Decision-Making for HIV AIDS Prevention: Altruism and the Moral Norm

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ABSTRACT
The purpose of this enquiry was to understand how gay men form and maintain their attitudes toward HIV transmission preventative behaviors. Autobiographical life histories of sixteen gay men showed that once they acquired knowledge of preventative behavior they consistently adhered to that behavior. They adhered because of fear of HIV infection and because they held a moral norm that obliged them to behave altruistically (Schwartz, 1977) to protect not only themselves, but also their sex partners, loved ones, and their positive self-evaluation. They saw their HIV negative status, and their adherence, as pre-requisite and enabler for achieving their goals in life. Dick and Basu’s (1994) Framework for Customer Loyalty, a commercial marketing communications theoretical framework, explains development and maintenance of these men’s loyalty (their consistent adherence). This understanding, within a marketing communications framework, will inform development of social marketing communications aiming to increase adherence to behaviors that prevent HIV transmission.

KEYWORDS
HIV/AIDS; prevention; moral norm; altruism; adherence; loyalty; gay

Introduction

Soon after the advent of AIDS in Australia, a behavioral intervention to prevent the transmission of HIV was promulgated (Mindel & Kippax, 2013). This intervention, termed safe sex, required the consistent use of condoms and lubricant for insertive anal intercourse. The generally high rate of adherence to safe sex in Australia was largely successful in limiting the spread of HIV from the mid-1980s (Mindel & Kippax, 2013). In the new century, new biomedical interventions are being deployed in Australia (Department of Health, 2018; Department of Health and Ageing, 2014; Kirby Institute, 2017; Victorian AIDS Council, 2017). These are Post-Exposure prophylaxis (PeP), Pre-exposure prophylaxis (PrEP) and Treatment as Prevention (TasP). PeP stops HIV infection when taken immediately after a possible transmission event. On the other hand, PrEP and TasP require consistent adherence to a treatment regimen if they are to successfully prevent transmission of HIV (Department of Health and Ageing, 2014). “PrEP is more than 99% effective when taken as
prescribed in preventing HIV. There are over 660,000 people on PrEP worldwide and less than a handful of cases where someone contracted HIV while taking PrEP.” (Thorne Harbour Health, 2022b; formerly known as Victorian AIDS Council). Similarly, men not using PrEP or TasP need to maintain consistent condom use (Holt et al., 2017; Thorne Harbour Health, 2022a). Therefore, while HIV transmission preventative methods have evolved over the course of the epidemic, the need to maximize adherence to preventative regimens remains unchanged if new HIV infections are to be prevented. The introduction of biomedical interventions has led to the suite of transmission prevention measures (which includes use of condoms) being termed Combination Prevention; “... the application of evidence-based biomedical, behavioral and social prevention interventions to achieve a common outcome: the prevention of HIV transmission. Elements of combination prevention include safe behaviors and condom use, testing and counselling, linkage to and retention in care, and treatment.” (Department of Health and Ageing, 2014, pp. 16 referring to de Wit, Adam (2014)).

The targets of the Australian Government’s Eighth National HIV Strategy (Department of Health, 2018, p. 17) are that by the end of 2022:-

1. “Increase the proportion of people with HIV (in all priority populations) who are diagnosed to 95%.
2. Increase the proportion of people diagnosed with HIV on treatment to 95%.
3. Increase the proportion of those on treatment with an undetectable viral load to 95%.
4. Reduce the incidence of HIV transmissions in men who have sex with men . . .
5. Increase the proportion of eligible people who are on PrEP, in combination with STI prevention and testing to 75%.”

Progress toward goals is as follows (The Kirby Institute, 2021):-

1. “Between 2015 and 2019, the estimated proportion of people who were living and diagnosed with HIV increased from 88% to 90%.” (p. 4)
2. “Between 2015 and 2019, the estimated proportion of people diagnosed with HIV who were receiving antiretroviral treatment (ART) increased steadily from 87% to 91%.” (p. 5)
3. “Between 2015 and 2019, the estimated proportion of PLHIV receiving treatment with a suppressed viral load (less than 200 copies of HIV per millilitre of blood) increased from 95% in 2015 to 97% in 2019. The 95% target was met in all years from 2015 to 2019.” (p. 5)
(4) “The number of HIV notifications attributed to male-to-male sex declined from 702 notifications in 2015 to 533 notifications in 2019, a decline of 24%.” (p. 6)

(5) “Among non-HIV-positive participants of the GCPS*: the proportion were reported being aware, eligible and who reported using PrEP in the previous 6 months increased from 0.6% in 2015 to 21.0% in 2019.

- among the men who reported using PrEP, the proportion who also received an STI test in the previous 12 months remained close to 100% for all years, 2015 to 2019.
  - of the men who reported engaging in condomless anal intercourse with casual male partners in the previous six months, the proportion who reported using PrEP increased from 1.2% in 2015 to 31.1% in 2019.” (p. 7). (*Gay Community Periodic Surveys.)

Current knowledge about how to increase/maintain adherence to Combination Prevention regimens comes from research primarily focused on understanding current behavior.

The need existed to understand more about how gay men initially form and then maintain their attitudes toward preventative behavior. Obtaining this knowledge was the first aim of this enquiry. The second aim is for this understanding to inform the development of social marketing communications intended to increase the degree of adherence. This will require behavior change. Effective behavior change communications require the communications designer to have an insightful understanding of the people to be targeted by the communication. Consequently, our understanding is based on insights into attitudes and behaviors rather than simply on a description of those attitudes and behaviors. We understood from our review of literature, that gay men’s sex practice evolves over their lifetimes. Accordingly, the Narrative Inquiry method (Chase, 2005), an ethnographic method, was chosen because it would enable the collection of autobiographical life histories. These autobiographies provided rich and insightful data about how attitudes are initially formed and how they might change and/or be maintained throughout the life course.

The effectiveness of marketing and education in changing attitudes and behaviors has been documented in the commercial marketing (Kotler et al., 2010), social marketing (Andreasen, 2003; Donovan & Henley, 2003) and Health Education and Health Behavior (HEHB) fields (Glanz et al., 2008). Commercial marketers aim to persuade target consumers to develop favorable attitudes toward, and regularly purchase the marketer’s preferred brand of good or service (Kotler et al., 2010). Similarly, health promotions communicators aim to persuade their targets to consistently practice the communicator’s preferred health behavior (Glanz et al., 2008). People may maintain
their initial attitudes and behaviors for a long time, possibly a lifetime. This is why creating initial (first-held) loyalty, that is, to consistently purchase the preferred brand, is an objective of commercial marketing (Dick & Basu, 1994; Kotler et al., 2010), social marketing (Donovan & Henley, 2003; Evans et al., 2002), and education and training. See for example, the Jesuit Maxim “Give me a child until he is seven and I will give you the man” (Duneier, 2009, p. 341), which has been extensively discussed in terms of education, early experience and environment (Brierley, 1994; Duneier, 2009; Lunn, 1995; Thorne, 2009). Communications intended to change or maintain a particular behavior work more effectively when they are developed using theoretical frameworks. This is the case in both the HEHB area (Glanz et al., 2008) and in commercial marketing (Kotler et al., 2010). Therefore, finding appropriate theoretical frameworks is essential if we are to translate understanding of attitude formation and maintenance into effective promotions to increase adherence to Combination Prevention regimens.

Our analysis of the narrators’ autobiographical life histories (described in the next section) showed that they held a moral norm (their “internal values”) that required them to behave altruistically to express values important to them (Schwartz, 1977). These “values” were the protection of their sex partners and loved ones, themselves and their positive self-evaluation. The narrators saw their HIV negative status, and their safe sex practice, as both pre-requisites and enablers for achieving their goals in life. These were men with goals beyond short-term pleasures. They took a long-term view of life and planned accordingly. Their autobiographies were a narrative of their life trajectory (Tamboukou, 2008, 2009), something we term their Quest for the Ideal Gay Life, in whatever terms they imagined it.

Dick and Basu’s (1994) Framework for Customer Loyalty (FCL) is a commercial marketing communications theoretical framework. It enabled us to frame our understanding of the process by which gay men develop and maintain their attitudes toward adherence to Combination Prevention regimens. In the language of the FCL, men who are loyal to a Combination Prevention regimen will demonstrate repeat patronage, that is, they will consistently adhere to their regimen. This understanding, framed within a marketing communications theoretical framework, provides managerial direction for the design of promotions intended to create initial (first-held) loyalty and to maintain that loyalty over the lifetime. This article concludes with recommendations for further research and for trials of recommended marketing communications campaigns.

Materials and methods

We had concluded that we needed to study gay men’s life histories in order to understand their evolution of attitudes and behavior. Research which is intended to inform health promotion interventions is best performed among
the target population in the environment in which that target will be expected to undertake the preferred health behavior (Glanz et al., 2008). Similarly, commercial marketing research is best performed among the target potential consumers (Kotler et al., 2010). Therefore, in order to acquire an insightful understanding we needed to focus on the psychosocial dynamics operating in the one milieu, the one social location. Therefore, we needed to recruit gay men who had been living in that milieu for some years. One author, Dr Campbell, a fellow gay man, was deeply familiar with the Melbourne, Australia gay milieu and therefore qualified to conduct research within that milieu.

He used his interpersonal networks to recruit narrators. This method is most similar to Connell (1992), who implemented a life course perspective to study a group of men in one social milieu. To avoid any sense of social obligation, it was important that our author not know the participants. Accordingly, he approached his friends and network members, and asked them to locate suitable participants from within their networks. This recruitment method is called “snowball sampling” (Wright & Stein, 2005, p. 495), and is in keeping with the ethnographic style of this enquiry (Agar, 2001). The method is similar to the work of Adam (2005), Celsi et al. (1993), and Connell (1992). They also conducted ethnographic studies of groups of people in the one social location.

He sent an e-mail to gay men in his personal network. He asked them to on-forward the e-mail to other gay men, inviting them to contact him. He specified that narrators needed to be gay men who did not know him (to limit bias), were over 25 years of age, and were living in the gay milieu in Melbourne. When potential narrators initially made contact, they were provided with an informed consent pack and discussion guide, indicating those areas to be covered in the interviews. The statement forewarned that given some of the areas about which they would be talking, they might come to feel distressed. They would be free to stop or pause the interview at any time, and/or withdraw their participation, data and material. Furthermore, the statement explained how the potential narrator’s confidentiality would be protected (always an important reassurance for participants (Khumsaen & Stephenson, 2019)). In order to allow potential narrators time to study the materials and make a fully informed decision about their participation, the first interview was not held for at least three days after the informed consent pack was delivered. At the time of the first interview, the potential narrators were again provided with a copy of the consent information statement, together with contact details of counseling services. They were then run through the statement and then signed the consent information form. They were also asked to agree to the researcher taking notes and making audio recordings during the narration sessions. During the interviews the narrators were constantly monitored, and if they began to show signs of such distress, they were
offered the contact details of counseling services. In addition, the university took measures to protect the researcher by arranging for the allocation of professional counseling by an in-house psychologist. We obtained Ethics Approval for the project from the Swinburne University of Technology Ethics Committee Ref SUHREC Project 0708/130.

All narrators signed the consent documents, agreed to the electronic recording (sound only, no video), and returned for their second session where needed. None withdrew from the project or exhibited a great deal of stress during the interviews. As far as is known, only one narrator availed himself of any counseling services (regarding issues to do with his partner’s unpleasant behavior within their relationship, a subject the narrator discussed in his narration). The lack of recourse to counseling is probably because the narrators volunteered to participate, were fully aware of the subjects to be discussed, were years beyond the coming-out process, and were accustomed to recounting their life stories to other gay men.

In the manner of Connell (1992), we intended that their autobiographical life histories incorporate a description of what actually happened—not just how the event was experienced—any adjustments to new life conditions, and the history of their sexual practices and so on. Institutional transitions provided framework for memory (e.g., entry to workforce, entry to school; Connell, 1992). Life histories included the interactive practice in those institutions (particularly families, workplaces and schools; Connell, 1992). Sixteen gay men aged 23–69 narrated their autobiographical life histories. (Please refer to Table 1 for a Profile of each narrator.)

Narrations were usually given over two sessions of three hours each. There were over 30 interview sessions, totaling approximately 80 hours. The transcripts and recordings were reviewed with attention to both the narrative thread and the themes for each narrator. Identification of themes is a commonly used method in health research (Haas et al., 2017; Owens et al., 2020). Researchers such as the aforementioned typically seek to locate distinct themes across a number of participants.

On the other hand, as narrative inquiry researchers we sought connections by theme across stories from the one narrator (Chase, 2005). Seeking themes for each narrator concurs with Stake’s (2005) discussion of qualitative case study methodology, where he noted that a single researcher can understand the case as personal experience if they can embrace it intellectually. This requires that the researcher “become personally knowledgeable about the activities and spaces, the relationships and contexts, of the case” (Stake, 2005, p. 455). Therefore, once the researcher has become experientially acquainted with a particular case (in this instance, a particular narrator), it becomes embraceable, and the researcher can see and enquire about the case personally and come to understand the case “in the most expected and respected ways” (Stake, 2005, p. 455). Embraceability aligns with the concept
Table 1. Profile of narrators.

| Code Name | Age at Interview | Class | Ethnicity (1) | Born | Education (2) | Occupation | HIV status | Religion (self-description) | Refer to Table |
|-----------|------------------|-------|---------------|------|---------------|------------|------------|----------------------------|----------------|
| Alistair  | 47               | Middle | AC & Danish   | Australia | Masters | Lab mgr. virology | positive | Atheist | 2                           |
| David     | 48               | Middle | AC            | Australia | HS + part of Bachelor | Retired | positive | Not Disclosed | 2                           |
| Coort*    | 50               | Middle, ex-Working* | Irish-Maori & Danish | New Zealand | HS + part of Bachelor | IT and former sex worker | negative | No Religion | 2                           |
| Chris     | 43               | Middle | English       | New Zealand | HS + part of Bachelor | Airline call center | negative | Atheist | 2                           |
| Zedd      | 51               | Middle | AC            | Australia | Masters | Public servant | negative | Anglican (Episcopal) | 2                           |
| Buster    | 56               | Middle | AC            | England | Bachelor | Chef | negative | Protestant | 2                           |
| Des       | 69               | Middle | AC            | England | Trade | Retired fmr. mgr. | negative | No religious belief | 2                           |
| Marcel    | 74               | Middle | French        | France | Not disclosed | Former cartage contractor | Not disclosed | Not disclosed | 2                           |
| Tim       | 33               | Upper-Middle | AC            | Australia | Bachelor | IT manager | negative | Roman Catholic | 3                           |
| Zac*      | 23               | Working* | AC            | Australia | Bachelor student | Student | negative | Atheist | 3                           |
| Josh      | 44               | Middle | Japanese      | Japan | Masters | Teacher | negative | Not specified | 3                           |
| Simon     | 31               | Middle | AC            | Australia | High School | Store mgr. | negative | Agnostic | 3                           |
| Toby      | 38               | Upper-Middle | AC            | Australia | Graduate Dip | Teacher | negative | Roman Catholic | 4                           |
| Getz      | 61               | Working | AC            | Australia | Trade | Retired | negative | Not disclosed | 4                           |
| Herman    | 49               | Middle, ex-Working | AC            | Australia | Bachelor | Social worker | negative | No organized religion | 5                           |
| James     | 39               | Middle, ex-Working | Irish-Polish | Australia | Masters | IT | negative | No religion | 5                           |

*Zak and Coort are Partners. (1) AC = Anglo-Celtic (English, Scottish, Irish, Welsh etc.) (2) HS = High School, Masters = Grad School.
of immersion, an excellent way to learn (Lindholm-Leary, 2005). One of our authors, Dr Campbell, had been immersed in the milieu since 1985, closely involved with HIV/AIDS as an experiential phenomenon through socializing, caring, visiting hospitals, funerals and so on. Based on the above, he analyzed the transcripts and recordings.

Life events were documented in chronological sequence with emphasis on key events, transitions, changes in life circumstances (Connell, 1992), and sexual behavior over time with special focus on adherence or non-adherence to safe sex, and casual and long-term relationships. Clandinin’s (2005) recommendation was adhered to—that is, to study the story of each life in three dimensions: personal/social (what happened and with what feelings and how this relates to the milieu); temporal (when it happen); and place (where physically, and with what relation to the milieu; Clandinin, 2005). Studying these three dimensions also enabled us to analyze life histories with reference to Dick and Basu’s (1994) loyalty relationship. That is, the strength of the relationship between the individual’s relative attitude toward the brand (in this enquiry, adherence or non-adherence to the behavior of safe sex) and the individual’s pattern of repeat patronage behavior. That is, to what extent did the narrator adhere to safe sex? Thus, we needed to know what happened, where, when, in what milieu context, and what feelings did the narrator feel (the dimensions described by Clandinin above). In doing so we took account of demographics, personality traits, and beliefs about outcomes and the attitudes of significant others—the referents as Ajzen and Fishbein (1980) would call them.

Life histories were also analyzed within the Framework for Customer Loyalty (FCL; Dick & Basu, 1994) to understand the process of development of loyalty to safe sex. We closely studied the antecedents to loyalty. These are the cognitive (thought processes and acquisition of information); the affective (feelings and emotions, especially about homosexual masculine identity and safe sex or condomless anal intercourse (CLAI), mortality, self-protection and protection of others); and the conative (behavior) antecedents—previous behaviors and their outcomes.

Similarly, the impact of mediating factors was studied—both social norms (attitude toward safe sex by current and potential sexual partners, peers, desire for approval, love, other emotional situational factors) and situational factors (availability of condoms and lubricant, influence of drugs and alcohol). Particular emphasis was placed on events and factors that influence strength of attitudes and perceptions of the differentiation between safe sex and CLAI (unsafe sex). This perception of difference is an essential pre-requisite to the individual developing different relative attitudes toward safe vs. unsafe sex practice.
In the next section we review the outcomes of these narration sessions. In the words of Agar (2001, p. 4859), “Ethnography has a defined starting point, but as it progresses a study is emergent.”

**Structure of the remainder of this article**

Results are presented firstly at Topline level. The narrators’ autobiographical life histories are then reviewed in detail. Extensive verbatim quotes illustrate key points and Tables summarize the narrators’ progress to *safe sex* loyalty. This is followed by Discussion demonstrating how the enquiry data correlate with the bio-medical literature, and describing the search for theoretical concepts and frameworks to help understand and interpret the Results, intended to enable understanding of the process by which gay men develop and maintain their attitudes toward *adherence*. This section is again illustrated with verbatim quotes. Finally, a brief Conclusion includes final reflections, limitations, and recommendations.

**Topline results**

The narrators acquired knowledge about safe sex variously through health promotions, gay community attachment, word-of-mouth, education at school, and from their early-and/or-initial sex partners. Once loyalty to either safe sex or CLAI was established, only a major external event would cause change. These were the advent of AIDS (older narrators), or a personal epiphany. The rationales for the narrators’ behavior were fear that they would become infected with HIV, and a moral norm that obligated them to behave altruistically to achieve values important to them (Schwartz, 1977) —protection of their sex partners and loved ones, themselves and their positive self-evaluation. This double obligation and double motivation explains why they became adherent to Combination Prevention upon learning that it would protect them from HIV infection. The Framework for Customer Loyalty (Dick & Basu, 1994) enables understanding of the formation and maintenance of their attitudes to safe sex within a marketing communications theoretical framework, thereby providing managerial direction for the design of social marketing communications promotions intended to create and maintain adherence to a Combination Prevention regimen.

**Results—in detail, illustrated with verbatim quotes from the narrators**

The narrators are discussed in groups based on how they developed their attitudes and behavior regarding *safe sex* and *unsafe sex*. 
The importance of the milieu

Those narrators who became sexually active before the advent of the AIDS epidemic practiced CLAI, because it was the peer norm in their milieu.

Loyalty to unsafe sex (CLAI) formed before the advent of AIDS, and then changed to safe sex with the advent of AIDS. (For a summary, please refer to Table 2.)

David had numerous casual sexual experiences and short-term boyfriends. He was infected only twice with STIs in the period 1972–81;

David: “... amazingly for the amount of sex I had in that time;
Gordon: Without any condoms.
David: Well people didn’t use them then ... if someone said to you they wanted to use a condom, you would think they were very strange ... although there was sort of knowledge that there was other STD’s everyone knew they were curable.”

Chris; One of the women with whom Chris worked in the hairdressing salon match-made him with a young man who worked in a neighboring shop; this was in the pre-AIDS era, and so Chris was unaware of safe sex. They did not use a condom or lubricant;

Chris: “... Well I guess it was good in parts. I mean the first night we had sex he penetrated me and we were both kind of novices at it so there was no lubricant and I found the whole experience painful and unpleasant. And I remember crying myself to sleep that night because I thought God, if this is what gay sex is like I don’t want to know anything about it . . .”

Coort had heard about AIDS, probably through word-of-mouth within the milieu, or safe sex promotions, or both. This time a doctor, an authoritative source, provided specific safe sex education.

Table 2. Loyalty to unsafe sex (CLAI) formed before the advent of AIDS, and then changed to safe sex with the advent of AIDS.

| Narrator | Source of information about AIDS |
|----------|----------------------------------|
| Marcel   | Friend told him about visiting a friend in hospital and seeing many men sick with AIDS—gave Marcel safe sex advice. Doctor provided further information. |
| Alistair | Word-of-Mouth (WOM) at university, gay community events, Victorian* AIDS Council (VAC)—he became a safe sex educator. (*Victoria is the state of Australia in which Melbourne is located.) |
| David    | Newspapers and news sources, Middle Park gay doctor for further information after testing positive. (Tested because unwell.) |
| Coort    | WOM on the gay scene. Doctor gave test, education and condoms. |
| Zedd     | Safe sex advertising on television (including the Grim Reapera), death of a tenant of his friend’s due to AIDS, VAC course. |
| Buster   | Newspapers and news sources. Doctor and posters in the doctor’s surgery. |
| Des      | News sources and knowing people who found out that they were positive. |
| Chris    | Flatmate in London, other sources not explicated. |

**The “Grim Reaper” campaign ... aimed to increase awareness and knowledge of HIV (Mindel & Kippax, 2013). The campaign used a fear appeal—use condoms to prevent transmission.**
Coort: “So I was a computer nerd by day in a suit and tie, and I had a change of clothes in my bag which were the T-shirt and jeans and I was selling my ass for sex . . . But when we found out that it was through anal sex, the easiest way to catch it, it was when we got tested we were going ‘we’re screwed, literally.’ If anyone is going to get it, we must have it, already. Yeah, ten a night . . . both of us came back negative . . . Told the doctor to do it again (laugh) and told him we were prostitutes . . . He said well . . . you’ve both been very lucky boys, use condoms from now on and here, here’s a whole pile of them. It’s the first I’d seen one.”

**Zedd:** being the 1970s, Zedd’s first sexual experiences were unsafe, the peer norm of the time;

Zedd: “ . . . we used to often drink in the pub across the road and that’s where I encountered a young fellow, when I was about twenty six and he was twenty two and in short order, he moved in with me in Hawthorn . . . that went on for a little while and certainly we had unsafe sex.”

**Loyalty to safe sex formed before sex activity started**

Those who became sexually active after the advent of HIV/AIDS fell into two groups, determined by the peer norm of the milieu in which they started having sexual intercourse. Most narrators started their sex practice in a milieu in which safe sex was the peer norm. Some had learned about safe sex before they started having sexual intercourse. This learning came through promotional information, sex education in school, and/or through word-of-mouth. *(For a summary, please refer to Table 3.)*

**Tim** received safe sex education at his school and developed a loyalty to safe sex before he started sexual activity. Safe sex was the first type of sex he experienced. *(Parts of this narration were published in Dr Campbell’s conference paper—Campbell & Brennan, 2009;)*

Gordon: “What was your awareness about safe sex at that time? This is 1993, so you’d been educated about safe sex at school and you knew what to do and what not to do? . . .

Tim: And he had condoms I think. We had no real use for them but I’m sure they were there.Gordon: Okay. What would have been your attitude toward safe sex at the time?

**Table 3.** Loyalty to safe sex formed before sex activity started.

| Narrator | Source of information about AIDS |
|----------|----------------------------------|
| Tim      | Sex education at school. He became a voluntary educator with the VAC* when aged 19. (* Victorian AIDS Council)* |
| Zak      | Sex education at school although not specifically about safe sex. HIV/AIDS and safe sex education through WOM and television. His first insertive anal intercourse was with condoms. After which he was rather irregular in their use until he met Coort. Coort became his partner, and educated him. Coort provides structure within which Zak practices safe sex outside their relationship. |
| Josh     | News media, television (including mention of the Grim Reaper), brochures about protection, and word-of-mouth |
| Simon    | Television (including mention of the Grim Reaper). His first insertive partner initiated him into safe sex. |
Tim: Oh, one hundred percent, that was the only way forward at that time. Like, there would have been no question about it for me.”

**Josh’s safe sex** education caused him to commit to safe sex:-

Gordon: So people that you started to be with, they would ask you to practise safe sex?
Josh: Sure . . . Once I was in a relationship, I didn’t use condoms.
Gordon: But all the rest of the times, before you were in a relationship you did use condoms?
Josh: I did . . . because simply it was I was scared, you know, of that disease.”

**Josh** practices unsafe sex within a monogamous relationship;

Gordon: “And you continued in a monogamous relationship with him?
Josh: Yes, until we broke up. I had three sort of long term relationships, well, this is my third one now . . . Personally I don’t like using a condom, I don’t like that but then again I felt that if you don’t trust someone then what is the point of having a relationship. Yeah, it’s just lucky that, in a way that looking back, the guys I had intimate relationships with they’re really monogamous.”

Others learned about safe sex from their early-and/or-initial sex partners.

**Simon** has his first penetrative anal sexual experience, and is initiated into safe sex by his (slightly) older partner. He has arranged to meet Michael during one of his school choir visits to Sydney;

Simon: “ . . . met up with Michael, got to his place, had dinner in the oven and a glass of wine. Several wines and all over me like a rash, basically all we did was just skull the wine, into the bedroom, kiss, kiss, kiss, kiss, kiss, grope, grope, grope, grope, grope reached out into his top drawer, gets some lube out and some condoms and I went (gasp) and I’m like that’s right. I mean you know that there’s sex going to happen at some point but I was eighteen.”

Fortunately, for both Michael and Simon, they were fully aware of safe sex, thanks to previous social marketing advertising:

Simon: “Oh, the Grim Reaper had been out years earlier and that campaign was just synonymous with fear and dread and guilt, and you knew that if you didn’t have safe sex you’d die. That was the message.”

**Loyalty to safe sex formed soon after sex activity started**

Others started their sexual experiences with Condomless Anal Intercourse (CLAI). Soon afterward, they sought information about safe sex, or others in their milieu told them about it. Once they learned about safe sex, they became safe sex loyals—adherent to a regimen of consistent condom use. *(For a summary, please refer to Table 4.*
Table 4. Loyalty to safe sex formed soon after sex activity started.

| Narrator | Source of information about HIV/AIDS and safe sex |
|----------|---------------------------------------------------|
| Toby     | Sex education in school, although not specific to HIV/AIDS and safe sex. Found the Grim Reaper fear campaign too scary to process. His former boyfriend (an authoritative source) told him he was now using condoms and so should Toby, and this led Toby to seek education. |
| Getz     | The Grim Reaper campaign did not mean much to him because he was not having insertive intercourse. Posters and videos at the sauna led him to understand safe sex, and then the Grim Reaper made sense. Then started to use condoms for insertive intercourse outside the relationship and unsafe sex within his long-term relationship. |

Toby had a relationship with his first boyfriend Michael which involved solely CLAI due to the fact that they had not internalized the safe sex message. In due course, Toby followed the lead of his (by now ex-) partner Michael in adopting safe sex. He regarded Michael as an authoritative source;

Toby: “... Michael fell in love with a nurse guy ... and Michael used to talk about how big he was ... and he said, it’s hard to get the condom on and everything. And I thought oh good, so you’re using condoms and I realised that, oh, this is outside advice, you’ve got to use a condom so ... I thought I’d better use a condom if I have a boyfriend. Because I didn’t read the gay press”

Even in the period after the advent of AIDS some narrators developed loyalty to CLAI because it was the norm in their milieus.

On the other hand, two narrators consistently practised CLAI for long periods of their lives. This was because the peer norm was CLAI in the milieus in which they started to have sexual intercourse. (For a summary, please refer to Table 5.)

Unfortunately for Herman, the men with whom he had casual sex or ongoing relationships did not practice safe sex. The peer norm of that part of the gay scene which he frequented was not safe sex:-

Herman: “we were hanging out at gay venues ... yeah, I ended up with different dudes, never safe sex, never discussed safe sex, never have practiced safe sex.”

James began his sex experience at the Melbourne Bayside beats (1) at the age of twelve, with no attitudinal loyalty. His initial sex was unsafe, and he did not become HIV positive. He consequently developed loyalty to unsafe sex and demonstrated total and intensive repeat-patronage.

(1) - Beats—Informal noncommercial locations, usually public toilets, where men go to have sex with other men. Akin to “cottages” in England.

Table 5. Loyalty formed to CLAI because it was the norm in these narrators’ milieus. Epiphanal event changed loyalty to safe sex.

| Narrator | Source of information |
|----------|-----------------------|
| Herman   | He received information from safe sex materials and advertising but could not process the information. As his mental health improved, he began to practice safe sex intermittently. Only after his epiphany did he implement safe sex in a rigorous manner. |
| James    | Received sex education at school but did not change his behavior. Over the years, he gained knowledge, but he did not use condoms unless partners specifically asked for them. After his epiphany, he converted to safe sex. |
James; “So when I was walking along the beach as a twelve year old I was looking at the men or just thinking about my own thoughts and then I went into a toilet one day . . . and I just happened to notice that this week this guy was looking back . . . and he turned to me and said to me so do you want to suck my cock, and I said yep. So he led me off into the bushes . . .” 

Gordon; “Okay and no questions about safe sex at this stage?

James; No.

Gordon; Was AIDS around, was AIDS known of?

James; I knew of it outside of that environment. By the time I was about fourteen or fifteen we started hearing about AIDS and it was for poofers . . . And this was at school. This was not at the beach, this was at school. We knew about AIDS and AIDS was for poofers and gay men got AIDS . . .” (Poofter—Australian for male homosexual.)

And in their own estimation, James and his associates were not poofers.

The narrators’ life stories align with the extensive literature on the importance of gay men belonging to a personal network where they are educated about safe sex practice. “Being involved in and connected to gay community activities (what, in Australia is described as ‘gay community attachment’) predicted the adoption of safe sex practices.” (Holt et al., 2011, p. 857).

External interventions can change loyalty

In addition to the learning processes described in the foregoing, external events caused some men to commit to safe sex. The first external event was the advent of AIDS, and the second were personal epiphanies that befell two narrators. In the period before the advent of HIV/AIDS, those narrators who were having sexual intercourse practiced CLAI, the norm at that time. After the advent of HIV/AIDS, their new fear of HIV infection, plus the new information about safe sex, caused these narrators to convert from CLAI to safe sex loyalty. Their community attachment and the effectiveness of the safe sex communications caused them to convert to safe sex.

David early in the epidemic, before AIDS awareness was widespread, David became HIV positive. After testing positive and receiving safe sex education he and his partner John continued their lives, practising unsafe sex between the two of them and strategic positioning and condom use outside the relationship.

David: John and I never used condoms, we weren't having anal sex so we didn’t use them in that situation, although we did occasionally. On the very rare occasions, on the very few occasions we had anal sex we never used condoms. Rather, I was always the receptive partner and I was still having sex with other people and it was always on the basis of being the receptive partner.”

David and John practiced strategic positioning in order to protect John’s negative status, which continues to the present day.
**Chris:** some time after his first experience of gay sex, AIDS appears and in due course Chris learns about *safe sex* and practices it consistently. He is now aware of the benefits of condom use.

Chris: “Well for me safe sex was to do with condoms and penetrative sex. Pretty much everything else I’ve always considered to be low risk or no risk. I remember a doctor at the time, I’d gone to the doctor about something and he said to me about safe sex, he said something about using condoms when you’re giving a blow job and I thought you’ve got to be joking. I remember thinking, now whether I actually said that, I’m not going to do that, no way.”

**Des:**

Des: “From 1983, when the word of this strange new disease … plague … that was a real shock … It seemed impossible that I wouldn’t have been infected”

It seemed impossible to Des that he had not been infected during his travels in Europe and through his generally promiscuous life—despite his preference for condoms, he had not been able to use them for every encounter because potential partners rejected them. Now that AIDS was around;

Des: “I basically stopped having penetrative sex.”

… Des:“Oh yes I was very conscious of developments, it was a kind of constant … You were reading reports and you knew what the prognosis was, etc. etc. and knowing some people who contracted—you needed no more encouragement to be careful. It was just devastating.”

Gordon: “so from early in the 1980s you started to practice safe sex,

Des: yes.”

Des: “I think most people do (practice safe sex), I would be shocked if anyone was prepared to have sex without a condom … I think in terms of the world I mix in most people would not have sex without a condom …”

**Coort:** from the visit to the doctor onwards Coort and his long-term partners have protected each other by practising *unsafe sex* inside the relationship and always *safe sex* outside of it.

Coort: “ … The only unsafe sex I’ve had has been with my boyfriend after proper process, due process … And trust, yes …”

**Zedd’s** Moral Norm and consistent practice of *safe sex* are enablers of his *quest for the ideal gay life;*
Gordon: “...You’ve had numerous changes in your relationships, where you’ve lived, what jobs you’ve done, the death of loved ones, but your safe sex loyalty has never varied. Zedd: No...I don’t want to contract a significant illness willingly.”

**Buster** and his partner Ross learnt about AIDS and safe sex through the news and from doctors.

we heard about it on the news, and in the doctors’ surgeries there were posters with promos on them. When the news came out a lot of the gay community stuck their heads in the sand...And then we realised it was happening to a lot of our friends.

In addition, Buster and Ross knew that it applied to them;

it should apply to everyone

Moreover, Buster and Ross understood what safe sex meant;

We just used condoms and that...we always knew you couldn’t get it orally...and that was all, just safe sex with condoms or no anal penetration, quite simple.

**Epiphanal event changed loyalty to safe sex**

For two narrators, personal epiphanies caused them to convert to safe sex. *(For a summary, please refer to Table 5.)*

Eventually an epiphanal event led even James to convert to safe sex.

James: “...at the beginning of last year when I was just turned thirty-eight, I heard a radio story which was repeated in the newspaper and it just went around about statistics about new HIV infections and they were saying that the highest number of new HIV infections was amongst single gay men in their late thirties and I went guess what...A close friend of mine had become infected just a few years before...and that didn’t turn me around. It was this news story that turned me. Not only was I in a high-risk group I was in the highest risk category in that high-risk group.”

Herman had an epiphanal experience; he realized that trusting men to accurately disclose their HIV status before having CLAI was jeopardizing his potential to achieve his ideal gay life;

Herman: “There has been a situation where one guy two weeks after unsafe sex told me he was HIV.”

**The outcome for the narrators**

David became HIV positive very early in the epidemic. Safe sex had not been codified at the time of his infection. The 15 others were HIV negative at the start of the epidemic, or the start of their sexual activity, whichever came first. All but one remained HIV negative; he too would have remained HIV negative except for a flukish accident (see Alistair’s story below).

Five narrators practiced unsafe sex (CLAI) within the relationship. The exceptions were;
• Marcel—not specified
• David—strategic positioning
• Des never acquired a long-term partner and continues to always use condoms for insertive intercourse.

Outcomes

• Six narrators were HIV negative at the time of the outbreak of the epidemic, and all remain negative to this day.
• David became HIV positive at the start of the outbreak (before safe sex was codified) and continues always using condoms if he is the insertive partner in anal intercourse. His long-term partner remains HIV negative.
• Alistair became HIV positive as the result of a flukish accident. He continues to practice safe sex in order to prevent his acquisition of a different strain of the HIV virus.

Alistair: “So I met this boy and I went back to his place and I knew he had HIV … He told me … That was his way you know … we went back to his place and had fun and I got some cum in my eye, I didn’t think anything of it, washed it out, didn’t think anything of it and about three weeks later I thought I had the flu. I came home from work one Friday, woke up Saturday morning with the flu and it wasn’t, it was sero-conversion illness.”

HIV testing did lead to changes in behavior in some narrators, and not in others

HIV testing did lead to changes in behavior in some narrators, and not in others. David felt unwell, and had an HIV test with a positive result. He then changed his sexual practice to strategic positioning (Prestage et al., 2001). At the advent of AIDS, Des changed his sex practice on learning about safe sex. Some time later he had an HIV test. His negative result did not lead him to change away from safe sex, because in his view the risk of CLAI remained. Des regards safe sex as a simple solution which he has no difficulty practicing, and as he says:-

Des: “And it is the preventative for HIV and STI’s and is such a cheap and disposable, and does not need to be taken internally, and not affecting my system in any way at all.”

The importance of integrated marketing communications campaigns

The narrators’ stories indicate the importance of integrated marketing communications campaigns and the need to make that message immediately relevant to the recipient in a way that they understand. Both technically (what do I need to do?) and as a high-risk threat to them personally (why does this apply specifically to me? … and why now?).
The ‘Grim Reaper’ campaign . . . aimed to increase awareness and knowledge of HIV and to position AIDS as a disease which affected everyone, not only gay men (Mindel & Kippax, 2013). The campaign used a fear appeal – use condoms to prevent transmission.

Toby; the following passage shows that fear appeals are not successful with every target audience member;

Toby: “The Grim Reaper didn’t educate me, it scared the shit out of me and I didn’t understand and I didn’t understand about intercourse, I didn’t understand that blood, semen—there was nowhere to read it. How can you read it if there was nowhere? I didn’t know there was gay press when I was eighteen, nineteen, I didn’t know you’d go to a pub and pick up an advertisement saying put the condom on like this.”

And to Toby’s mind the television advertising failed to effectively communicate what do I need to do;

Toby: “I didn’t even really understand it. I didn’t really understand what—maybe even though the commercial—but the commercial is vague, it says like it gets transmitted . . . I didn’t really think what the commercial was saying, it was just scary and that’s what I resented. I think a lot of gay guys resented it, didn’t they? Because it wasn’t methodical, medical, clear, it was just awful.”

Getz did not understand the Grim Reaper television commercial until he talked to people and saw the supporting (integrated marketing communications) materials:-

Getz: “Yeah my learning came from staying at Spa Guy with the guy at the counter and the little video . . . and Steamworks they got signs everywhere . . . beware of this and beware of that . . . and from then on, I started to take notice of the ads on TV. They made sense to me.”

And communications need to be made personally relevant to the target audience as in James’s narration (see above) of his epiphanal experience when he realized that he was now in the “highest risk category in that high risk group.”

All narrators, positive and negative, single or partnered, retired or working, consider safe sex as the enabler of their happiness. They regarded safe sex as protecting themselves and their sex partners, loved ones and their self-evaluation. The narrators’ report more-rigorous adherence than the general population with regards to use of condoms outside of their steady relationship (Holt, 2017).

**The overall themes of the narrators’ autobiographical life histories**

The overarching themes of the narrators’ autobiographical life histories regarding sex practice were fear and protection. All sixteen narrators cited self-protection as an important reason to adhere (be loyal) to safe sex. Several narrators, unsurprisingly, explicitly cited the fear of illness as a major driver. Several mentioned that their health was their own responsibility.
Des - Des: “There is no chance that I would ever risk that . . . Because I don’t want the mess and the hell and devastation that might fall . . . For me and for the other person. It is always a two-way thing. You can’t say to yourself . . . you’ve got to say “I will do . . .” You have to take full responsibility. You can’t say “I thought you were . . .” - You’ve got to be sure the condom is on.”

Marcel;

Gordon: “So under what circumstances would you use a condom?
Marcel: “If I’m going to take it I would always go down and make sure he got something or I put it on and then if you like to do yourself, well it is very important.”

Zedd:

Gordon: “But I guess that . . . your safe sex loyalty has never varied.
Zedd: No.
Gordon: And why do you think that is?
Zedd: I don’t want to contract a significant illness willingly.

Tim:

Gordon: Okay. What would have been your attitude toward safe sex at the time?
Tim: Oh, one hundred percent, that was the only way forward at that time. Like, there would have been no question about it for me.

Importantly, protection extended beyond the self. The protection of their long-term partners was, if anything, an even more important driver of the narrators’ adherence to safe sex than was self-protection. Of the 12 narrators with long-term partners, all mentioned the very high importance of protecting them.

Chris;

Gordon: “Did any of these casual encounters ever suggest unsafe sex?
Chris: I don’t know. I can’t speak for John obviously.
Gordon: No. I’m asking you.
Chris: For myself, yes. And I guess the reason why I took part and wanted to take part in this is because in the last few years I’ve become aware for myself recently that when guys have suggested unsafe sex or not suggested it at all, but moved to carry on having sex without condoms I’ve been aware that several times the only thing that has been stopping me is the fear that if I was to contract anything I would pass it on to John and I’ve been thinking about the reasons why I’ve got to that point now even though I hold these real strong views about these things. I’ve got to the point now where I’m thinking if I was single would I still say no, we have to have safe sex and I have to be honest I am not sure that I would always.
Gordon: Okay. So that’s led you to wonder how you are feeling about yourself. You’re very sure you want to protect John, your partner, but you wonder about protecting yourself.
Chris: Yeah. And my best friend in New Zealand, he contracted HIV through his partner and they were in a supposedly monogamous relationship but it turned out;
Toby: His partner Paul is working overseas now, and will return in a few months. Here, Toby demonstrates his moral norm and altruistic behavior.

Gordon: “Suppose he comes back and then one night you have unprotected sex, what would you do then? (Meaning; condomless sex outside of their relationship.) Toby: Oh no, I would never endanger him, no way, like no. If the three-month window doesn’t work out suppose, just suppose then I would have to be honest. If he came home tomorrow and I was waiting on a test I would just divulge oh God, no, and I would just say okay you know I’m waiting on a test because I had unprotected sex, yeah, oh definitely.
Gordon: So, you would protect him as well as yourself.  
Toby: Oh yeah. I know we spoke before about just being selfish. But I’d never put anyone else in danger, Paul or anyone, God no, no way, no way.”

Cort applies the Moral Norm by protecting himself and his own HIV negative status, that of his two long-term partners, Steve (former, 20+ years) and Zak (current), and the other men with whom they have sex. They do that by practicing unsafe sex inside the relationship and always safe sex outside of it.

Cort: “... The only unsafe sex I’ve had has been with my boyfriend after proper process, due process... And trust, yes...”

Cort also applies the Moral Norm by training other sex partners in safe sex practice;

Cort: “That’s like when I have boys around here for sex, it sounds corny but I educate them. If I’m going to F**k them, I make sure they either see me put a condom on or they touch it first, so they know what’s going on in their holes. And I’ve had a few go, why do you do that? I said you need to know that I’m wearing a condom. They say oh but you don’t have HIV and I said, don’t I?”

Zak, Cort’s current partner corroborates Cort’s story above. Now in a steady, live-in relationship with Cort, they practice unsafe sex within the relationship and safe sex outside the relationship; Zak’s life demonstrates a persistent quest for his ideal gay life. He places a high importance on his relationship with Cort, with whom he is deeply in love. Therefore, their Moral Norm, manifested in their practice of safe sex outside of the relationship, is an enabler of their loving relationship and of Zak’s quest for the ideal gay life.

Zak: “when we happen to find a group of people who are interested in the both of us well then of course we’ll play with people together... Which, we happen to be doing that a lot more than going off separately because it’s more a fact of yes we’re having sex with another person but it’s also for the fact that we’re having it together. So that’s always good as well.
Gordon: ... And when you have sex with Cort?  
Zak: Unprotected... So then you have high trust in each other;  
Gordon: Well you trust that you’ll have protected sex when you’re with other people?  
Zak: Yeah and we have high trust in each other (1) for this and if anything did happen we would instantly tell each other and all that sort of stuff, especially with Cort’s immune
(2) system. I really don’t want to give him anything” (1—this aligns with Coort’s narration, where Coort talks about the need for trust in an open relationship.) (2—Coort’s narration explains his testicular cancer illness, which has permanently degraded his immune system.)

Caring for others was also a prime driver of adherence for our narrators. Three narrators are carers for HIV positive people. Herman is a social worker, caring for abused men and boys (abused sexually and otherwise). Getz brought up two young children on his own after his wife (their mother) left them. Toby was additionally motivated by his need to protect his mother’s feelings by not becoming HIV positive.

Toby’s sense of moral responsibility toward his parents also reinforced his loyalty to safe sex;

Toby: “It was also the parents bit. I mean my parents were just getting over me being gay and God forbid and mum, the first and last things she always said was look after yourself. You know, when I came out that night after dinner it was you better look after yourself, that’s all I ask. I think the second thing was I want you to be happy but the first thing was; Gordon: Be alive.”

Tim sees safe sex as enabling his quest for the ideal gay life, and explains;

Tim: “Well because I value myself. I value my health. I value my relationships. I value the life that I have and I don’t want to do things to jeopardize that. You know I’m a cautious person anyway. I’m a responsible sort of, usually, person most of the time. Gordon: So you’re also concerned about caring for others? Tim: Absolutely, and I don’t ever want to have to turn around to my parents or my friends or whatever and tell them that I’m HIV positive . . . if I can do something to avoid that then I should be, I don’t want to—I mean I also have the experience of having friends who are HIV positive . . . I have a very good friend in Sydney who is HIV positive and I don’t have illusions about, oh well, it’s okay, there is medicine for that now. I don’t have that illusion . . . Because I know how horrible life is using those medications.”

Josh sees his commitment to safe sex as a moral one, to protect himself and his partners;

Josh: “We’re talking about a matter of life and death, there’s no two ways about it . . . And a responsibility. And how would you feel if maybe without knowing that you might have AIDS and you pass it on to someone else, it just would be . . . I’d suffer for the rest of my life knowing that I killed that person, knowing that fact. I couldn’t live like that, I can’t. I’m sure there are a lot of people like that . . . I won’t deny that though, of course I have to protect myself.”

Others saw adherence as a moral commitment.

Tim explains that it is his Moral Norm, which forms the bedrock of his commitment to safe sex;

Tim: “. . . So either way that’s kind of no excuse, unless you’re in a situation, you know, a long-term committed relationship and you know for certain your partner’s HIV status
you should not be participating in unsafe sex. But then, in order to protect other people, and yourself.”

Coort, a (former) professional sex worker, was scrupulous in always using condoms with his clients. He also took the trouble to explain to them why consistent condom use was so important, and why relying on people telling you that they are HIV negative is neither reliable nor sensible. Caring for others was also demonstrated by initiating novice men into consistent condom use:-

Simon—see section above where Simon was initiated into safe sex by his slightly older partner.

James (at this stage not a safe sex practitioner) meets Keith.

James; “I met him when I was just twenty two and he was about seventeen. I met him at my local Beat and he was straight. But he was there to have sex with a man for the first time ever. A very, very nervous young man. Very hot but very straight, but very much wanted to have sex with a man. I happened to be the man that he found so we went back to my place. He was very nervous. He was shy but very determined that no, no, we’re going to do something. He didn’t want to just drop his pants and wank him off a little bit, we were going.”

Keith meets James again.

James; “As my friends say, my favorite pastime is talking about myself. So I don’t know whether he was seventeen or eighteen by now but he was definitely there specifically looking for me to have sex again. He was drunk and he’d fallen over and he’d hurt his knee, ripped his cricket whites (1) open, there was blood all over his knee and yeah, he was staggering because he was drunk and he was limping. We went back to my place and he begged me to f**k him. Actually no, I was just about to say something which contradicted everything I’ve just said because I put a condom on. I was twenty-one or twenty-two, just turned twenty-two and I put a condom on. I did know about safe sex, I was doing it.

Gordon: Okay. This is a significant change of your self-belief and self-image.
James; Oh no, no.
Gordon: So why do you think you put the condom on?
James; I don’t remember.
Gordon: To protect you or to protect him, or to set an example for a younger man?
James; I think it was just to set an example or partly to protect him. I knew he was a young virgin and I suppose I should have—I told myself to try to do the right thing, to set the example. That if I was the one he was learning from, he should learn the right thing.”

(1)-Cricket whites—the white uniform worn by cricket players.
Years later James again trains a younger man in safe sex practice:-

James; “One rule about the open relationship though was that we would have unsafe sex with each other and safe sex with everybody else.
Gordon: Okay.
James; Which came to a head about six or seven months later when we were having one of our sort of semi-regular—we had threesomes as well as open, as well as one on one, yeah and you know, the threesomes were usually with guys that I knew and this particular one was with Rod, the formerly married man who’d been at my orgy and who I’d been having unsafe sex previously and he’d been having unsafe sex with other guys that I knew who were also having unsafe sex with everybody else. So we were having a threesome and there was a period during that where I had to go downstairs and go to the toilet or get a drink of water or something like that and left them two in the room by themselves and came back and found them f**king unsafe.

Gordon: And you knew that Rod had definitely been unsafe with a lot of other people. James; Yes. And again, there’s this whole; it was almost a do as I say not do as I do kind of philosophy. But especially because he was young and because he was mine and my responsibility in a whole lot of ways, you know and again, flashing back fifteen years to Keith and you know, me wanting to have safe sex with him because it was the right thing to do when he was a virgin. So I was trying to teach him the right things even though I knew damn well I’d been doing the wrong things for twenty years.

Gordon: Yeah, but you did try nevertheless to teach the young the right things to do. James; So we had an argument after that which led to I think the only time I had ever seen him cry because I was bitterly disappointed in him and was very upset that he had upset me and stuff like that. And I felt horrible for doing that whole emotional blackmail thing but it was to push home an important point that he should not be having unsafe sex with people even though I knew damn well I’d been doing it for twenty years. But I went out and tested myself. When we got into a relationship and agreed to be open I tested myself to confirm that I was still negative and I was still negative so I knew I wasn’t going to put him at risk him through me.

Gordon: No, but he was risking something by being with Rod.James: He was risking himself. But it wasn’t just Rod, it was well if you’re doing that while I can see what are you doing when I can’t see.”

For all narrators, self-identity was closely aligned with their consistent adherence to safe sex and with protecting their HIV negative status (negative narrators), their general good health (positive narrators) and the protection of others. Seven narrators stated that their self-identity is closely entwined with their partner and the need to protect them. (For a summary, please refer to Table 6.)

And finally, the narrators all consider that what we termed their Quest for the Ideal Gay Life (however they defined it) was facilitated by their adherence to safe sex. All narrators articulated their life satisfaction and overall happiness with their present-day lives. Four were happy in their retirement. Another enjoys his part-time job while seven are enjoying their full time careers. Some are continuing their studies, and several have found fulfillment in their relationships.

Discussion—the theoretical rationale for caring

The narrators cared for others because they held a moral norm that obligated them to behave altruistically to achieve values important to them (Schwartz,
1977), namely, the protection of their sex partners and loved ones, self-protection (the protection of their HIV negative status), and the maintenance of their positive self-evaluation. Altruistic motivations are internal sources of motivation for helping (Schwartz, 1977). They are “intentions or purposes to benefit another acting as an expression of internal values, without regard for the network of social and material reinforcements.” (Schwartz, 1977, p. 222). Schwartz therefore considered altruism to be distinct from social and material reinforcements.

Social norms act as external controllers on the individual’s behavior, with various social sanctions attached should they be transgressed (Schwartz, 1977). In contrast, personal norms are anchored in the self and bring with them the individual’s self-evaluation (Schwartz, 1977). That is, the individual’s view of themselves and their expectations therefore of their own behavior. Because behavior is tied directly to the maintenance of the self-evaluation, the self-evaluation acts to support some behaviors and to sanction others (Schwartz, 1977). Conforming, or the anticipation of conforming, enhances positive self-evaluations such as pride, self-esteem and security (Schwartz, 1977). Violating the self-evaluation, or anticipation thereof, brings negative self-evaluations such as loss of self-esteem, guilt and self-criticism (Schwartz, 1977). (See for example, Tim’s and James’s narrations below regarding their feelings of remorse and shame after having CLAI.) In their meta-analysis, regarding the Theory of Planned Behavior (TPB), Conner and Armitage (1998) found support for the inclusion of the moral norm in the TPB. Rivis et al. (2009) found the moral norm to be strongly associated with significant consequences for others. Conner and Armitage (1998) concluded that strong self-identity would strengthen attitude through the mechanism of attitudinal consistency. The narrators’ stories concur with these findings. The adherent narrators’ narratives showed a consistent drive to maintain a favorable self-evaluation through their consistent execution of safe sex. Schwartz summarized the drivers of this behavior in the foregoing explanation. The narrators therefore reinforce Schwartz’s observation that “internalized norms are standards for behavior which are self-reinforcing” and “represent ideals against which events are evaluated.” (Schwartz, 1977, p. 231).

There was one instance where Tim broke his commitment to safe sex and it is not something of which he is very proud; he was at a party and bonded with someone he found to be very attractive. Suddenly one of Tim’s friends snatched his new love interest away from under his nose and Tim was devastated. The following passage relates a common story, where commitment to safe sex dissolves in drugs and/or alcohol, especially when self-esteem is at a low ebb; he left the party and went to a sex-on-premises venue;
Table 6. Narrators’ self-identity aligned with safe sex.

| Narrator | Self Identity aligned with safe sex |
|----------|------------------------------------|
| Alistair | Yes—as a safe sex educator. Alistair has a strong desire to be fit and well, participating in sports and fitness is important to him. Feels that being HIV positive is something to overcome with a positive attitude and hard work. |
| Marcel | Motivated to protect himself. His primary identity seems to be to be true to himself and to make the most of life’s pleasures. |
| David | The protection of his partner is very important to him. He takes steps to ensure that his partner stays well. He understands that this protection is based on his implementation of strategic positioning. |
| Coort | Trust and protection of himself, partner (Zak), group sex participants and sex work clients. |
| Zedd | “Does not want to contract a significant illness willingly.” Also demonstrated care and protection of others. |
| Chris | Self-identity closely aligned with his feelings for partner and the need to protect him. |
| Buster | Clearly concerned to maintain negative status for himself and his partner. Effective at doing so. |
| Des | His Boy Scouts training taught him to be self-reliant, clean, and prepared. Has been careful to use safe sex to protect his HIV negative status. |
| Tim | Explicitly, safe sex as an instrument to protect himself, his health and his relationships. Considers safe sex to be “congruent with my personality.” |
| Zak | Like David and Chris, Zak’s identity and use of safe sex as protection is closely bound up with his relationship with his partner (Coort). |
| Josh | Clearly concerned to maintain negative status for himself, his partners and others. “How would you feel if maybe without knowing that you might have AIDS you pass it on to someone else? I would suffer for the rest of my life.” |
| Simon | A champion state-level swimmer in his teens followed by a successful career in business development; we can conclude that being HIV negative is important to him and to his self-image and identity. He has demonstrated this through seven relationships over 10 years where he has maintained negative status. |
| Getz | Clearly committed to his children and grandchildren and his partner. “I did not want to die by getting a disease I could avoid … When you could avoid it.” |
| Toby | At school, in Religious Education class, he was told that homosexuality was evil. He determined to have a good life anyway. He has been successful in caring for his parents, developing his teaching career, and is now committed to his relationship with Paul—“Oh, I would never endanger him.” They are parishioners at the same church. |
| Herman | After his epiphany, safe sex and retaining his negative status is “about your own self-respect.” He had been very trusting until his epiphany—he found that that breach of trust was “destruction … of relationship dreams like that my life.” “You don’t need something like that (becoming positive) to hinder a beautiful relationship you can have with another man.” |
| James | After his conversion to safe sex he had condomless sex in the sauna because there were no condoms conveniently available. He is now very embarrassed about this and he said that this is the first time in his life that he has ever been ashamed of having sex. |

Table 7. High correspondence between model construct measures will result in the behavior being performed.

| Components | Safe Sex Loyals | Unsafe Sex Loyals |
|------------|----------------|------------------|
| Attitude   | Positive toward Safe Sex | Positive toward Unsafe Sex |
| Norm       | Safe Sex | Unsafe Sex |
| Perceived control | High | High (1) |
| Intention  | To practice | To practice |
| Behavior   | Safe Sex | Unsafe Sex |
| Action     | Safe Sex | Unsafe Sex |
| Context    | Sexual intercourse | Sexual intercourse |
| Time       | Every Time | Every Time |

Tim: “That happened because I was incredibly drunk, I was incredibly lonely and I was probably not in the capacity to; it sort of happened without me realizing it, sort of. I sort of knew that there were no condoms, but I didn’t really have an awareness of that… Because I wanted to be wanted. I wanted to have that sexual experience that I’d been I guess denied earlier in the evening.”
James had recently committed to safe sex.

James: “So I found my resolve tested a few times.

Gordon: Yes. But you’ve stuck with it.

James: Mostly. As recently as two weeks ago I didn’t.

Gordon: For the reason that?

James: For the reason that I was horny, he was in the sauna and there were no condoms there.

Gordon: Okay. How did you feel afterward?

James: Ashamed.

Gordon: But that was a new feeling for you?

James: It was. I’ve never been ashamed about sex before.

### The preexisting content-specific norm

Schwartz (1977) proposed a process for moral norm construction. He termed these “preexisting content-specific norms” (Schwartz, 1977, p. 233). These norms were formed based on the individual’s past experiences, were then internalized, and would create self-expectations to be drawn on in current situations (Schwartz, 1977). Therefore, the preexisting context-specific norm obviates the need to construct a norm on every decision-making occasion. It therefore acts in a similar way to brand loyalty within the Framework of Customer Loyalty (FCL; Dick & Basu, 1994). Loyalty to a particular brand removes the need for the individual to evaluate competing brands each time he needs to make a purchase (Dick & Basu, 1994). The addition of the moral norm and the preexisting content-specific norm to the FCL is illustrated in Figure 1.

The adherent narrators possessed a preexisting content-specific norm, their loyalty to safe sex, which they consistently practiced without undertaking a process of norm construction every time they contemplated undertaking sexual intercourse. In this regard, it is likely that the narrators’ consistent reporting of their adherent practice is akin to what Schwartz (1977) describes as “a well-practiced instrumental reaction [which] may be elicited directly by the appropriate stimulus without feelings of obligation (e.g., a medic treating a wounded soldier under fire)” (1977 p. 233).

### Double obligation and double motivation

The narrators went beyond invoking their preexisting content-specific norm and adhering self-protectively to protect themselves. In addition they adhered
Altruistically to protect their sex partner and loved ones and to maintain their positive self-evaluation. This form of double obligation and double motivation explains the consistent and rigorous implementation of this norm by the adherent narrators. The narrations provide numerous examples of double motivation and double obligation whereby the narrators acted to protect themselves and others. Double obligation and double motivation concurs with studies which have identified both self-directed (egoistic) and altruistic motivators (Batson et al., 2002) and that individuals exhibit the highest motivation when they have both a high concern for self and for others (De Dreu, 2006). How double obligation and double motivation contributes to the creation of the preexisting content-specific norm can be explained in detail by Schwartz’s Processual Model (Schwartz, 1977). It is an actionable model for the creation of a preexisting content specific norm (such as consistent adherence) to a Combination Prevention regimen which then acts as an instrumental (automatic) reaction whenever the appropriate cue (that sexual intercourse is imminent) is provided to the actor (Schwartz, 1977).

Other authors have identified that caring for others is likely to create effective health promotion campaigns to further increase adherence (Adam, 2005; Nimmons & Folkman, 1999; Stancombe Research and Planning, 2008; Wohlfeiler, 2011).
**Personal norms as a source of sanctions**

Persons who are a potential source of sanctions in the specific situation thereby influenced the behavior of the individual; “considering in particular, possible sanctions for acting one way or another; then he makes his action decision.” (Acok & DeFleur, 1972, p. 725 emphasis in the original). This concurs with the narrators’ stories—because sexual intercourse is a private matter (and therefore, as in the Acok study, the social norm referents would be unlikely to find out about the behavior), it is the personal norms that determine behavior and not the social norms. On the other hand, the sex partner is a potential source of sanctions. When confronted with requests for CLAI, the narrators imposed the social sanction of withholding sexual intercourse. Thereby, as per Ajzen (1991) the narrators demonstrate high Perceived Behavior Control. Examples follow of narrators imposing sanctions on sex partners include refusing CLAI, and in some cases ending the relationship if condom use was refused.

**Tim’s** loyalty to safe sex was demonstrated when he walked out of a relationship rather than practice unsafe sex. His Moral Norm of mutual protection was violated when his partner tried to have unsafe sex with him. His community attachment and Moral Norm to protect others included voluntary teaching of safe sex to other young men through the Victorian AIDS Council. He was and is a passionate advocate for safe sex.

Tim: “So by the time I’ve met Paul, at twenty, you know, and he had a lovely twenty first party for me or a small gathering with my friends at his place for me and it was really nice. It may have even been the same day or it a few days later we sort of had sex and he tried to f**k me without a condom essentially during that and had sort of started to and then I don’t think he’d penetrated; if he had it was just barely and I sort of said, what are you doing and essentially that was the end of our relationship. It only lasted another week or two because I took it very seriously and very personally that he would try to do that . . . I mean I had been teaching. I was a facilitator for the Young and Gay Program at the Victorian AIDS Council and the core message of that was safe sex . . . I was very passionate about it and so I was passionate about that.” . . . “So I broke up with Paul based on that kind of sexual experience.

Gordon: And you’re feeling that he didn’t really respect you?

Tim: Yeah, I think that’s what it came to.”

**Chris’s** commitment to safe sex was tested and found to be strong. His Moral Norm would not allow him to have unsafe sex, and acted as an enabler of his quest for the ideal gay life;

Chris: “ . . . I went home one night with an Irish guy who wanted me to f**k him and he wanted me to do it without a condom and I was horrified and refused and he was begging me to and it just seemed so—I was completely unaware that people would even think about having sex, like, if they are at that point in sex, it was an automatic thing, there was no question. And he was my age or he may have even been a year or two younger than me and it just seemed like such a self-destructive thing to do . . . I was horrified by it. I walked
out. And he was begging me and I said no, I’m not going to do it . . . Because it was unsafe . . .”

**Exposure to a direct appeal will result in safe sex practice**

The narrators’ stories concur with Schwartz (1977) that “A final basis for responsibility is exposure to a direct appeal.” (p. 249). A direct appeal will focus responsibility very clearly from the person needing help to the person being addressed (Schwartz, 1977). Some narrators mentioned that their partner requested condom use, and of course, in other circumstances the narrator requested the use of condoms. Both forms of request constitute a direct appeal.

**James** agrees to use a condom when a direct appeal is made to him;

James: “But by now there were occasional people who would occasionally ask if I could use a condom, but far and away the minority, way less than ten percent . . . .

Gordon: And what was your response when they asked?

James; Yeah, okay.

Gordon: Okay, right, so you’d rather have sex with a condom than no sex?

James; Yes. (laughter)

Gordon: That’s an extremely stupid question. Alright.

James; Yes. Well I mean it wasn’t that I was out to only have unsafe sex, I was just out to have sex and enjoy myself, and part of enjoying myself was making sure that they enjoyed themselves and if they wanted me to use a condom then that was not a problem.

**Direct activation of social norms**

Schwartz (1977) concluded that social articulation of a norm (such as advertising to promote adherence) might block the activation of personal norms, and create “perception of social pressure to act which elicits reactance.” (Schwartz, 1977, p. 269). The narrators did not support Schwartz on this point. They reported (see, Table 3) that social articulation of safe sex had acted to educate them (although fear appeals might not be effective—see, Table 4).

**Conclusions regarding normative influences on altruism**

This enquiry enables understanding of attitude formation and evolution in a way that provides managerial direction for the creation of social marketing communications to promote adherence to Combination Prevention regimens. Most notably, the key role of the personal moral norm, altruistic behavior, double obligation and double motivation, preexisting content specific norms and the nine step Processual Model. Finally, the use of the direct appeal to activate
the personal moral norm. These findings inform the design of future Combination Prevention promotions.

Sadly, not all men possess a moral norm, and so not all men behave altruistically. In a Sydney court a man “pledged guilty in March (2018) to recklessly causing grievous bodily harm to his former partner” by transmitting the HIV virus to him (“I never got an apology,” 2018). His former partner said in court, “He made no reasonable effort to stop the prevention of a completely preventable disease. I never got an apology. I never got any sympathy from him for what he did to me. And for what he put me through, I will never be able to forgive him.” (“I never got an apology,” 2018).

A theoretical framework provides managerial direction for health promotions to increase adherence to combination prevention regimens

Effective implementation of the findings requires the identification of theories and frameworks. Campaigns/interventions are more likely to succeed when they are based on theories or frameworks (Glanz et al., 2008; Kotler et al., 2010). Marketing loyalty frameworks have been shown to be effective in other contexts in recruiting and retaining “clients” (Kotler et al., 2010). We selected Dick and Basu’s Framework for Customer Loyalty (FCL; Dick & Basu, 1994) because it is a well-known marketing framework for managing customer loyalty. In addition, other researchers have referred to it as the classical model of loyalty in marketing (Ngobo, 2017). Furthermore, others had researched it in an attempt to provide empirical evidence to demonstrate its predictive ability (Garland & Gendall, 2004). Our analysis of the narrations demonstrate that firstly, the Framework for Customer Loyalty (FCL; Dick & Basu, 1994), illustrated in Figure 1, provides an illuminating method by which to categorize and understand the narrators’ autobiographical life histories. Secondly, FCL provides a framework that enables understanding of each narrator’s process by which he developed and changed his attitude and behavior regarding adherence. That is, in terms of the FCL they exhibited consistent repeat-patronage of safe sex. Therefore, findings support the predictive capabilities of the FCL; they either practiced CLAI consistently if they had a strong relative attitude in favor of CLAI, or they practiced safe sex consistently if they had a strong relative attitude in favor of safe sex.

We also found passages in the narrations that illustrate all the components of the FCL and explained the evolution of safe sex loyalty. We conclude therefore that the FCL framework provides managerial direction as to how to deploy the understanding (of formation and evolution of attitudes) into social marketing communications to create and maintain adherence to Combination Prevention regimens.

Garland and Gendall (2004, p. 81) conducted “a test of the predictive ability of Dick and Basu’s model in personal retail banking.” in New Zealand. Their
findings concur with ours “both relative attitude and share loyalty are significant predictors of number of banks used.” (Garland & Gendall, 2004, p. 85). They concluded that the FCL might have validity in “subscription type markets” with a small number of brands and low customer churn rates (Garland & Gendall, 2004, p. 81). This concurs with our findings, in that it could be argued that the gay sex “market” is similar to Garland and Gendall’s (2004, p. 81) “subscription type markets” in that there are a small number of brands (today there are three brands; abstinence, non-adherence and adherence) and low customer churn rates (most gay men remain loyal to one brand, most of the time). Our findings regarding the non-defection of safe sex loyals also concurs in that the most loyal customers have “the lowest probability of defection” (Garland & Gendall, 2004, p. 85).

The individual’s self-evaluation (Schwartz, 1977) and the individual’s drive to maintain it, shares characteristics with the cognitive antecedent of centrality (Dick & Basu, 1994). Centrality is the degree to which an attitude toward the brand relates to the value system of an individual (Dick & Basu, 1994). Attitudes that are central cause both the individual’s values and the likely outcomes of proposed actions to be considered in the decision-making process (Dick & Basu, 1994). Central attitudes are important, are stable over time, resistant to counter-persuasion and are strongly associated with behavior (Dick & Basu, 1994). From the narrations it is clear that safe sex loyals held safe sex as a central attitude which was closely related to behavior through its’ impact on accessibility (ease of retrieval; Dick & Basu, 1994).

Ajzen and Fishbein (1980) and Ajzen (1991), have shown that it is critical to have a high degree of correspondence between measures of the various model components. They found that any change in any of these factors would result in different behavior being explained (Montano & Kasprzyk, 2008). In short, individuals will consistently perform the preferred health behavior if there is alignment amongst all their antecedents to action. The narrators’ stories concur with these findings. Both safe sex loyals (all narrators by the end of their autobiographical life histories) and unsafe sex loyals (James and Herman during their unsafe sex loyal periods) had alignment of antecedents and performed their behavior consistently. Table 7 below summarizes accordingly:-

1-During his unsafe sex period James would use condoms if requested.

Moreover, the narrators were completely resistant to counter-persuasion (Dick & Basu, 1994). See for example, the narrations of Tim (broke off his relationship with Paul after Paul attempted unsafe sex with him) and Chris (refused to have unsafe sex with the Irish boy). Dick and Basu (1994) refer to a study by Sirgy and Samli (1985) who found that congruity between store image and self-image is related to store loyalty. In our enquiry it was clear that the safe sex narrators strove to achieve congruity between their self-image
(their self-evaluation) and their perceived image of safe sex (Refer to Tables 6 and 7.).

**Discussion—HIV/AIDS literature**

The specific sexual behaviors acknowledged as effective in preventing transmission of HIV have evolved over the course of the epidemic. The original safe sex practice was codified in the early 1980s as the frontline preventative action to prevent the transmission of HIV (Mindel & Kippax, 2013). From the mid-1980s, the public health authorities in Australia promulgated safe sex (always use condoms for insertive sex and always assume that everyone else is HIV positive). This campaign was largely successful in that the rate of new infections slowed considerably. Between 1986/7 and 1996/7 there was a rapid uptake of condom use (Mindel & Kippax, 2013) “. Closely associated with a concomitant decline in HIV and STI transmission,” due to behavioral change by gay men (p. 352).

Race (2001) considers that gay men balance precaution with preference for condomless anal intercourse (CLAI). Consequently, some gay men began using HIV positive/negative status as a strategy to negotiate CLAI (Race, 2001). Accordingly, from the mid-1990s a steady increase in the proportion of gay and other Men who have Sex with Men (MSM) reporting CLAI with both regular and casual partners was identified (Van de Ven et al., 2002). Evolution of transmission preventative methods continues. New biomedical preventative methods are being deployed now in Australia (Department of Health, 2018; Kirby Institute, 2017; Victorian AIDS Council, 2017). Post-Exposure prophylaxis (PeP) stops HIV infection when taken immediately after a possible transmission event. Pre-exposure prophylaxis (PrEP) protects an HIV negative man from infection, and Treatment as Prevention (TasP) prevents an HIV positive man from transmitting the virus to others. The PrEP and TasP users must adhere consistently to their medication regimens to prevent the transmission of HIV (Department of Health and Ageing, 2010). Men not on TasP or PrEP must use condoms consistently to prevent virus transmission (Holt et al., 2017). The number of new HIV diagnoses in Australia increased in the period 2010–2017, and the proportion attributed to MSM rose slightly to 75% (Holt, 2017) CLAI by MSM with casual partners is the main risk factor for HIV transmission in Australia (Holt et al., 2017). (In the USA, the main risk is CLAI with a steady partner (Holt et al., 2017)). Condom use by men not on TasP or PrEP will need to be maintained, “to achieve the maximum net benefit of antiretroviral-based intervention” to reduce the rate of new transmissions (Holt et al., 2017, p. 77).

In conclusion, consistent adherence to a Combination Prevention regimen is required.
Conclusions and contributions to knowledge regarding Dick & Basu’s framework for customer loyalty

(1) The FCL enables understanding of attitude formation and evolution in a way that provides managerial direction to the developer of social marketing communications to increase adherence to Combination Prevention.

(2) This enquiry’s finding supports the predictive capabilities of the FCL model. This is broadly aligned with some previous studies (Garland & Gendall, 2004).

(3) The findings suggest two additions to the FCL. These are the Feedback Loop and the additional consequence of Satisfaction (see Figure 1).

(4) Dick and Basu (1994, pp. 107–109) provide specific direction for managing loyalty. In addition, the FCL provides a linkage to the extensive body of marketing research that is available to the developer of social marketing communications to increase adherence to Combination Prevention.

Conclusion

This enquiry achieved its purpose; to understand how gay men form and maintain their attitudes toward HIV transmission preventative behaviors. Our intention, in common with that of many health researchers in the HIV field is that this understanding be used to guide the development of communications programs to increase adherence to transmission prevention behaviors (Macapagal et al., 2017).

Limitations

In common with other qualitative studies in HIV health this inquiry had a small sample size (Khumsaen & Stephenson, 2019; Haas et al., 2017). As described on page 7, Dr Campbell sent an e-mail to gay men in his personal network. He asked them to on-forward the e-mail to other gay men, inviting them to contact him. He specified that narrators needed to be gay men who did not know him (to limit bias), were over 25 years of age, and were living in the gay milieu in Melbourne. In this sense the narrators volunteered themselves for the enquiry. This recruitment method is called “snowball sampling” (Wright & Stein, 2005, p. 495), and is in keeping with the ethnographic style of this enquiry (Agar, 2001). Nevertheless, as Connell (1992, p. 739) said of his study, upon which the method used in this inquiry was based, “Although representativeness is not measurable with a small group of case studies, I am confident that these cases are not atypical.” Likewise, the narrators live in one
social location, in one milieu and we are confident that they are not atypical. Therefore, the results in our view are generalizable to other, similar milieu.

**Recommendations for future research**

We recommend the following research:-

1. A trial social marketing communications campaign to increase adherence to Combination Prevention, especially of condoms, using the findings of this project.
2. Investigate how altruism as a driving force, changes with biomedical interventions, since the motivation for both PrEP and HIV-treatment is largely self-protective (albeit with extremely powerful benefits for reducing risk to partners) rather than altruistic.

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**References**

Acock, A., & DeFleur, M. (1972). A configurational to contingent in the attitude-behavior relationship. *American Sociological Review, 37*(6), 714–726. https://doi.org/10.2307/2093582
Adam, B. (2005). Constructing the neo-liberal sexual actor: Responsibility and care of the self in the discourse of barebackers. *Culture, Health & Sexuality, 7*(4), 333–346. https://doi.org/10.1080/13691050500100773
Agar, M. (2001). Ethnography. In N. Smelser & P. Baltes (Eds.), *International encyclopedia of the social & behavioral sciences* (pp. 4857–4862). Elsevier.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Prentice-Hall.

Andreasen, A. (2003). The life trajectory of social marketing: Some implications. *Marketing Theory, 3*(1), 293–303. https://doi.org/10.1177/147059310333004

Batson, C. D., Ahmad, N., & Tsang, J. A. (2002). Four motives for community involvement. *Journal of Social Issues, 58*(3), 429–445. https://doi.org/10.1111/j.1540-4560.00269

Brierley, J. (1994). *Give me a child until he is seven; brain studies and early childhood education* (2nd ed.). The Falmer Press.

Celsi, R., Rose, R., & Leigh, T. (1993). An exploration of high-risk leisure consumption through skydiving. *Journal of Consumer Research, 20*(1), 1–23. https://doi.org/10.1086/209330

Chase, S. (2005). Narrative inquiry. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 651–679). Sage Publications Inc.

Clandinin, D. (2005). Qualitative analysis, anthropology. In K. Kempf-Leonard Ed., *Encyclopedia of social measurement* (3rd ed., Vol. 3, pp. 217–223). Elsevier. https://www.sciencedirect.com/search?authors=clandinin&pub=Encyclopedia%20of%20Social%20Measurement&origin=ref_work&zone=qSearch&cid=273418&withinJournalBook=true

Connell, R. (1992). A very straight gay: Masculinity, homosexual experience, and the dynamics of gender. *American Sociological Journal, 57*(6), 735–751. https://doi.org/10.2307/2096120

Conner, M., & Armitage, C. (1998). Extending the theory of planned behavior: A review and avenues for further research. *Journal of Applied Social Psychology, 28*(15), 1429–1464. https://doi.org/10.1111/j.1559-1816.1998.tb01685.x

De Dreu, C. K. W. (2006). Rational self-interest and other orientation in organizational behavior: A critical appraisal and extension of Meglino and Korsgaard (2004). *Journal of Applied Psychology, 91*(6), 1245–1252. https://doi.org/10.1037/0021-9010.91.6.1245

Department of Health. (2018). *Eighth national HIV strategy 2018 - 2022*. Attorney-General’s Department.

Department of Health and Ageing. (2010). *Sixth national HIV strategy 2010-2013*. Attorney-General’s Department.

Department of Health and Ageing. (2014). *Seventh national HIV strategy 2014-2017*. Attorney-General’s Department.

de Wit, J., & Adam, P. (2014). Can Treatment-based HIV Prevention Curb the Epidemic Among Gay and Other Men Who Have Sex with Men? A Narrative Synthesis of Increasing Evidence for Moderating and Countervailing Effects. *Sexual Health, 11*(2), 137–145.

Dick, A., & Basu, K. (1994). Customer loyalty: Toward an integrated conceptual network. *Journal of the Academy of Marketing Science, 22*(2), 99–113. https://doi.org/10.1177/009207039422001

Donovan, R., & Henley, N. (2003). *Social marketing principles and practice*. IP Communications.

Duneier, M. (2009). Michael apted’s up! series, public sociology or folk psychology through film? *Ethnography, 10*(3), 341–345. https://doi.org/10.1177/1466138109342832

Evans, W., Wasserman, J., Bertolotti, E., & Martino, S. (2002). Branding behavior – the strategy behind the truth social marketing campaign. *Social Marketing Quarterly, 8*(3), 17–29. https://doi.org/10.1080/105245000214134

Garland, R., & Gendall, P. (2004). Testing Dick & Basu’s customer loyalty model. *Australasian Marketing Journal, 12*(3), 81–87. https://doi.org/10.1016/S1441-3582(04)70108-1
Glanz, K., Rimer, B., & Viswanath, K. (2008). The role of health behavior and health education. In K. Glanz, B. Rimer, & K. Viswanath (Eds.), Health behavior and health education. Theory, research and practice (4th ed., pp. 3–22). Jossey-Bass.

Haas, S. M., Perazzo, J. D., Ruffino, A. H., Ancona, R. M., & Lyons, M. (2017). The know*now project: Facilitated sero-sorting in HIV-status sexual partner communication. AIDS Education and Prevention, 29(5), 432–442. https://doi.org/10.1521/aap.2017.29.5.432

Holt, M. (2017). Progress and challenges in ending HIV and AIDS in Australia. AIDS & Behavior, 21(2), 331–334. https://doi.org/10.1007/s10461-016-1642-0

Holt, M., Lea, T., Mao, L., Zablotska, I., Lee, E., de Wit, J., & Prestage, G. (2017). Adapting surveillance to antiretroviral-based HIV prevention: Reviewing and anticipating trends in the Australian gay community periodic surveys. Sexual Health, 14(1), 72–79. https://doi.org/10.1071/SH16072

Holt, M., Rawstorne, P., Bittman, M., Worth, H., Wilkinson, J., & Kippax, S. (2011). Predictors of HIV disclosure among untested, HIV-negative and HIV-positive Australian men who had anal intercourse with their most recent casual male sex partner. AIDS & Behavior, 15(6), 1128–1139. https://doi.org/10.1007/s10461-009-9645-8

I never got an apology. (2018, September 14). “I never got an apology: Man infected with HIV by former lover sobs in court”. The Age. Retrieved October 27, 2018, from https://www.theage.com.au/national/nsw/i-never-got-an-apology-man-infected-with-hiv-by-former-lover-sobs-in-court-20180914-p503u6.html

Khumsaen, N., & Stephenson, R. (2019). Feasibility and acceptability of an HIV/AIDS self-management education program for HIV-positive men who have sex with men in Thailand. AIDS Education and Prevention, 31(6), 553–566. https://doi.org/10.1521/aep.2019.31.6.553

Kirby Institute. (2017). HIV, viral hepatitis and sexually transmissible infections in Australia, annual surveillance report 2017.

The Kirby Institute. (2021). Tracking the progress 2020: National HIV strategy.

Kotler, P., Brown, L., Burton, S., Deans, K., & Armstrong, G. (2010). Marketing (8th ed.). Pearson Australia.

Lindholm-Leary, K. (2005). The rich promise of two-way immersion. Educational Leadership, 62(4), 56–59.

Lunn, T. (1995). Selecting and developing talent: An alternative approach. Management Development Review, 8(1), 1–5. https://doi.org/10.1108/09622519510077529

Macapagal, K., Birkett, M., Janulis, P., Garofalo, R., & Mustanski, B. (2017). HIV prevention fatigue and HIV treatment optimism among young men who have sex with men. AIDS Education and Prevention, 29(4), 289–301. https://doi.org/10.1521/aap.2017.29.4.289

Mindel, A., & Kippax, S. (2013). A national strategic approach to improving the health of gay and bisexual men: Experience in Australia. In S. O. Aral, K. A. Fenton, & J. A. Lipshutz (Eds.), The new public health and STD/HIV prevention: Personal, public and health systems approaches (pp. 339–360). Springer. https://doi.org/10.1007/978-1-4614-4526-5_17

Montano, D., & Kasprzyk, D. (2008). Theory of reasoned action, theory of planned behavior, and the integrated behavioral model. In K. Glanz, B. Rimer, & K. Viswanath (Eds.), Health behavior and health education (pp. 67–90). John Wiley & Sons.

Ngobo, P. (2017). The trajectory of customer loyalty: An empirical test of Dick and Basu’s loyalty framework. Journal of the Academy of Marketing Science, 45(2), 229–250. https://doi.org/10.1007/s11747-016-0493-6

Nimmons, D., & Folkman, S. (1999). Other-sensitive motivation for safer sex among gay men: Expanding paradigms for HIV prevention. AIDS & Behavior, 3(4), 313–324. https://doi.org/10.1023/A:1025437418276
Owens, C., Hubach, R. D., Williams, D., Lester, J., Reece, M., & Dodge, B. (2020). Exploring the pre-exposure prophylaxis (PrEP) health care experiences among men who have sex with men (MSM) who live in rural areas of the Midwest. *AIDS Education and Prevention, 32*(1), 51–66. https://doi.org/10.1521/aepa.2020.32.1.51

Prestage, G., Van de Ven, P., Grulich, A., Kippax, S., McInnes, D., & Hendry, O. (2001). Gay men’s casual sex encounters: Discussing HIV and using condoms. *AIDS Care, 13*(3), 277–284. https://doi.org/10.1080/09540120120043928

Race, K. (2001). The undetectable crisis: Changing technologies of risk. *Sexualities, 4*(2), 167–189. https://doi.org/10.1177/136346030004002004

Rivis, A., Sheeran, P., & Armitage, C. (2009). Expanding the affective and normative components of the theory of planned behavior: A meta-analysis of anticipated affect and moral norms. *Journal of Applied Social Psychology, 39*(12), 2985–3019. https://doi.org/10.1111/j.1559-1816.2009.00558.x

Schwartz, S. H. (1977). Normative influences on altruism. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 10, pp. 222–276). Academic Press.

Sirgy, M., & Samli, C. (1985). A path analytic model of store loyalty involving self-concept, store image, geographic loyalty, and socioeconomic status. *Journal of the Academy of Marketing Science, 13*(3), 265–291. https://doi.org/10.1007/BF02729950

Stake, R. (2005). Qualitative case studies. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 455–463). Sage Publications Inc.

Stancombe Research and Planning. (2008). *Formative research for the national sexually transmitted infections (including HIV/AIDS) prevention program.* Department of Health and Ageing, Canberra, Australia.

Tamboukou, M. (2008). Re-imagining the narratable subject. *Qualitative Research, 8*(3), 283–292. https://doi.org/10.1177/1468794106093623

Tamboukou, M. (2009). Leaving the self: Nomadic passages in the memoir of a woman artist. *Australian Feminist Studies, 24*(61), 307–324. https://doi.org/10.1080/08164640903075081

Thorne, B. (2009). The seven up! Films, connecting the personal and the sociological. *Ethnography, 10*(3), 327–340. https://doi.org/10.1177/1466138109342830

Thorne Harbour Health. (2022a). *HIV Transmission* Retrieved April 4, 2022, from https://thorneharbour.org/hiv-aids/hiv-transmission/

Thorne Harbour Health. (2022b). *Pre Exposure Prophylaxis (PrEP).* Retrieved April 4, 2022, from https://thorneharbour.org/hiv-aids/pre-exposure-prophylaxis-prep/

Van de Ven, P., Rawston, P., Crawford, J., & Kippax, S. (2002). Increasing proportions of Australian gay and homosexually active men engage in unprotected anal intercourse with regular and with casual partners. *AIDS Care, 14*(3), 335–341. https://doi.org/10.1080/09540120220123711

Victorian AIDS Council. (2017). *Pre Exposure Prophylaxis (PrEP).* Retrieved December 3, 2017, from http://vac.org.au/hiv-aids/pre-exposure-prophylaxis-prep/

Wohlfeiler, D. (2011). What difference can we make in reducing syphilis among gay men? And how? *Sexually Transmitted Diseases, 38*(12), 1159–1160. https://doi.org/10.1097/OLQ.0b013e31823b1001

Wright, R., & Stein, M. (2005). Snowball sampling. In K. Kempf-Leonard Ed., *Encyclopedia of social measurement* (3rd ed., Vol. 3, pp. 495–500). Elsevier. https://librarysearch.swinburne.edu.au/primo-explore/fulldisplay?docid=SUT-ALMA51246802670001361&context=L&vid=SWIN2&search_scope=Blended&tab=combined&lang=en_US