The goal of sexual risk reduction is to lower risk for HIV and other sexually transmitted diseases (STDs). Although latex condoms are an effective barrier for preventing HIV transmission, many people do not regularly use condoms during sex. This issue of PERSPECTIVES explores HIV risk reduction strategies for people who choose to engage in unprotected sex.

Research Update

Although consistent and correct condom use is the most effective strategy other than abstinence for reducing the risk of sexually transmitting HIV, consistent condom use is rare among heterosexually active adults and adolescents, and it is only slightly more common among urban gay men.\(^1\)\(^-\)\(^3\) According to a 1996 national survey, 62 percent of adults reported condom use at last intercourse outside of an ongoing relationship, 19 percent reported condom use when the most recent intercourse occurred within a steady relationship, and 40 percent of injection drug users reported condom use at last intercourse.\(^4\)

People forego condom use for many different reasons, including discomfort, inconvenience, reduced sexual sensation and spontaneity, and embarrassment. Some people feel that condoms compromise intimacy. Many gay men, for example, consider the act of sharing semen to be an expression of intimacy.\(^5\) Many people avoid discussing condoms, fearing that requesting condom use may reduce their desirability and cause them to lose a sex partner.\(^6\)

The ability to make decisions about condom use may also be related to a person’s perceived level of control in the relationship. For example, women may feel uncomfortable asking male partners to use condoms because of cultural norms and concerns about personal safety.\(^7\) Some people avoid requesting condom use because of fear that doing so may be interpreted as mistrust.\(^8\) In many cases, becoming pregnant takes precedence over HIV prevention, and in some cultures and religions, contraceptive use is taboo.

People who are allergic to latex may avoid using condoms or use condoms made from other materials. Lamb skin condoms have traditionally been the main alternative to latex, but these are less effective than latex at preventing transmission of HIV and other sexually transmitted diseases (STDs).\(^9\)

The recent introduction of polyurethane condoms provides another option for people who are allergic to latex.\(^10\) Polyurethane condoms are virtually non-allergenic, offer equivalent levels of contraceptive protection as latex, and can be used with a wider variety of lubricants. But research indicates that polyurethane condoms are more likely to break or slip. One study of
Harm Reduction Theory and HIV Risk

The commonly accepted HIV risk reduction model related to sexual risk is an adaptation of harm reduction theory, a client-centered intervention strategy developed for substance use recovery. Recognizing that some clients will use substances for a variety of reasons, and that substance use inherently causes some level of harm, harm reduction interventions seek to explore a client’s reasons, methods, and practices for using substances and then work to alter behaviors to minimize harm. In the context of sexual risk, it is similarly reasonable to expect that many people will not consistently use condoms simply because it reduces HIV risk. Unlike substance use, however, sex does not in itself cause harm, so the term “risk reduction” is more appropriate than “harm reduction,” but the theory is essentially the same.12

Harm reduction theory calls for interventions to engage and meet clients “where they are” in relation to risk behavior and to move in small, manageable steps toward improved levels of self-care, health, and well-being.13 Harm reduction programs seek to move clients toward increased safety by promoting behaviors that offer incrementally greater levels of protection. Because abstinence—from substance use or risky sex—has a realistic goal, harm reduction theory uses a “hierarchy of risk” model that identifies risk behaviors, recognizes that some risks are greater than others, considers which, if any, behaviors to modify, and encourages clients to progress along the continuum of behavior change.14

On the generally accepted spectrum of sexual HIV risk behaviors, unprotected receptive anal sex ranks as the highest risk, followed by unprotected receptive vaginal sex. Unprotected insertive anal and vaginal intercourse fall into the mid-range of the HIV risk spectrum. Any anal or vaginal sex with a condom is a moderate- to low-risk sexual behavior when the condom is used correctly. Unprotected oral sex is considered to be a low-risk behavior, and oral sex with a condom or dental dam poses the lowest HIV risk on the spectrum.15,16

In a recent three-city study of 2,198 gay and bisexual men, the estimated per-contact risk of acquiring HIV from unprotected receptive anal sex was 0.82 percent with partners known to be HIV-positive and 0.27 percent with partners of unknown serostatus. With HIV-positive or unknown serostatus partners, the estimated per-contact risk of unprotected insertive anal sex was 0.06 percent, and the estimated per-contact risk of unprotected receptive oral sex was 0.04 percent.17 In another study, male-to-female HIV transmission was 2.3 times more likely than female-to-male transmission.18

Oral Sex

Although penile-oral sex without a condom is a relatively safe alternative to other forms of unprotected sex, there have been 39 case reports from major urban centers throughout North America and Europe that suggest HIV transmission by this route.19 There have been only two documented cases of female-to-female oral HIV transmission, the causes of which remain unknown.20

There are no definitive studies of oral HIV transmission because infections caused by oral sex are rare, and it is difficult to find HIV-positive people whose only risk behavior was oral sex. One theory suggests that the presence of mouth trauma, gum disease, recent oral surgery, or lesions in the mouth provide a route of entry for HIV.19 During oral sex, it is generally the receptive partner who is at risk. Unprotected oral sex can substantially reduce the risk of HIV transmission.
Related Issue: Female Condoms

The Reality brand condom, marketed as the “female” condom, was developed primarily as a female-controlled alternative to penile condoms. The Reality condom is a polyurethane pouch that lines the vagina, with a removable inner ring and fixed outer ring to keep it in place.

The Reality condom is an effective barrier against HIV and other sexually transmitted diseases (STDs). A one-year study found a 90 percent decrease in HIV infection among women who had sex twice a week with an HIV-positive man and used the Reality condom correctly. The Reality condom may also reduce risk of transmitting the genital warts and herpes viruses by providing greater protection to the vulva and base of the penis than does the penile condom.

Since its approval for vaginal use by the Food and Drug Administration (FDA) in 1994, an increasing number of people, especially gay men, have begun to use the Reality condom for anal sex. There are no published data on its efficacy in preventing HIV transmission during anal sex, but the Reality condom appeals to some men who have trouble maintaining erections during sex or who do not want to stop sexual foreplay to apply a penile condom.

In response to an anonymous questionnaire about using the Reality condom for anal sex, 86 percent of 100 men who have sex with men said they would use Reality again, and 54 percent said they would rather use it than penile condoms. Acceptability was higher among participants who were HIV-positive, who were in non-monogamous relationships, or who had serodiscordant partners. In addition, 33 percent of the participants reported difficulty inserting the Reality condom into the anus, 17 percent reported irritation, 12 percent reported bunching up, 10 percent reported unpleasant texture, and 9 percent reported noise when using the Reality condom. Breakage was reported three times in 334 episodes of use.

In a Seattle study of 7,000 gay and bisexual men, 96 percent reported engaging in unprotected oral sex.

Some prescription and recreational drugs, including crack and speed, cause dry mouth or chapped lips. Because saliva acts as a protective agent against many types of infection, including HIV, dryness in combination with a tear or sore in the mouth may facilitate oral HIV transmission. Drinking water helps to rehydrate mucous membranes.

A recent New York study of 20 young HIV-negative gay men found that during unprotected receptive oral sex, 55 percent did not take ejaculatory fluid into the mouth, 35 percent did not swallow ejaculatory fluid taken into the mouth, 10 percent did not engage in deep-throating the penis, and 10 percent rinsed their mouths after oral sex. These findings indicate that many of the study participants were aware of HIV risk reduction practices for oral sex.

While some of these risk reduction methods may be useful in reducing HIV risk, unprotected oral sex still poses a high risk for transmission of other STDs that are more infectious than HIV, including gonorrhea, chlamydia, hepatitis A and B, herpes, syphilis, and human papilloma virus (HPV), which causes genital warts. Infection with STDs other than HIV may increase the risk of HIV transmission.

Anal and Vaginal Sex

Despite high risks for HIV infection, unprotected anal sex, often called “barebacking,” appears to have regained popularity in the gay community, especially among young gay men. Some gay men feel that the pleasure of barebacking, also called “going raw” or “skin-to-skin,” outweighs its risks.

A San Francisco study found that between 1994 and 1996, there was a 25 percent increase in the number of men who had unprotected anal sex with at least two partners, an 84 percent increase in rectal gonorrhea cases—an indicator of unprotected anal sex—in men over the age of 14, and a 6 percent decrease in the number of men who reported consistent condom use during anal sex.

For people who decide to forego condom use during anal or vaginal sex, strategies that may help to reduce risk of HIV and other STDs include: engaging in unprotected anal sex only with HIV-negative partners who test regularly; reducing the number of sex partners to limit exposure to HIV; using lubrication to reduce the likelihood of tearing; having the insertive partner “pull out,” that is, withdraw his penis before he ejaculates; avoiding use of poppers and Viagra, which dilate blood vessels in the rectum and vagina, making it easier for viruses to enter the bloodstream; checking potential partners for lesions, warts, discharge, or other physical signs of STDs; avoiding douching or using enemas with detergents that can strip away pro-
detective cells in the rectum or vagina; and being vaccinated for hepatitis A and B because unprotected sex may cause exposure to fecal matter and other hepatitis-carrying fluids.5

To reduce the HIV risk of unprotected sex, people in primary relationships sometimes agree to conditions of “negotiated safety.” Negotiated safety refers to an arrangement between sex partners of the same HIV infection status to engage in unprotected sex with each other but to also reduce HIV risk either by being monogamous or by always using condoms with other sex partners. Many people entering new relationships use negotiated safety to reduce their HIV risk. In a study of 1,500 clients at an HIV testing clinic in London, more than half of heterosexual men and women and one-third of gay men reported preparing for a new relationship by testing for HIV antibodies.25

There is also evidence suggesting that HIV infectivity and therefore transmission risk increases with higher levels of viral load, a measure of concentration of HIV in the blood. A study in Uganda followed 415 “serodiscordant” couples, in which one partner is HIV-positive and the other is HIV-negative. After 30 months, 90 of the HIV-negative participants had become infected. The mean viral load level was significantly higher among HIV-positive participants whose partners became infected (90,000 copies per milliliter) than among those whose partners did not become infected (38,000 copies per milliliter). Further, there were no instances of HIV transmission among the 51 participants with a viral load of less than 1,500 copies per milliliter.26 This is the first such study, but if the results are confirmed by further research, a risk reduction strategy for serodiscordant sex partners may be to engage in unprotected sex only when the infected partner has low viral load levels.

Fallacies

Some people attempt to reduce HIV risk by mistakenly using methods that, in fact, are not effective. These methods include using hormonal contraceptives, regularly testing for HIV under the misconception that testing negative is in itself a prevention method, and douching after sex with ingredients that can strip away protective cells in the rectum and vagina.5,6

In a Missouri study of 2,256 low-income women, 59 percent of participants who had sex with men reported using at least one prevention strategy other than condom use, many of which are largely ineffective: 68 percent tested for HIV, 44 percent reported that their partners had tested for HIV, 41 percent asked partners about sexual history, 19 percent used oral contraceptives, 14 percent asked partners if they were HIV-infected, 12 percent douchèd, and 2 percent engaged in anal sex instead of vaginal sex.6

Although the spermicidal agent nonoxynol-9 can kill HIV, recent research indicates that using it may slightly increase HIV risk. Nonoxynol-9 can have an irritating effect on vaginal mucosa and anal tissue, leading to lesions that can create a route of entry for HIV. In a four-year study of nearly 1,000 female sex workers in Africa, participants who used nonoxynol-9 with condoms became infected at about a 50 percent higher rate than those who used condoms with a placebo gel. The study also found an association between increased HIV risk and frequency of use of nonoxynol-9 gel without a condom.27

As a result of these findings, the Centers for Disease Control and Prevention (CDC) has stated that nonoxynol-9 is not an effective HIV prevention strategy.28 Other “microbicides”—substances that kill microbes—that effectively protect against HIV are in development, but none is currently available to replace nonoxynol-9.
Implications for Counseling

Clients who for a variety of reasons do not use condoms during penetrative sex present one of the most challenging situations for HIV test counselors. When counseling such clients, it is essential to remain client-centered and non-judgmental and to understand why a client chooses not to use condoms.

Even if clients choose not to use condoms, there are other options to reduce risk that are, in many cases, related to the reasons clients cite for not wanting to use condoms. For instance, clients who believe that condoms reduce intimacy may benefit from a discussion that explores their interpretations of the meaning of intimacy and how they can attain intimacy without placing themselves at risk. For clients who are allergic to latex, it may be appropriate to discuss natural or lamb skin condoms or polyurethane condoms, making it clear that lamb skin condoms do not offer the same level of HIV protection as synthetic condoms.

When working with clients who are in the contemplation stage of behavior change related to condom use, it can be helpful to ask what clients like and dislike about condoms and under which conditions they would engage in unprotected sex. This exploration can help clients to identify conditions under which they may be able to have sex with relatively low HIV risk. In addition, clients who understand that HIV risk varies depending on the situation may be more willing to use condoms when there is a high risk for infection. For instance, unprotected sex with “casual” or “anonymous” partners is more risky than unprotected sex with a regular or primary partner who is HIV-negative. It is also important to explain that condoms help prevent the transmission of other STDs, and that infection with an STD increases risk for HIV transmission.

Hierarchy of Risk

Educating clients about the levels of risk associated with different sexual behaviors offers sexual options that may be acceptable alternatives to unprotected anal or vaginal intercourse. Help clients to view risk as a hierarchy rather than seeing sexual behaviors simply as either having risk or not having risk. For example, unprotected oral sex is a lower risk behavior than unprotected anal or vaginal sex.

When working with gay men who engage in unprotected anal sex, compare the levels of risk for receptive and insertive anal sex. Although unprotected anal sex poses HIV risk for insertive partners, the risk is substantially lower than it is for receptive partners. Unless the client adamantly refuses to ever use condoms, explore situations in which he may be willing to use a condom, for example, when having sex with multiple partners.

Another risk reduction option is the Reality brand female condom. When exploring this alternative with clients, it is helpful to use a Reality condom as a visual aid and to give interested clients a few to try. Reality condoms are made of polyurethane and can be used with water- or oil-based lubricants.

A Counselor’s Perspective

“I sometimes get annoyed with gay clients who have unprotected anal sex while knowing the risks. But I try not to let it show and force myself to remain neutral.”

Negotiated Safety

It is important to explore with clients their ability and willingness to discuss HIV and other STDs with their partners. When counseling clients who do not tell their partners that they are testing for HIV, explore their reasons for doing so, and ask what would happen if their partners knew about it. This type of discussion can help clients begin to talk to their partners about how to minimize risk for infection.

To further address the possibility of infection, encourage clients who are in monogamous relationships to discuss with their partners how they would react if one of them had sex with someone else. Although it may be true that neither partner intends to be “unfaithful,” people make mistakes, and exploring possible reactions increases the likelihood that a partner will disclose his or her “mistake.”

With encouragement, clients may begin to perceive the possibility of sex outside of the relationship as an unfortunate mistake and initiate discussions with partners about ways to minimize risk in the event of such a mistake. Establishing this kind of mutual understanding and agreement between partners is called “negotiated safety” and is a critical component of HIV risk reduction for people who do not use condoms with regular partners.
To help clients implement negotiated safety, it can be useful to suggest bringing up the topic by saying that it was the test counselor’s idea. For example, a client may say, “The HIV counselor thinks it’s important for us to discuss what we can do to minimize risk in case one of us has sex outside of the relationship.”

Another challenge to sexual negotiation may be the power dynamics in a relationship. The partner who is perceived to have more power or control in the relationship is also more likely to have the most influence over the use of condoms or other risk reduction measures. In some cases, one partner uses intimidation or violence to control the other partner. If a client discloses such a situation during a counseling session, it is important for the counselor to remain neutral, listen, and offer support. Never encourage clients to risk their personal safety in a violent relationship, for instance, by insisting on discussing risk reduction with partners. However, it is a counselor’s responsibility to help clients discuss difficult situations and to offer referrals such as for shelters, further counseling, and support groups. For some clients, the test counseling session provides a rare opportunity to engage in such discussions.

Negotiation can also be a risk reduction strategy for clients who are in non-monogamous relationships with primary partners. For example, partners may agree to limit sex with other partners to low-risk behaviors such as oral sex without ejaculation and protected anal or vaginal sex. Partners may

References
also agree to disclose instances in which they do not adhere to the negotiated guidelines or other situations that may place them at risk such as when a condom breaks with another partner.

**Clients Who No Longer Use Condoms**

When working with clients who choose not to use condoms during sex, it is useful to assess if they have used condoms in the past, and if so, explore their reasons for changing their behavior. How did they feel about their HIV risk when they used condoms? Are all of their friends infected? Evaluate their need for further support, and discuss referrals to local resources that may offer the support they need.

Referral options may include an HIV support group for gay men, a more general gay men’s support group, individual counseling, and social clubs.

Ask Jim if he feels his risk behavior is acceptable to him. If so, initiate a discussion about what he would do and how his life would change if he were to test HIV-positive. Ask him if he would place his partners at risk by not using condoms and if he would disclose his status to them. Counselors should never use this type of discussion as a scare tactic. The purpose, rather, is to help the client to realistically examine the possibility of HIV infection.

If Jim is uncomfortable with his risk, ask him what he is willing to do to reduce it. Then ask him if what he suggests is realistic, and if it is not, ask him what is. For instance, if drinking alcohol is related to Jim’s risk and he promises to reduce his drinking, ask him if this is something he can realistically accomplish. If he is unable to come up with any realistic solutions, explore other ways to reduce risk, such as engaging in oral sex instead of unprotected anal sex. It can also be helpful to explore the circumstances under which he would feel safer having unprotected anal sex. Some of these prerequisites may include commitment, trust, and mutual HIV-negative status.

**Case Study**

Jim is a 40-year-old gay man who had always used condoms during anal sex until about two years ago, when he stopped using condoms for insertive anal sex but continued to use condoms when he was the receptive partner. Jim says that he tests for HIV antibodies once a year and that he has recently begun to have unprotected receptive anal sex without ejaculation.

**Counseling Intervention**

Validate Jim for testing each year, and evaluate his understanding of how HIV is transmitted. If he is uncertain or mistaken about the risks related to unprotected receptive anal sex without ejaculation, explain that pre-ejaculate fluid can contain HIV and that there is still risk for infection (although it is a lower risk than if his partner ejaculates). Educate Jim about his risk for sexually transmitted diseases (STDs) other than HIV and their relationship to HIV transmission, and recommend STD screening.

Ask Jim what led to his decision to engage in unprotected insertive anal sex and to the recent shift to having unprotected receptive anal sex without ejaculation. If he talks about feeling fatigued by the epidemic, try to help him see the bigger picture of how his risk fits into his life by exploring how he feels about his risk, the role sex plays in his life, and the ways in which alcohol or other drugs may affect his risk. Also, explore Jim’s personal support systems. Does he have friends who are also HIV-negative, or are all of his friends infected? Evaluate Jim’s need for further support, and discuss referrals to local resources that may offer the support he needs.

Counseling may reveal that substance use has influenced a client’s decision to abandon condom use. If this is the case, continue asking open-ended questions to help clients talk about their feelings and the circumstances that led them to stop using condoms. To take the discussion further, ask what the client is willing to do to reduce his or her risk. Make appropriate referrals to clients for ongoing support.

For clients who have previously tested HIV-negative, counselors may ask questions that are more confrontational than usual. The counselor may ask, for instance, “How have you managed to stay HIV-negative all these years? Have you considered how your life would change if you were to get a positive test result?” It is important to use caution when asking these types of questions because of the potential to sound judgmental, parental, or threatening, which may cause clients to resist discussing anything further with the counselor.

Also explore if receiving an HIV-negative test result might reinforce a client’s risk behavior. If so, it may be helpful to review the client’s level of HIV risk. At such times, a counselor may become irritated by what a client says, but it is important to remain neutral without letting the irritation become apparent. After the session, discuss these feelings with colleagues or with a supervisor to be better prepared.
Test Yourself

Review Questions

1. True or False: Even occasional condom use can significantly reduce the risk of HIV transmission.

2. Which of the following are elements of harm reduction theory? a) ranking practices as safe, possibly safe, and unsafe; b) recognizing that abstinence is not a realistic goal for everyone; c) encouraging manageable and incremental steps toward behavior change; d) all of the above.

3. True or False: Not all sexual behaviors carry the same degree of risk for HIV infection.

4. True or False: Oral sex without condoms or dental dams is a safe behavior because there is no risk for HIV transmission.

5. During unprotected penile-oral sex, which partner is at highest risk for HIV infection? a) the receptive partner who takes ejaculate into his or her mouth; b) the insertive partner; c) the receptive partner who does not take ejaculate into his or her mouth; d) there is no difference in risk.

6. Which of the following strategies can reduce risk of HIV transmission for people who choose to engage in unprotected anal or vaginal sex? a) having sex only with HIV-negative partners who test regularly; b) reducing the number of sexual partners; c) using enough lubrication; d) all of the above.

7. Which of the following is an example of negotiated safety between sex partners? a) agreeing not to discuss their HIV status; b) agreeing to have unprotected sex with one another but to always use condoms when having sex with other people; c) avoiding discussing condom use out of fear of creating mistrust or violence; d) none of the above.

8. True or False: The Reality female condom can be used only by women and protects the vagina from HIV infection.

Discussion Questions

1. How can counselors remain neutral and client-centered when working with clients who refuse to use condoms?

2. How can counselors shift their thinking from an abstinence or no-risk perspective to focus on reducing risk for clients in manageable ways?

3. How can counselors get support if they feel uncomfortable advocating behaviors that pose risks for their clients?

4. In which situations can a discussion about the hierarchy of risk be helpful for clients who choose not to use condoms?

5. What can counselors do if they feel frustrated with clients who continue to have high-risk sex?

Answers

1. True.

2. d.

3. True.

4. False. Although unprotected oral sex is considered to be a very low risk behavior, HIV transmission is still possible.

5. a.

6. d.

7. b.

8. False. The Reality brand condom may be used by men engaging in anal sex with other men as an HIV prevention strategy.
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