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Will I? Won’t I? Why do men who have sex with men present for post-exposure prophylaxis for sexual exposures?

C Sayer,1 M Fisher,2 E Nixon,2 K Nambar,2 D Richardson,2 N Perry,2 C Llewellyn1

ABSTRACT

Background: Failures of post-exposure prophylaxis (PEPSE) to prevent seroconversion following sexual exposure (PEPSE) have been reported and are often associated with ongoing risk exposure. Understanding why men who have sex with men (MSM) access PEPSE on some occasions and not others may lead to more effective health promotion and disease prevention strategies.

Methods: A qualitative study design using semi-structured interviews of 15 MSM within 6 months of them initiating PEPSE treatment at an HIV outpatient service in Brighton, UK.

Results: PEPSE seeking was motivated by a number of factors: an episode that related to a particular sexual partner and their behaviour; the characteristics of the venue where the risk occurred; the respondent’s state of mind and influences of alcohol and recreational drug use; and their perceived beliefs on the effectiveness of PEPSE. Help was sought in the light of a “one-off” or “unusual” event. Many respondents felt they were less likely to behave in a risky manner following PEPSE.

Conclusion: If PEPSE is to be effective as a public health measure, at risk individuals need to be empowered to make improved risk calculations from an increased perception that they could be exposed to HIV if they continue their current behaviour patterns. The concern is that PEPSE was sought by a low number of MSM implying that a greater number are not using the service based on failure to make accurate risk calculations or recognise high-risk scenarios.

Methods

Design

The study consisted of a qualitative design using semi-structured interviews of 15 MSM within 6 months of them initiating PEPSE treatment at an HIV outpatient service in Brighton, UK. Interviews were tape recorded, transcribed and analysed using framework analysis.

Participants

Participants were MSM attending a dedicated PEPSE clinic who were currently receiving or had received PEPSE in the last 6 months. Seventy-five MSM attended the clinic between January 2007 and January 2008 and were given a patient information sheet and consent form by the nurse consultant (EN). The recruitment period was limited to 1 year due to time constraints. The aim was to recruit sufficient numbers to achieve theoretical saturation. Participants were only approached in a nurse-led clinic following verbal consent to being telephoned by the researcher the following day. Altogether, 19 were approached and 15 subsequently agreed to be interviewed.

Interviews

Participants undertook a semi-structured interview with a single interviewer (CS) in a designated interview room separate from the HIV outpatient services. The interviewer was not part of the clinic staff and had no contact with the participants outside of the research setting. A topic guide was used to underpin the interviews, although questions were open-ended and non-directive allowing participants to expand on their personal experiences. Data were collected by audio-recording and transcribed verbatim by an independent agency.
Data analyses
Data were analysed by framework analysis, which seeks to take the accounts and observations of the population being studied and develop categories and themes from the data when and where they arise.27 This consisted of repeated emersion and re-emersion in the transcripts; identification of a thematic framework (table 1); indexing and coding of the data; and mapping and interpretation.28 CS carried out the principle analysis. Major themes were checked and discussed with MF and CL. The later transcripts failed to issue any novel themes or categories and it was agreed that theoretical saturation had been reached.

Results
Of the fifteen MSM interviewed, seven participants were currently taking PEP, four had finished treatment and were awaiting 6 month follow-up and three were awaiting 6 month testing (3 participants were currently taking, or had taken, a previous course of PEPSE). The mean age was 35 years, with a median age of 44 years (range 19–46). Twelve participants were in full-time employment, two were unemployed and one was in full-time education. Ten participants classed themselves as white UK, four as white non-UK and one as black Caribbean. A nationwide survey reported a similar demographic of MSM with a median age of 34 years, although with higher numbers of white British (79.4%) and fewer white non-UK (13.0%) and 1.4% black.16 These differences could be explained by local population epidemiology.

Knowledge and understanding
All the participants were able to talk about their prior knowledge of PEPSE before they presented to HIV/genito-urinary medicine (GUM) services. That PEPSE was available and it could potentially prevent HIV seroconversion was the dominant theme; however, indepth knowledge of what PEPSE consisted of was scant (box 1).

Source of information largely consisted of magazines, posters and leaflets, and the Terrence Higgins Trust campaigns. Again, the details of any information seen was only basic and often highlighted different levels of engagement in the health promotion information when out socially.

All respondents were able to articulate a change in their perceived level of understanding since they had presented for treatment: the length of treatment that they would be taking perceived level of understanding since they had presented for promotion information when out socially.

Perceptions of PEPSE effectiveness before and after contact with HIV services were markedly varied. There was no obvious pattern found, with many participants claiming to have “no idea” before presenting. Others, who would not commit to a figure, described a pragmatic belief along the lines of, “they say it works, it’s better to be safe than sorry” (respondent 14) or “[I didn’t know] figures, just there’s a way to stop the spread” (respondent 3). Many respondents recognised, after initiating PEPSE, that success was dependent on other qualifiers; for example, presenting in less than 72 hours, good adherence and if the partner was known HIV positive or not.

Circumstances leading to PEPSE
The main circumstance leading to presentation for PEPSE was unprotected anal intercourse (UAI); condom failure made up only a small proportion (box 2). That a particular event was worthy of PEPSE due to being a “rare” or a “one-off” event was the dominant theme, as was the use of alcohol or drugs. This was frequently attributed to behaviour that was particularly “unusual” or “out of character” representing a single episode deviating from what was considered “normal” low-risk behaviour. These findings echo previous work on the subject.2 10

Commonly, an unusual event was linked to an “unusual partner” or a partner who had not been entirely honest with them or even just receiving particular “feelings” from a person.

Alcohol and recreational drug use was a leading factor in taking a risk worthy of PEPSE. Only a minority claimed not to have drunk alcohol prior to sexual intercourse. Of the majority who did, it was common to ascribe particular significance to this in view of their “unusual” or “rare” behaviour that led to PEPSE.

Most participants were able to articulate times when PEPSE could have been applicable but was not sought. This linked strongly with the themes already explored on the circumstances leading to transmission and often a previous episode did not fulfill the “special” status of being “unusual” or “one-off.” Indeed many recipients claimed they would always come for PEPSE if they deemed it necessary. Some respondents said that prior failed considerations to take PEPSE rested on a partner or situation not confirming itself to be of high enough risk or not having a confirmed HIV diagnosis in a partner. Not wanting to “waste” healthcare resources was identified by a minority of the participants, although it was not clear to what extent this influenced the decision not to come for PEPSE. Not knowing about the 72 hour time to presentation rule was a further reason, which highlighted a specific gap in knowledge, rather than a difference in attitude, from some of the participants.

Concepts of risk and HIV
Type of partner was the major theme to arise (box 3). Participants equated risk with a variety of aspects; for example, having other sexually transmitted diseases, promiscuity, someone who was
they still recognised areas where risks could be allowed to occur.

Before they came for PEPSE.

to modify certain behaviours that had led to taking it in the first

last 6 months). Other participants used their experience of PEP

episode of UAI outside of the context of negotiated safety in the

the majority of participants had continued to have at least one

seen in the dramatic reduction in UAI with casual partners since

contributed to perceived modified behaviour (box 4). This was

All participants stated that taking PEPSE had in some way

that living in Brighton itself carried an increased risk of HIV.

researched population, although some purported to wanting to

informed as would be expected from such a targeted and heavily

demographic and responses were typically well-rehearsed and

frequently recognised themselves as belonging to a high-risk

into “adventurous sex,” “guys who don’t do safe sex,” casual

partners and known HIV positive men. Universally, these were all

characteristics that were identified in other people and not

themselves. This theme linked strongly with a general theme of

“othering” in which participants distanced themselves from

proceedings and implied the other party was responsible for the

risk, not themselves. This appropriation of responsibility being in

the realm of the “other,” as we have seen already, extended to the

use of alcohol and recreational drugs. These elements making an

“unusual event” more likely or being the driving force for “heat of

the moment” encounters.

Most participants grouped the general concept of risk with

the risk of HIV and articulated this in the terminology of “thrill

seeking,” gambling or “regrettable” behaviour. Participants

frequently recognised themselves as belonging to a high-risk
demographic and responses were typically well-rehearsed and
informed as would be expected from such a targeted and heavily
researched population, although some purported to wanting to
rebel against this once in a while.

Risk was coupled to venue by many participants. Certain sex

venues, saunas or clubs were associated with risk. Others noted

that living in Brighton itself carried an increased risk of HIV.

Box 1 Knowledge and understanding of post-exposure prophylaxis for sexual exposure (PEPSE)

Knowledge prior to presentation for PEPSE

“I [knew that] there was a treatment available. But yeah the

actual mechanics of it I wasn’t aware of.” (Respondent 1)

Finding out about PEPSE

“I’d seen a poster in a gay venue… I don’t think there’s enough

info about PEP. Little leaflets on bars, you don’t pick them up

when you’re out drinking with friends. You know posters in

venues… I’ve seen them and you don’t pay much attention to

them.” (Respondent 10)

Realisation of what PEPSE entailed

“I got home read through the leaflets and basically realised then

that it was a medication designed for people with HIV… It was a

bit of a slap round the face reading that.” (Respondent 1)

Understanding post-PEPSE

“They were talking about like if you did it within the timescale,

like sort of 80% success rate, if not higher really.” (Respondent 8)

“Well, it’s like really not very successful the PEP sometimes, but

sometimes very, very successful.” (Respondent 13)

Out of character behaviour

“I had just separated recently, so it [UAI] was kind of a way of

me trying to react, I don’t know, trying to, just forget about it, just

have fun, you know do drugs and get drunk.” (Respondent 4)

Unusual event

“It was certainly kind of a one-off I think… I was in a sauna,

where I’d gone after I’d been out drinking… it was something I

wouldn’t normally do because, like I said, I’d been in a

relationship for the previous six years.” (Respondent 9)

Partner characteristics

“It was his attitude after the event, he was very cagey and went

very quiet… our encounter was an accident and he was sort of

very strange about it… he got a bit upset then disappeared very

quickly… it made alarm bells ring.” (Respondent 10)

“He was into the heavier sort of sexual scene, more than I was…

through that there was obviously a greater danger… He asked

me to fist him after sex, which I was a bit reluctant to do because

my nails were sharp and it caused him to bleed… he then wanted

to have sex again at which point I refused until he cleaned himself

up, at this point I broached him on the subject of HIV status, he
told me he was positive.” (Respondent 15)

Alcohol and recreational drugs

“My attitude after the event, I took drugs, I drank a lot, so

I wasn’t really aware of what I was doing. It just happened you

know, it was just more of a one off thing and that’s probably why

I was so worried about it.” (Respondent 4)

“I certainly think [alcohol] was the primary reason for what

happened.” (Respondent 9)

“I was really drunk and did something that was quite out of

character for myself.” ( Respondent 11)

Box 2 Circumstances leading to presentation of post-exposure prophylaxis for sexual exposure (PEPSE)

Why on this occasion and not others

“All the circumstances around it which made me think well

maybe something’s trying to tell me something, that should go

and take some action.” [Respondent 8]

“What was different? To be honest nothing apart from they didn’t

tell me they had HIV, so they might as well been positive and they

just didn’t tell me.” (Respondent 4)

Most recounted prior themes of unusual events, alcohol and
drugs, or just misfortune as reasons for a particular risk. The
concept that PEPSE could be seen by some as a “safety net” or
analogous to the morning-after pill was well documented. The
participants frequently associated this thinking with other
MSM and not themselves, again reinforcing the theme of
“othering” found earlier.

The benefit of hindsight weighed heavily on statements of
perceived behaviour modification and this followed firsthand
experience of length of treatment, potential side-effects and the
realisation they were taking HAART.

Participants who identified themselves as sometimes having
unprotected sex always qualified it with reference to the
partner’s status: either a “long-term relationship” or exclusively
“trusted” or regular “casual partners”. However, these arrange-
ments were rarely confirmed by mutual screening for HIV. In
other cases so-called “trusted partners” only later disclosed their
positive HIV status highlighting a disparity between subjective
and objective views of risk.

Behaviour modification in the light of PEPSE

All participants stated that taking PEPSE had in some way
contributed to perceived modified behaviour (box 4). This was
seen in the dramatic reduction in UAI with casual partners since
taking PEP to a period of complete celibacy in some (although
the majority of participants had continued to have at least one
episode of UAI outside of the context of negotiated safety in the
last 6 months). Other participants used their experience of PEP
to modify certain behaviours that had led to taking it in the first
place. However, most considered their behaviours to be low risk
before they came for PEPSE.

In other cases PEPSE had changed their outlook on risk, but
they still recognised areas where risks could be allowed to occur.

That the existence and provision of PEPSE could have directly
influenced a particular risk was abhorrent to all the participants.

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other cases so-called “trusted partners” only later disclosed their
positive HIV status highlighting a disparity between subjective
and objective views of risk.
Box 3 Concepts of risk and contracting HIV

Rebelling against health promotion
“‘You must always use a condom,’ blah blah blah. You get this kind of drummed into you that maybe of some, them people will just want to say ‘fuck you’ basically.” (Respondent 3)

Risky venues
“Regularly going to the ‘Brighton cruising ground’ and not being that careful… going to one of Brighton’s saunas and not being careful. I don’t put myself at risk cruising around.” (Respondent 10)

Risky partners
“Guys who don’t do safe sex, have multiple partners… it sounds a bit xenophobic, like people from America are more likely to have it than not… some guys just don’t like to wear condoms, some guys try to push you into not wearing a condom.” (Respondent 10)

“There was a weird rash on the face and part of the body so I was very, very scared.” (Respondent 13)

Risky lifestyle
“Being drunk or on drugs can make you just forget about how big a risk you now take if you are doing unprotected sex.” (Respondent 2)

Taking drugs, alcohol or risking yourself, it’s too easy to lose control of yourself, it can leave people to do whatever they want with your body or… you know, it’s like you don’t pay attention.” (Respondent 13)

Box 4 Changes in behaviour and post-exposure prophylaxis for sexual exposure (PEPSE)

Modification of sexual behaviour
“I’ve slowed down a bit, I’m not going to the ‘bushes’ so much and like maybe I’ll be seeing more people that I know better and stuff like that, not too much casual sex now.” (Respondent 6)

Long term commitment to change
“As time goes by it drifts back into the recesses of your mind rather than the forefront, but I think I will probably be more cautious.” (Respondent 15)

“I’ll certainly learn from it and hopefully even if I’m blind drunk I’ll kind of remember, you know, like to behave myself… [but] if it was like five years later, or whatever, you know, we’re all kind of human I guess.” (Respondent 9)

Knowledge of PEPSE being a catalyst for risky behaviours
“No! [knowing about PEP] wouldn’t change anything for me. You can’t use it like a morning after pill, they’ll stop giving it to you.” (Respondent 6)

“[PEP] it’s not something that I can say ‘oh it’s ok I can do what I want because I know I can just be like effing get it and it’ll be alright.” (Respondent 12)

The benefit of hindsight
“I don’t think it could make you more risky. I think anything but, you know side-effects, appointments, remembering to take meds… I’ve seen people in the waiting room I know and they would obviously make like the complete two plus two decision in their heads as soon as they see I’m here.” (Respondent 9)

DISCUSSION

Although awareness of PEPSE was high, a detailed knowledge of what it consisted of was lacking. Nonetheless, a substantial change in the level of understanding post-treatment represents the value of face-to-face health promotion in this setting. The assumption is that better education of this population is fundamental in reducing the number of sexual risks resulting in PEPSE uptake; however, as of yet there is no evidence to support this. Not wanting to waste healthcare resources is perceived to have been modified by the participants after taking PEPSE: Risk was equated with alcohol, venue, partner characteristics and life events, and it was these factors that were associated with the context of “negotiated safety” combined with the accuracy of subjective risk calculations.

Modification of sexual behaviour: As has been seen, a propensity for participants to purport irresponsible behaviours to “others” demonstrates that there is a problem with the subjective view of personal risk. It seems that the key message that UAI is dangerous is embedded within the population of PEPSE patients. However, UAI outside of the context of “negotiated safety” combined with the associated behaviours already mentioned represents a driving reason for presentation. Furthermore, these presentations only came as a result of a real suspicion, or genuine knowledge, that the partner was HIV positive; otherwise the participants simply did not present for PEPSE and continued to put themselves at risk.

The fact that no participant agreed with the statement that knowledge of PEPSE could increase risk behaviour was encouraging, as was the overwhelming consensus that personal experience of PEPSE had changed perceived behaviours for the better. A long-term commitment to recognise that risks are being taken and are not necessarily unusual or one-off is still in doubt and thus far studies have only shown a reduction in risk following PEPSE for 2 years or less. There are still good grounds for supporting the theory that PEPSE does not increase perceived risk behaviour in MSM and there is evidence that key areas contributing to risk were identified and, subsequently, perceived to be modified by the participants after taking PEPSE: notably, alcohol consumption, partner selection, venues and individuals presenting at GUM services and increasing their ability to make risk assessments through risk-reduction counselling and information packs.

Self-reporting of behaviour patterns, particularly the statements that their “normal” behaviour was low risk, mimicked data from other studies. It was interesting that the group distanced themselves from what they considered to be high-risk behaviour. As has been seen, a propensity for participants to purport irresponsible behaviours to “others” demonstrates that there is a problem with the subjective view of personal risk. It seems that the key message that UAI is dangerous is embedded within the population of PEPSE patients. However, UAI outside of the context of “negotiated safety” combined with the associated behaviours already mentioned represents a driving reason for presentation. Furthermore, these presentations only came as a result of a real suspicion, or genuine knowledge, that the partner was HIV positive; otherwise the participants simply did not present for PEPSE and continued to put themselves at risk.

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type of sex. It is important to note that there is a difference between the participants’ perception of behaviour modification and actual measurable changes in behaviour.

One of the most powerful implementations that could result from this study is the provision of PEPSE “starter packs” that allow MSM to initiate treatment themselves in the event of sexual risk. This strategy has been trialed previously with some success.16 By removing the perceived barriers regarding PEPSE, and the concern of not wanting to waste the time and resources of healthcare professionals, this could be a worthwhile strategy. Furthermore, the process of obtaining these packs would provide a point for health promotion and a focus to the individual as to how to reflect differently on their own risk experiences and ultimately avoid having to use them in the first place.

Limitations
The use of a sample chosen for its convenience due to resource and logistical restraints is rarely ideal and it must be recognised that the population of MSM in Brighton is an already well searched group. From analysing the data, two major improvements would logically follow: the inclusion of a group of MSM who had not taken PEPSE for sexual exposure and a long-term follow-up of the study population. The former would certainly improve areas where the experience of PEP had coloured the opinions on risk and HIV and modified risk behaviour. The latter would again give a better understanding into the effects of PEPSE on future risk-reduction strategies with the “knee-jerk” element of the responses post-PEPSE counselling removed. However, with these issues aside, this study does add valuable understanding to MSM’s experience of PEPSE.

CONCLUSION
Individuals can never make entirely objective assessments of risk probability; it is part and parcel of the human condition that we are subjective beings and we make decisions based on our social and sexual contexts. If PEPSE is to be effective as a public health measure, at-risk individuals need to be empowered to make improved subjective risk calculations. By increasing the population of MSM’s perception as to the likelihood that they could have been exposed to HIV through identification of triggers that the men in this study identified, health promotion can target additional interventions, information and even starter packs to encourage MSM to reflect differently on their own risk experiences.

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Contributors: CS was principal investigator responsible for study and interview design, data collection, primary analysis and presentation of results. MF was principal supervisor responsible for study conception and contributed to study and interview design and secondary data analysis. EN was clinical nurse consultant involved in recruitment and consent. KN was assistant supervisor and contributed to study and interview design. DR was assistant supervisor responsible for proof reading and amendments. NP was research manager responsible for the logistics of interviewing, transcription and funding. CL was supervisor of ethics, study design and secondary data analysis.

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