still do not know if harm-reduction strategies regarding unsafe anal sex decrease significantly the likelihood of being contaminated with HIV. But we do know for sure that the 'condom for all' slogan is not working for many psychosocial reasons (Holmes and Warner, 2005; Dean, 2009).

Final Remarks

According to Scarce (1999), the gap between HIV/AIDS prevention messages and the sexual behaviour of gay men is greater than ever. Initially, the majority of prevention strategies focused on fear and shame; more recently, a law enforcement model has become prevalent. Both strategies have a chilling effect on discussions about sexual intercourse without condoms. Moreover, and perhaps more important, these strategies reveal that AIDS groups have not been sufficiently in touch with their communities, which is where the real threat lies. As such, because these strategies ignore the most important danger surrounding unsafe sex, that is, the inability of community members and leaders to address what is truly at stake in hard reduction strategies, they also point towards a solution.

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