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The use of scientific argumentation in choosing risky lifestyles within the scenario of aids

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This article deals with the use of scientific arguments that circulate in the day-to-day lives of men who have sex with men (MSM) in casual partnerships, as a strategy for managing the risks relating to sexual practices. The theoretical basis for this investigation was the discursive practices regarding risky lifestyles within the scenario of AIDS. Through the snowball technique, seven participants were chosen and they gave responses in semi-structured interviews. The results showed that scientific information circulating in the daily lives of the interlocutors of this study had been assimilated and that these individuals interpreted this information as a potential source for risk management. In summary, these men had developed risk management strategies relating to infection by STD and HIV and/or HIV reinfection, without necessarily basing them on the Brazilian government's official preventive policies.
Keywords: Scientific argumentation. Risk management. Sexual practices among men who have sex with men.

This article results from a master's study within social psychology in which the objective was to understand how men who have sex with men (MSM) in casual partnerships manage the risks of infection caused by sexually transmitted diseases (STDs) and the human immunodeficiency virus (HIV), and/or HIV reinfection, when they choose to have sexual practices without using condoms. For this discussion, we elected to bring together the interlocutors' discourse and the scientific knowledge in the field of AIDS. It is worth emphasizing that the information discussed here is taken to form discursive practices that circulate in the day-to-day lives of our interlocutors, and is used as a potential source of risk management for these men.

The greatest hope of a cure or discovery of other strategies for AIDS prevention lies in the development of vaccines that might impede establishment of the virus in the human organism and, in the case of infected individuals, might eliminate it. To this end, billions of dollars have been invested in studies with the aim of producing results with the field of AIDS. Until such time that discoveries may be made, society has to become accustomed to the epidemic scenario and deal in some way with the infection risks that are implicated both in clinical trials on human beings (Spink, 2007) and in day-to-day sexual practices.

For example, Table 1 was drawn up by the Centers for Disease Control and Prevention (2005) in order to help healthcare managers working within the field of prevention to analyze the risk of HIV according to exposure route.

Table 1. Estimated risk of HIV according to exposure route*

Exposure route	Risk per 10,000 exposures to an infected source	References
Blood transfusion	9,000	Donegan et al. (1990)
Needle-sharing injection-drug use	67	Kaplan and Heimer (1995)
Receptive anal intercourse	50	Varghese et al. (2002), European Study Group on Heterosexual Transmission of HIV (1992)
Percutaneous needle stick	30	Bell (1997)
Receptive penile-vaginal intercourse	10	Varghese et al. (2002), Leynaert, Downs and De Vincenzi (1998), European Study Group on Heterosexual Transmission of HIV (1992)
Insertive anal intercourse	6.5	Varghese et al. (2002), European Study Group on Heterosexual Transmission of HIV (1992)
Insertive penile-vaginal intercourse	5	European Study Group on Heterosexual Transmission of HIV (1992), Varghese et al. (2002)
Receptive oral intercourse	1	Varghese et al. (2002)**
Insertive oral intercourse	0.5	Varghese et al. (2002)**
***Estimates of risk for transmission from sexual exposures assume no condom use.** ****Source refers to oral intercourse performed on a man.**		

Source: Centers for Disease Control and Prevention. Recommendations and Reports. Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. MMWR, Atlanta, 2005.

In addition to the risk table, there is a series of studies on new biomedical prevention technologies within the field of AIDS. The word technology comes from Greek and means "conjugation of techniques with knowledge to satisfy people's needs" (Kalichman, 2009, [s.n.]). For human beings, these needs are constructed within the social framework and change according to the context. From this perspective, Kalichman advocated that development of new technologies aimed towards sexual prevention of AIDS among MSM should be envisaged, within a new scenario of the epidemic differing greatly from what existed in past decades.

In this regard, researchers within the field of AIDS have developed new technologies that can be grouped into two major types: "soft" and "hard". According to Brito (2009), both intervention models are important, but the second returns to the notion of individual risk. Soft

technologies relate to issues within administration and management of programmed actions and social participation; organization of work processes; human resources; development of educational and communicational techniques; reception; counseling; and comprehensive care. On the other hand, hard technologies encompass condoms, vaccines, microbicides, surgical strategies such as circumcision and drug strategies such as prophylaxis before and after sexual exposure in situations of risk.

The monthly editions of the anti-HIV/AIDS Vaccine Bulletin (VAX) give information about the main studies currently in progress, relating to anti-HIV immunobiological agents and the new biomedical prevention technologies (Prevenção..., 2006). These are experiments that supposedly may mitigate the possible risks of HIV infection and/or reinfection.

> It can be said, in passing, that the profusion and polysemy of this information, which is a compilation of evidence from present and past investigations that are validated today and discredited tomorrow, increase the responsibility for seeking information [...]. (Spink, 2007, p.256)

The point at issue is that until the start of the 2010s, in relation to these new preventive technologies, no study had proven their efficacy such that their safe use among the population could not be guaranteed.

In an interview with Mary Jane Spink (2010), Nikolas Rose reported that experiments in the fields of life sciences, biomedicine, neuroscience and biotechnology are very unstable. Nobody knows for sure whether these tests will be successful. Thus, enormous hopes are placed on research that may not confirm the data, as has been the case with gene therapy. The uncertain future and expectations precipitate the time to conclude studies, which fail as often as they succeed. The increasing development of biotechnologies can be explained by their power to offer people strategies to compensate in advance for their deficiencies and weakness, even future ones (Amorin; Szapiro, 2008).

Method

This study began in 2009. We resorted to the internet to gain access to men who choose to have sex always or occasionally without a condom. Studies conducted by Silva (2009; 2008) and Hine (2006) affirmed that the internet is a good resource for aiding researchers when dealing with polemical topics, such as sexual practices without condoms, given that it enables free participation by such individuals and, at the same time ensures their anonymity.

The first step was to create an e-mail address (projetoeva@hotmail.com.br) and do a search for relationship websites for MSM. For this, we used Google to identify the main websites dealing with the sexual practices of this group. We selected the websites www.manhunt.net and

www.bareback.rt because they were in line with the purposes of this study. On these pages, we used the descriptors bare, bareback and barebacking[1] to locate men who self-identified with sexual practices without using a condom.

Subsequently, we invited these men to take part in a discussion on the topic of barebacking. Over a six-month period, 20 men participated in weekly discussions by means of e-mail and/or MSN Messenger, through addresses created for this purpose. We made it clear to the participants in the discussion that this was a moment of informal investigation and did not constitute production of information for this study, given that the project was at the initial stage and still had to be forwarded to the Research Ethics Committee of the Pontifical Catholic University of São Paulo (PUC-SP), where the master's research was accomplished. Likewise, we guaranteed total confidentiality of the information and anonymity of the participants, who were all using false profiles on the internet.

After six months of discussion by means of MSN, the research moved forward to another stage: face-to-face interviews. For this, we resorted to the snowball technique. We invited all the people on the researcher's list and suggested that they could forward this invitation to their own contact lists, successively. This allowed us to amplify our network of interlocutors. This method has been debated and used by researchers working with delicate topics such as abortion, prostitution and sexual practices without a condom, among whom we can cite Browne (2005) and Faugier and Sargeant (1997).

As we went on receiving positive responses from possible participants in face-to-face interviews, we evaluated whether they would fit within the study objectives. For this, we defined the following inclusion criteria: a) affirmation that they had sexual intercourse with casual partners without using condoms; b) living in the cities of São Paulo or Rio de Janeiro; c) age over 18 years. These two cities were chosen because they present the largest numbers of AIDS cases in Brazil (Dias; Nobre, 2001).

At the start of the interview, each participant signed a free and informed consent statement that had been approved by the Research Ethics Committee of PUC-SP under registration number 332/2009, in accordance with Resolution number 1 of the National Health Board (CNS), which sets the standards for research involving human beings (Brasil, 1996).

The interviews were held between December 2009 and March 2010. Eighteen men were interviewed in order to ascertain their risk management strategies within the context of sexual practices without a condom. Out of the total number of interviews, eight were not used for the following reasons: a) they affirmed that they only had unprotected sexual intercourse with a fixed partner; b) they were in a distressed emotional state; c) they did not agree to sign the free and

[1] The practice of barebacking is generally understood as intentional anal intercourse between MSM without using a condom (Berg, 2009).

informed consent statement. Among the ten participants, seven showed through their words that they had some familiarity with scientific knowledge, which is the basis of this article.

Below, we present a chart characterizing the participants. This information will facilitate comprehension of the arguments discussed in the next section. Information that might identify them has been omitted, including their names, which are fictitious here, as chosen by each of them.

Chart 1. Characterization of the study participants

Fictitious name	Age	State of origin	Schooling level	HIV serological status
Gabriel	30	SP	Master's degree	Unknown
Aristóteles	35	RJ	Doctoral student	Positive
Agileu	22	SP	Undergraduate student	Unknown
Yuri	43	SP	MBA	Unknown
Cristian	36	SP	Specialization	Positive
Edu	35	SP	High school	Unknown
Daniel	57	RJ	Higher education	Positive

We chose to use interviews as our source of discursive material. Audio recordings were made and a field diary was kept. To analyze the material, a complete transcription of the interviewees' words was firstly made, using the convention of Jeffersonian Transcription Notation (Jefferson, 1984). Following this, sequential transcription was performed: a summary of the interviews according to the order of the dialogue between the researcher and the study participants.

From this, dialogue maps as proposed by Spink and Menegon (1999) were produced in order to identify the main topics present in the participants' narratives. These maps were important for systematizing the discursive material and enabling a search for repertoires relating to prevention strategies. Moreover, they had a double objective: to assist in the interpretation process and to facilitate communication in the steps connected with the interpretation process.

To present and discuss the results, we used passages from the narratives shown in the dialogue maps. In this article, we focus on the topic of appropriation and use of scientific information as potential sources for managing the risks relating to STDs, HIV and HIV reinfection.

Use of scientific arguments in constructing risk management strategies within a scenario of uncertainties

The way in which MSM manage the risks implied in choosing to have sex without condoms involves knowledge, technologies and meanings that are constructed from the concepts

of health, disease, life, death, risk, power and sexuality. Regarding the level of complexity of knowledge production within these individuals' daily lives, it has been observed that this is close to the scientific production on AIDS that circulates by means of the internet, printed material and academic studies (Camargo Jr., 1994). Information coming from knowledge sources, even if it does not correspond to the official discourse of the Brazilian Ministry of Health regarding prevention, for example, is increasingly incorporated and used by these individuals to manage the risks implied in this practice.

Thus, MSM reflectively appropriate data published by specialists in which the premise is better management of day-to-day life. Social relationships are regulated through this information, guided by the scientific nature of studies that enable choices in calculating risks, because the abstract systems are trusted. It can be seen from this that the Brazilian government's AIDS prevention strategies end up forming risk management actions, given that they aim both to protect the health of the population at risk through nonuse of condoms and to enable recovery among individuals who are infected with an STD or HIV (Czeresnia, 2004). This is a complex area permeated by tensions between individual and collective rights, between individual autonomy and the social order, between global and local contexts and between the public and private spheres (Castiel, 1996).

One recent example is provided by evidence-based medicine studies. This approach seeks to emphasize the scientific factors needed for the process of systematization and legitimization of information. Through this emphasis, it is sought to bring together observable proof relating to the subject under investigation, by means of techniques coming mainly from statistics, which can be interpreted and applied by doctors to their patients (Lopes, 2000). In this regard, the CDC in the United States conducted a meta-review on the existing literature, which resulted in the Risk Table. This provides a summary of the state of the art relating to estimating the risk of acquiring HIV according to the infection route (CDC, 2005).

The Risk Table can be found on the internet, hosted on American and Canadian websites. Cristian, one of the participants in this study, reported that in seeking to understand whether and how he could manage the possible risks resulting from his sexual practices without condoms, he decided not to ejaculate inside his partner. When he was asked where he got this information from, he referred to the Risk Table. He firstly set forth how to search for this information and then specified it:

"Through searches on the internet, except that these were searches outside of Brazil, either on American or on Canadian websites, investigating specific medical websites on HIV/AIDS. Hmm… I got the information from the Risk Table, you know? About types of intercourse and forms in which you have higher and lower risk, you know? So, practice without a condom is a risky practice, but you can reduce the risk if you don't ejaculate inside the partner."

Cristian seemed to suggest that news found outside of Brazil was supposedly more valid than news circulating inside Brazil, and that this made him feel more secure with regard to having unprotected intercourse. He was middle-class, had done a postgraduate course and had access to the internet, where he sought other possible sources of information that he considered to be trustworthy. He said that he was an engineer and worked in a field connected with the exact sciences. This profile may partly explain why he sought a way to manage the risks in his intimate life through his own scientific rationality, i.e. something close to his day-to-day life as an engineer.

The Risk Table has been used as a consultation parameter in risk management, particularly by the American government and some European governments. In Brazil, there is no evidence that it has been adopted in the official prevention discourse of the National Department for STDs, HIV/AIDS and Viral Hepatitis, of the Ministry of Health.

According to this table, the risk of HIV infection for active men is 6.5/10,000 cases. In the case of the partner who has the receptive role, this risk is 50/10,000 cases. From this perspective, in classifying his sexual practices as insertive, Cristian considered himself to be less exposed to HIV. At the same time, in choosing not to ejaculate into his partner's rectum, he managed his safety and that of his partner. In this regard, according to Brasil (2009) and Parker et al. (1998), certain strategies can be stimulated in order to diminish the risks of infection by the AIDS virus. Among these are masturbation and prioritizing oral sex.

Another argument used in risk management is in relation to the viral load of people living with HIV as an indicator of higher or lower risk of infection and/or reinfection by the AIDS virus. A Swiss study published at the end of 2008 caused polemic within scientific circles through stating that the possibility of HIV transmission was associated with the viral load (Vernazza et al., 2008). Thus, supposedly, the lower the viral load of people living with HIV is, the lower the chance of infecting a serologically negative partner would also be. This study was widely disseminated, particularly through the internet, and has circulated around the world via e-mail.

Consequently, this notion has become part of many people's day-to-day lives, and they now use this information to manage the possible hazards present when choosing not to use condoms. This was Cristian's argument in explaining his notion of risk management:

"So, well then, what there has been relatively recently is the Swiss study of 2008, and I fitted within the result that was given in the study. Well, I've been making use of the cocktail for a year and a half now, regularly, constantly and religiously. Hmm… after two months, we'll say? I now have an undetectable viral load and, over the last few months, my CD4[2] has even been going up. So, these data also add to the fact that I have zero chance or low risk of passing the virus to someone. Because the Swiss study says that a person who is positive but has had an undetectable viral load for more than six months and doesn't have any other type of disease, or an STD, does not present a risk of contaminating a negative partner."

[2] CD4 T-lymphocytes are cells that form part of the human immunological system.

At first sight, by complying with the antiretroviral treatment to the letter, Cristian was placed within the recommendation of the Swiss study. He used the expression "religiously" to emphasize that he was taking the medical recommendations seriously. According to the parameters for antiretroviral treatment, people living with the AIDS virus should make continuous and systematic use of the anti-HIV cocktail, since any alterations to the intake pattern could cause a gradual loss of efficacy of the drug arsenal. This is like a "religious ritual" (Cristian) that has to take place every day at the same time, systematically. In reflecting on his undetectable viral load, he considered that he had zero chance of infecting his partner. However, later on, he recognized that there could be a small risk, which would make the possibility of transmission of the virus contradictory from the point of view of the scientific literature on this subject.

This same issue appeared in the words of Agileu, although in an inverted form. He said that he was serologically HIV-negative, but that he had intercourse with people who he knew to be serologically positive, without ever having become infected. Consequently, he felt safe when he chose to have sex with people who were serologically HIV-positive, because his partners had sent him a study that presented a correlation between the viral load and the risks of infection. From his words, we were led to think that Agileu was referring to the Swiss study. When asked about this behavior, he said:

"[...] it's that there were three seropositive guys who I had intercourse with, even knowing that they were seropositive. And one of them sent me an article, from a doctor, stating that in seropositive guys who take the cocktail, the virus remains concentrated in the lymph[3], so that it's not so much in the blood. So, according to this article from a doctor, people who are treated with the cocktail don't transmit the virus, because the virus is under control and often undetectable. And this is based on an article, isn't it?"

Agileu ended his response and returned the question to the researcher in a sign of doubt about the information. In addition, the undetectable viral load of his HIV-positive partners led him to think that he was protected from the risks, given that the virus was concentrated in the lymph and undetectable in the blood, which is the main channel for circulation and infection.

It is interesting to note that as information comes out of production laboratories and circulates in people's day-to-day lives (in this case, through the internet), it acquires different meanings. Agileu's report, which assumed that HIV was concentrated in the lymph, with insignificant presence in the blood, indicates partial understanding of the scientific position on this

[3] Lymph is a whitish transparent liquid that may also have a yellowish or pinkish tone. It has characteristics similar to blood plasma and is responsible for transporting lymphocytes through the lymphatic vessels (Bergmann, 2000).

subject, given that the study he referred to does not state that the virus is located only in the lymph but, rather, that it is "hidden" in organs that have not yet been identified, as well as in the blood, which is the main source of HIV transmission (Vernazza et al., 2008).

What about STDs and the possibility of reinfection?

Studies that have based the likelihood of HIV transmission risk on the hypothesis of the viral load have brought to light the possibility that people might experience their sexual practices without a condom, through the possible reduction of the risk of infection by the virus caused by its load in the blood. Among the interviewees, the effect of this factor was that HIV ceased to be their greatest concern, and STDs became the main focus for care. Agileu reported:

"At a consultation with a doctor that I had at the time of a test to know whether I had HIV or not (I do this test periodically), she gave me some interesting information, telling me that there was a 0.5% chance that I could infect someone with HIV in intercourse without a condom, and that there was much more chance with other diseases like hepatitis and HPV. There are two types of hepatitis, and I don't remember the letters very well, and there's more than 30% or 25% chance of infection when you have intercourse without a condom. So, there's a lot of noise about HIV infection, but there are several other diseases that you can also get. Including me. It's interesting to report in an interview like this that I got syphilis recently."

Thus, he brought his experience of already having been infected with syphilis, but not with HIV, as a way of proving the statistical relationship that he thought existed.

There were also individuals who said that the AIDS virus was already incorporated into their daily lives, and therefore formed part of them. Since there is still no cure, there is nothing that can be done. In this manner, STDs become the great concern among these men. In Daniel's words:

"the risks that left me more affected were those of diseases that are more common, like syphilis or condyloma. It's not AIDS any more. AIDS doesn't frighten me any more: I've already got it."

Cristian added:

"what concerns me most is the other types of infections by other STDs that might occur."

However, according to Edu, STDs and HIV are at the same level and their risks are the same as for the unpredictable events of day-to-day life. In this regard, there was a generalization of this risk. He talked about his concerns at a high level of voice:

"due to HIV, syphilis, gonorrhea, hard chancre, soft chancre, HPV and a series of things other than just HIV."

A second question is in relation to the possibility of reinfection in men living with HIV. Attention was drawn to the fact that none of the participants believed in the possibility of reinfection, although all of them had declared that they were aware of the guidance given by their doctors that this event could occur and that, in this case, these individuals might acquire a virus that would be resistant to the drugs that exist. According to Aristóteles, reinfection only had meaning if he had intercourse with someone who was not following the antiretroviral treatment correctly. For this reason, he believed that this criterion did not apply to him, since he had followed the medical recommendations correctly and had sought to have intercourse with people in the same situation. He also argued that he had read about this subject and talked to healthcare professionals in this regard:

"The conclusion today is that the biggest risk when you have sex with someone without a condom is that this guy isn't undergoing treatment. When two people who are undergoing treatment have sex without a condom, the likelihood of risk is very small, provided that they are in a good state of health."

Aristóteles recognized that there was a small risk but that, precisely because it was very small, it was possible to have sexual intercourse without a condom. Along the same lines, Gabriel followed scientific rhetoric to be able to explain the reasons why he did not believe in reinfection. Thus, he started from the assumption that not even biomedicine had reached a consensus on this process, and he highlighted the contradictions between the different versions of this topic in this field:

"Firstly, there's a line of medicine that preaches that it's not like this. As I already mentioned and spoke about, there are lines within medicine that are controversial, like in any field of study and like in any field of knowledge. Going more deeply, you have lines that at certain times may even be contradictory. This also exists in medicine. I've had access to this information, both from a doctor and from my former partner, who is a pharmacist. And starting precisely from this argument or explanation that there are indeed different strains of HIV. This is a matter of consensus. Every individual, i.e. every seropositive person is infected by one strain specifically. From the time that I become reinfected, the medical discourse starts from the notion that the reinfection will change the virus that is inside the organism of the seropositive individual. First of all, this is not a plausible argument, because the virus will become modified naturally. This is a characteristic of HIV. Independent of whether I am infected and go into a state of abstinence, and don't use injection drugs, and don't have transfusions, and don't follow any other behavior that might put me in

contact with another strain of HIV, the virus that's inside me is always undergoing modifications, on its own, without needing any other strain. There's a possibility of creating a super-mega-ultra virus formed by other, different strains, thus creating a megamutant monster, which takes care of everything. I've read of two cases, via the internet, in specific journals, including within infectology."

It is worth noting that Gabriel went into specific characteristics of biomedicine in presenting his position in relation to reinfection. At the end of his reasoning, he raised his tone of voice and affirmed that he had knowledge of two possible cases of genetic mutation of HIV in the world. He then described the source of this information as specific journals in the field of infectology and the internet.

Some data in the study by Aza et al. (2010) indicated that four HIV subtypes existed within the MSM population in five regions of Brazil, namely: type B (80.3%); type C (10.5%); type F (4.9%); and other recombinant viruses (4.3%). Also according to these authors, the rate of resistance to the anti-HIV cocktail among MSM is high and, for this reason, they emphasized the importance of conducting new studies on this topic, with a larger sample from this population. This information challenges researchers to think of new AIDS prevention strategies.

New biomedical preventive technologies or technologies of uncertainty?

The strategies of new biomedical preventive technologies relate to large multicenter studies carried out around the world, which have generated estimates of the effects of reduction of the risks of HIV infection for a given population (Prevenção, 2006). These investigations have been disseminated through vaccine bulletins, journals, scientific articles, talks and reports published in the general media, which circulate on the internet.

One of these strategies relates to the recently-launched postexposure prophylaxis, which was not available at the time of the interviews and was then used only in two specific cases: situations of rape and in pregnant women living with HIV, with a view to avoiding virus transmission from mother to baby, i.e. so-called vertical transmission (Brasil, 2010). However, according to the recommendations for antiretroviral therapy among adults, the results relating to the possible efficacy of the method are controversial. The government's document says the following:

> In the absence of direct studies and definitive evidence relating to efficacy, effectiveness and safety of the recommendations for addressing sexual exposure to HIV, biological plausibility, experiments on animals and the theoretical model used in prophylaxis for use after occupational exposure will be taken into consideration. (Brasil, 2010, p. 52)

In this regard, it can be seen that postexposure prophylaxis is used in risk management relating to sexual practices among MSM. For example,

"I had sex without a condom. The guy asked me to cum inside him. Later on, I asked the doctor to include an HIV test among the periodic blood tests. I was frightened and my friend the doctor prescribed prophylactic use of antiretrovirals. [...] But this self-mutilation affected me and made me cause the guy to be ashamed. In reality, even one side of me was hoping that I'd vomit and have the adverse reactions that my friend the doctor could provide in order to generate trauma. You can't go home when the hormones return to normal and you think: 'Shit! Do it again! I could make myself unhappy with one of these by chance...' I never thought it would be worth it, but at that time…". (Yuri)[4]

He told how, after having had sex without a condom, he went to a doctor who was his friend, who in turn, noting his desperation, prescribed postexposure prophylaxis. However, Yuri thought that his own attitude could, in effect, be one of "self-mutilation", which in this case related to the side effects from using antiretrovirals, to "vomit and have the adverse reactions that my friend the doctor could provide in order to generate trauma" (Yuri). It was as if he needed to suffer because he had had unprotected sexual intercourse. In his words, we can perceive the feelings of guilt caused by having unprotected sex and the idea of atonement through suffering. It was as if, because of the pleasure, he could not make use of antiretrovirals without having severe side effects. Thus, sexual acts without a condom ended up occupying a place of suffering in his life, to the point of necessarily having to generate *"trauma"* (Yuri), and thereby avoiding repetition of this action.

Yuri was asked about his source of information for prophylactic use of antiretrovirals as a possible form of mitigating the risks of HIV infection, and he pointed towards a magazine that circulates in Brazil. In his words:

"I read it in Veja; it was a report on healthcare professionals who had had accidents. Some months later, a friend who is doctor confirmed this for me. He prescribed the package for me for 28 days, but was not sure about its efficacy."

Yuri reported that at the time that this interview took place, the recommendation for using post-exposure prophylaxis among MSM had not yet been published. For this reason, this method did not form part of the official Brazilian AIDS prevention program, except in cases of sexual abuse. In other words, he had had access to the method because of his closeness to a healthcare

[4] Yuri agreed to participate in the study but asked that his words should be noted down in a field diary. For this reason, it was not possible to transcribe the interview using the conventions of Jeffersonian Transcription Notation.

professional who, in accordance with the medical consensus, advised him that the efficacy of the technique was still under examination. Within this context, it was not possible to be sure that, if he had come into contact with HIV, he would not have become infected. This information is corroborated by Fischer et al. (2006), who highlighted the importance of establishing dialogue between the doctor who prescribes postexposure prophylaxis and the patient, thereby making it clear what the possible benefits, risks and side effects are. According to Benn (2001), the implications coming from the side effects of postexposure prophylaxis vary from person to person and may also include metabolic alterations, insulin resistance and intestinal and gastric problems.

In the same manner, we sought to understand other ways that the participants in this study used in managing the risks implicated in sexual activities. For this, we once again refer to the dialogue with Agileu, i.e. the participant who reported that the issue of an undetectable viral load was one of the factors determining his choice not to use a condom. He said that he was circumcised, and that this also contributed in some manner towards continuing to have sex without a condom, even in the light of information on the risks. He said:

"Because I am circumcised, and when you are circumcised, there isn't much of that anterior lubrication before you cum, so this diminishes the chance of infection".

In his view, circumcision supposedly produces less lubrication before ejaculation, which would reduce the risk of possible infection. In an article published in the anti-HIV/AIDS Vaccine Bulletin (VAX) (PREVENÇÃO..., 2006), the procedure is regarded as one of the new biomedical prevention technologies. In theory, this would be capable of reducing the chances of HIV infection by 60% among men who have sexual intercourse with women by means of vaginal coitus, but this does not apply to MSM. Furthermore, the supposed efficacy of circumcision is related to the fact that the foreskin that surrounds the glans penis is a region that facilitates entry of the virus and, when it is removed, this makes HIV infection via this route more difficult. In addition, because circumcision only benefits heterosexual men, it has not formed part of the Brazilian AIDS prevention program, at least over the short term (RELATÓRIO..., 2007). On the other hand, this notion is already circulating among MSM in Brazil, serving as an argument for risk management.

Final remarks

In this study, we have discussed the risk management strategies used by MSM in intercourse with casual partners without using a condom. We have perceived that people are increasingly developing their autonomy, appropriating scientific information and constructing distinct ways of managing the risks relating to STDs and HIV/AIDS. Thus, we have noted that these strategies mostly follow rational individual logic and do not reproduce the model used in the Brazilian government's prevention policies.

In the arguments used by the men who were interviewed, different aspects of the issues involved in the public policies are mixed: post-exposure prophylaxis; correlation between viral load and the possibility of infection; and others that, although they have a scientific basis, are not part of the reference framework of the government bodies involved, i.e. the Risk Table, the Swiss study and circumcision.

Given the imperative need for healthy lifestyles, people have developed various risk management strategies. For a variety of reasons, the dialogue in the present study was with a population of MSM predominantly from the middle class, who were well informed about AIDS and had access to condoms.

It was noted that these men had close contact with scientific production relating to AIDS, mainly through schools, non-governmental organizations, general media (TV, newspapers and the magazine *Veja*), doctors, internet, scientific journals, sexual partners, pharmacists and infectology journals. It is worth bearing in mind that the information coming from foreign sources was regarded as more trustworthy than the Brazilian information, or caused moral commotion. This was because the interviewees believed that the debates in other countries are franker and more open, while those that take place in Brazil preach caution in disseminating information that is still at the study phase.

It can also be argued that, in the light of the possibility that these studies may present alternatives for risk management, their possible effects do not apply to STDs. This leads to the perception that there is little discussion on the possibility that people become infected with other disease, in addition to HIV.

Another relevant question relates to the study participants' disbelief regarding the possibility of reinfection. None of them believed in this possibility because, supposedly, they had never heard of occurences of similar cases. This leads to the idea that people's belief in the information that they use to manage their risks is linked to its proximity to their day-to-day lives.

From the perspective that this study might contribute towards development of new STD and AIDS prevention strategies among the MSM population, we also stress that it is very important to discuss this subject within all the segments involved in the debate on public policies for combating AIDS. We also take the view that if everyone becomes aware of how to deal with this topic, it will be possible not to fall into the old association of homosexuals/risk group/AIDS/stigma that crystallized in some sectors of society.

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