Strategic Positioning

Insertive - receptive roles in anal sex

The estimated risk of HIV transmission for insertive versus receptive risk is not the same. The risk of transmission as a result of receptive anal sex is estimated to be 1:125 to 1:31 (which is less than or equal to three per cent). The per-contact risk for insertive anal sex is estimated to be 1:2,000 to 1:667 (or less than 0.1 per cent).[1] These estimates however are not absolute. Each episode of potential exposure to HIV carries its own unique transmission risk depending on the nature of the exposure, the infectivity of the source and host susceptibility. Cofactors that increase the likelihood of HIV transmission are high viral load and the presence of sexually transmissible infections (STIs).

Despite the fact that there is a risk of HIV transmission during unprotected anal sex if one partner is HIV-positive (whether that partner is insertive or receptive), it would appear that many gay men believe, quite correctly, that there is greater risk to the receptive partner. It seems logical to assume that the existence of published guidelines for PEP, for example, stating the relative risk of receptive and insertive roles will only further support the perception that the degree of risk is different.

For HIV-negative men however this per-contact risk of HIV transmission would also be considered in the context of the likelihood that their partner is HIV-positive (and this is rarely discussed in casual sex situations). This ranges from three to 15 per cent across different Australian capital cities.[2]

The term *strategic positioning* has been coined to refer to the practice of assuming the insertive or receptive position for anal sex based on serostatus. This is also sometimes referred to as *modality* and more recently *sero-sorting*.

A recent qualitative study among gay men in Sydney and Brisbane found that some positive men are deliberately adopting the receptive position of anal sex as a risk-minimisation strategy for HIV transmission.[3] This study also found that HIV-positive men were more able than HIV-negative men to articulate risk reduction strategies for anal sex. Analysis of data collected through the Gay Community Periodic Survey in Sydney from 1996 to 2000 also found that there is a distinct patterning of risk reduction for anal sex based on HIV status, which cannot be explained as mere sexual preferences.[4] Researchers looked at those men who reported any UAI *that included ejaculation inside*. (Any UAI that did not include ejaculation inside was analysed separately because this would have potentially been influenced by the risk reduction strategy of "withdrawal".)

The trend of distinct patterns of roles in anal sex based on serostatus was particularly apparent among regular serodiscordant sexual partners. Among men who reported only one role for UAI with ejaculation (i.e. not including those men who reported *both* roles, which was approximately 21 per cent of men) HIV-positive men were more likely to be receptive *only* (69 per cent vs. 9.9 per cent who were insertive only), and HIV-negative men were more likely to be insertive *only* (69.3 per cent vs. 9.3 per cent who were receptive only). Similar, but less clear patterns were evident among those practising withdrawal.

To a lesser extent this pattern was also evident among casual partners. Many more men who had UAI with ejaculation with casual partners were both insertive *and* receptive (one half of HIV-positive men and one third of HIV-negative men). Of the rest, HIV-positive men were more likely to be receptive *only* (32.4 per cent vs. 16.7 per cent) and HIV-negative men were more likely to be insertive *only* (44 per cent vs. 19 per cent). Again, there was a similar but less clear pattern among those practising withdrawal.

The reason for the conclusion that this indicates a deliberate risk reduction strategy (and not based on preference alone) is the important fact that these patterns are not evident when looking at anal sex *with* condoms. They only hold for sex without condoms and are the most pronounced where there is a known risk of HIV transmission ie. in regular relationships where one partner is known to be HIV-positive and the other HIV-negative. Therefore it is logical to assume that men are making decisions about anal sex that they believe is more likely to protect them or their partners from HIV transmission.

HIV transmission to the insertive partner

The urethral meatus is commonly known as the eye of the penis. The tube extending from this opening is called the urethra. Like the lining of the rectum, the urethra is a thin mucous membrane that can act as a point of entry for HIV. During anal sex, HIV may be transmitted via any breaches – whether visible or not – in the urethra or on the outer surface of the penis. Breaches in the urethra may occur as a result of infections (eg. urinary tract infections of non-specific urethritis) or other factors such as rough sex. The risk of HIV infection to the insertive partner during anal sex is identical if the penis is withdrawn before ejaculation or is ejaculation occurs inside.

While acknowledging the different risks, we need to emphasise through the campaign that there is still risk involved. It is also important to emphasise that this risk also increases over time.

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[1] *Guidelines for the Management and Post Exposure Prophylaxis of Individuals who Sustain Nonoccupational Exposure to HIV, ANCAHRD Bulletin no. 28, July 2001.*

[2] *Prestage G, Van de Ven P, Knox S, Grulich A, Kippax S, Crawford J. The Sydney Gay Periodic Surveys 1996-1999: Changes over time. National Centre in HIV Social Research; 1999.*

[3] *Rosengarten M, Touch wood, everything will be OK: gay men's understandings of clinical markers in sexual practice, NCHSR, Dec 2000.*

[4] *Van de Ven P et. al, 'Patterns in gay men's sexual practice indicate strategic positioning for risk reduction rather than unbridled sex,' NCHSR, NCHECR, AFAO, (submitted for publication*).