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ORIGINAL ARTICLE

Negotiating HIV Protection in the Era of Online Dating and Pre-Exposure-Prophylaxis (PrEP): Insights into How Men Having Sex with Men (MSM) Living in Switzerland Negotiate their HIV Protection with Non-steady Partners

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Abstract

HIV protection depends on the consent and cooperation of sexual partners, which requires negotiation. Early HIV-related research identified condom negotiation strategies. However, strategies used specifically among men having sex with men (MSM) remained underexamined. This project explored how HIV-negative MSM negotiate their protection from HIV when having sex with non-steady partners, considering current risk reduction practices, the availability of several effective biomedical prevention options, the strong presence of STIs and prevailing online dating. We conducted in-person interviews with a maximum variation sample of 29 MSM, aged 21–80, combining narrative interviewing with a virtual-reality serious game and a series of standardized questions. We analyzed the interview data using content analysis, combining deductive and inductive approaches. We identified three categories of negotiation strategies used in chats, during in-person dates or when having sex: (i) *subject-centered strategies* anchored in the will and determination of MSM; (ii) *strategies centered on sexual arousal*, asserting MSM's preferred protection strategy; (iii) *strategies centered on risk communication*. Further, we identified actions that interrupt negotiations and directly enforce protection or bypass negotiations. Participants combined several strategies during negotiations. The strategies also demonstrated versatility: most were used for various aims and were not systematically related to a specific personal protection strategy. This study posits an elaborate range of HIV-protection negotiation strategies used by MSM, including strategies not previously described. It contributes to a more nuanced understanding of negotiation strategies and encourages prevention professionals to reflect on the attention given to negotiation strategies in prevention offers.

Keywords Negotiation · Condom negotiation · Men having sex with men (MSM) · PrEP · Online dating · HIV prevention

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Introduction

It was recognized early on in the AIDS pandemic that the implementation of condom use—as the only proven effective HIV protection at that time—needed the collaboration or acceptance of the sexual partner(s) and, thus, required them to negotiate (see, for example, Edgar & Fitzpatrick, 1988). In the 1980s, the term 'condom negotiation' was coined to refer to the process by which individuals decide whether to use a condom in the context of a sexual relationship (Peasant et al., 2015).

Condom Negotiation

In their 1988 essay, Edgar and Fitzpatrick drew attention to the importance of condom negotiation for the implementation of condom use during sex and emphasized the significance of negotiations especially during sex with non-steady partners who cannot rely on a shared history and routinized patterns of sexual interaction. Drawing on communication theory (Witteman & Fitzpatrick, 1986), they postulated three categories of 'message strategies' (Edgar & Fitzpatrick, 1988, p. 394) used to assert condom use: (a) messages stressing the outcomes or the consequences of compliance or non-compliance; (b) messages leveraging the relationship between the sexual partners; and (c) messages referring to obligations and values held by the partners.

In their trailblazing study, De Bro, Campbell, and Peplau, took a social psychological, power-theoretical approach (Raven, 1992, 2008) to reconstructing the strategies used by heterosexual students in the United States. Drawing on previous work by McCormic (1979) on strategies to negotiate sexual intercourse, they distinguished the strategies of 'reward', 'emotional coercion', 'risk information', 'deception', 'seduction', and 'withhold(ing) sex', noting 'seduction' as a nonverbal tactic (De Bro et al., 1994). On this basis and with reference to studies on influence tactics in couples (Howard et al., 1986) or strategic sexual communication (Edgar et al., 1992), Noar and his team confirmed in their empirical study six condom negotiation strategies used among heterosexual partners: 'risk information', 'seduction', 'deception', 'withholding sex', 'direct request', and 'relationship conceptualizing' (Noar et al., 2002). Focusing on MSM, Elwood and his team called attention to the importance of non-verbal strategies among partners who had sex in local venues where silence is the norm (Elwood et al., 2003).

More recent work considered that negotiation strategies can have other goals than condom use, that it is not only partners who intend to use condoms who negotiate, but also those who intend to avoid using them. These studies extended the set of categories established so far by integrating strategies used to avoid condom use. These include 'risk information', 'seduction', 'direct request', 'relationship conceptualizing', 'deception', 'emotional coercion', and 'withholding sex'. Furthermore, the physical threat of violence or force, reference to a change in feelings due to the condom ('sensitivity') or even condom sabotage were observed (Peasant et al., 2015). In the same paper, Peasant et al. also suggested a systematization of the then described condom negotiation strategies along the three dimensions 'direction' (condom use promoting vs rejecting), 'directness' (direct vs indirect), and 'verbalism' (verbal vs nonverbal) (Peasant et al., 2015).

A Thin Thread with Gaps

Over the years, the research on condom negotiation has been taken further by several studies that concentrated on or at least touched on condom negotiations among various populations, including young heterosexual men and women in the USA or Australia (Bowleg et al., 2010; De Visser, 2004; Holland & and French, 2012; Horan & Cafferty, 2017; Tilley & Key, 2017; Tschann et al., 2010) as well as on women in Africa (Arthur-Holmes et al., 2023; Hunter & Tilley, 2015; Tenkorang, 2012) and female sex workers (Tan & Melendez-Torres, 2016). There were also studies investigating factors influencing condom negotiations, such as relationship motivation (Skakoon-Sparling & Cramer, 2020). However, strategies used by MSM and their experiences with condom negotiations seem to have been analyzed in less detail and less intensively (Peasant et al., 2015, p. 480).

Among the available studies, there are several on negotiations of MSM living with HIV (see, for example, Semple et al., 2000). Hoff and Manchikanti (2005) for example, investigated sexual communication between HIV-positive MSM and their non-steady partners and the condom negotiations involved. In addition to the verbal strategies, they identified further non-verbal strategies. These included direct actions of the participants (for example, handing over a condom to the non-steady partner) or indirect communication via cues (for example, placing condoms and lubricants where the non-steady partners are likely to see them). In their study on young MSM in the USA who meet their sexual partners on dating apps, Eisenberg et al. (2011) showed that some men directly encouraged condom use, while others broached condom use by asking questions. McInnes et al. (2011) took up the topic of condom negotiations in venues where silence is the norm. With their meticulous analysis, they draw attention to subtle—and as they also say-complicated forms of interaction to coordinate the use of condoms with (also multiple) non-steady partners. Importantly, with their case study they demonstrated that the partner involved experienced their wordless interaction as a negotiation.

Although we have traced a thread of studies exploring negotiation *strategies* thus far, it cannot be overlooked that the thread is thin and shows gaps. Despite MSM continuing to be disproportionately affected by HIV (see, for example, Beyrer et al., 2012; UNAIDS, 2023), also in Switzerland (Bundesamt für Gesundheit, 2024b), in-depth studies on condom negotiation *strategies* used among MSM appear to be a research desideratum that has remained insufficiently fulfilled to this day (Horan & Cafferty, 2017; Noar et al., 2002; Peasant et al., 2015). An empirically saturated categorization of negotiation *strategies*, as initiated in the early studies focusing on heterosexual women and men, does not appear to have been accomplished comprehensively regarding MSM. In particular, studies on the negotiation strategies used by HIV-negative MSM when having sex with non-steady partner have remained sparse (Peasant et al., 2015). This represents a gap, as negotiations are relevant to protective behavior.

Condom Negotiation as a Predictor of Condom Use

Empirical studies—the above-mentioned studies included—prove that condom negotiation is positively associated with condom use (see, for example, Holland & and French, 2012; Noar et al., 2006) and recently published analyses also refer to condom negotiations as an important factor for HIV protection (Plascencia-De la Torre et al., 2024). Condom negotiation, also termed 'safer sex negotiation' was thus integrated as a predictor of condom use into theoretical models developed specifically to explain HIV protection behavior[1]. The AIDS Risk Reduction Model (ARRM), for example, posits condom negotiation among the variables relevant in the 'implementation' stage of condom use (Catania et al., 1990). The Information-Motivation-Behavioral Skills (IMB) model considers sexual communication as one of the behavioral skills required for condom use (Fisher et al., 1996; Fisher & Fisher, 1993). However, closer examination shows that the variable is operationalized as a skill and thus the subjective assessment of negotiation self-efficacy was included in the model. This does not provide any insight into how the interactions around condom use unfold and *which strategies* are used. Although negotiations were recognized as important and have since often also been considered in studies on protective behavior among MSM (see, for example, Molitor et al., 1999; Prestage et al., 2001), the negotiation *strategies* or messages themselves are not evident.

Negotiation of HIV Protection among MSM in an Increasingly Complex Context

When turning specifically to negotiation strategies of MSM with non-steady partners, however, we have to consider that the context in which the negotiation of protection against HIV are taking place has undergone profound changes.

As in most regions of the world (UNAIDS, 2024a), the incidence of HIV in Switzerland has been decreasing significantly since the early 1990s. However, the epidemic has not come to a halt either in Switzerland or worldwide. In 2023, 4 in100,000 of the Swiss resident population were newly diagnosed with HIV. This corresponded to 352 cases. With around one new infection per week, the incidence is at a low level, but HIV is present and protection against infection remains important. MSM continue to be disproportionately affected (Bundesamt für Gesundheit, 2024b).

MSM have developed several risk reduction strategies (Grace et al., 2014), such as 'dipping', 'strategic positioning', 'serosorting', 'treatment sorting' or 'viral load sorting' or 'biomed-matching'. [2] What these multi-faceted risk reduction strategies have in common is that they were designed to prevent HIV infection while allowing the enjoyment of sex without a condom (Den Daas et al., 2020). They also have in common that they are based on the partner's willingness to provide information or accept the respective sexual practices and, thus, request negotiation (see, for example, Kava-

[1] Typically, social cognitive models that had been adopted from other fields and applied to HIV protective behaviour (Farin et al., 1996) such as the Theory of Planned Behavior (Ajzen, 1985; Albarracin et al., 2001), the Health Belief Model (Rosenstock, 1974) or the Protection Motivation Theory (Prentice-Dunn & Rogers, 1986) did not include condom negotiation (skills).

[2] For a description of these risk reduction strategies, see, Grace et al. (2014), Jin et al. (2007), Suarez and Miller (2001), Van de Ven (2002), Gredig et al. (2014), and Kuhn et al. (2016).

nagh, 2016). Negotiating the use of a risk reduction strategy is likely to amount to negotiating condomless sex.

For more than a decade, MSM have been offered Pre-Exposure Prophylaxis (PrEP) as a complementary effective means of HIV prevention (Grant et al., 2010; Liu et al., 2016; McCormack et al., 2015; Molina et al., 2015). Some MSM perceive PrEP as a reason to reduce condom use (Freeborn & Portillo, 2018) or practice PrEP as an explicit alternative to condom use (Gredig et al., 2016). What remains unknown is how MSM negotiate their preferred approach to protect themselves, given the availability of two effective means of protection opening an avenue to potentially mutually exclusive practices.

The move to use 'treatment as prevention' (Montaner et al., 2006) and the confirmation that people living with HIV who were undergoing effective treatment could not transmit the virus (Cohen et al., 2011; Rodger et al., 2016) (expressed and disseminated by the formula 'undetectable = untransmissible')—including among MSM (Bavinton et al., 2018; Rodger et al., 2019) –, brought new options, new challenges for communication (Newcomb et al., 2016) as well as ambiguities (Padilla et al., 2023) around HIV protection and further changed the landscape for negotiations.

'Condom etiquette' (De Bro et al., 1994, p. 166)—the established social norm (Elwood et al., 2003) that MSM should use condoms during anal intercourse-is no longer taken for granted and subject to discussion. In the current context, condomless sex is not necessarily equal to sex without protection from HIV.

Another challenge is the strong presence of other sexually transmitted infections among MSM (Omar et al., 2024; Tsuboi et al., 2021). Also in Switzerland, by 2023, the number of infections with chlamydia had continued to increase since 2000 (to 144.3 per 100,000 resident population) overall as had infections with gonorrhea (to 68.9 per 100,000 resident population), with MSM accounting for more than half of these cases (Bundesamt für Gesundheit, 2024a). After the Covid-19 pandemic, the number of reported syphilis infections increased again (to 12.7 per 100,000 resident population) and were mainly diagnosed among MSM (Bundesamt für Gesundheit, 2024c).

Finally, in clear contrast to the setting of early studies on condom negotiation, online dating has increased massively (Weber et al., 2019) and sets HIV and STI protection negotiations in a different framework.

Considering the current—considerably changed—context, the transferability of earlier findings to current condom negotiations seems us to be questionable. In particular, the earlier findings refer to negotiations in a different context and their transferability to today's situation has become questionable. In the era of risk reduction strategies, PrEP, and the popularized acknowledgement that people with suppressed viral load were not able to transmit HIV ('u = u'), negotiations over protection against HIV and other sexually transmitted diseases, we can no longer concentrate on 'condom negotiation'. Rather, we must expect far more open negotiations about what should or should not be done to protect against HIV and other sexually transmitted diseases.

However, it is still pertinent that negotiations in the context of sexual encounters with non-steady partners are of special interest and importance. This point was made by Edgar and Fitzpatrick (1988) at the onset of this research thread on protection

negations. However, compared to the initial consideration of 'condom negotiations', the locations, occasions and—depending on the personal protection strategy (Gredig et al., 2014) adopted by the MSM—the aims of the negotiations have changed dramatically.

In view of this, an in-depth study of negotiation strategies used among MSM to assert their preferred HIV and STI protection strategy seems to be a timely research desideratum (see, for example, Horan & Cafferty, 2017).

Aims of this Study

Against this background, this study aimed to identify strategies used by MSM in the negotiation of whether and how to prevent an infection with HIV and STI before and during sex with non-steady partners in the context of the 'u=u' paradigm, the practice of risk reduction strategies, increasing PrEP use among MSM, the increasing risk of STI, and online dating. Adopting the social psychological, power-theoretical perspective (Raven, 1992, 2008), we understand 'negotiation' as a deliberate and targeted social influence in which one of the partner's action leads or is intended to lead to determining another partner's behavior. 'Negotiation of HIV protection' refers to the process before or during a sexual encounter in which (potential) sexual partners decide what should or should not be done to prevent an HIV infection. It is conceived as a communication and interaction process in which one of the partners involved in the act tries to convince the other(s) to use the same protection strategy as he himself has adopted and tries to obtain consent or a binding commitment to act according to his protection strategy when having sex. In rough terms of outcome, a partner can assert himself and convince the other; the partners can compromise; a partner can agree or give in and comply with their partner's wishes.

The main aim of the study was to gain an insight into these courses of action and to establish the actors' perspectives, including their view on whether something should be done to prevent an infection with HIV or another STI and if so, what. The aim was not, however, to evaluate the effectiveness of these strategies in terms of objective risks of infection.

Our focus was on HIV-negative MSM who lived in the German-speaking part of Switzerland and, therefore, acted under similar societal, political, legal, and cultural conditions, including public health action and prevention offers.

In this paper we will explore the strategies used by MSM to negotiate whether and how to protect themselves from an infection with HIV when having sex with non-steady partners. However, the aim of this study is not to discuss the effectiveness of the strategies shown in terms of risk minimization or risk increase.

Methodology

Design

We aimed to obtain in-depth insight into the complexity and diversity of courses of negotiation in their respective contexts in order to be able to explore, describe and

categorize the variety of strategies used by MSM when negotiating HIV protection with non-steady partners whom they contacted either online or on site. As it was not an option to observe these negotiations live and on site, the aim was to capture the lived experience of MSM from their perspective. For this purpose, it was key to generate data that permitted us to capture participants' lived experiences and, from there, to reconstruct situated courses of action, the resulting history of negotiations and participants' ex post evaluations (Rosenthal & Loch, 2002). Therefore, we took an inductive approach (Flick, 2010) and developed a qualitative exploratory study design.

Methods and Procedures

We conducted 29 personal semi-structured interviews for data collection and performed qualitative content analysis on both, to confirm known negotiation strategies and identify strategies that have not yet been described in the literature. We categorized the observed strategies and organized them into a system.

Sampling and Recruitment

We decided on a purposive sampling strategy and aimed for a maximum variation sample (Patton, 2002) as this sampling strategy systematically increases the probability of including a diverse range of MSM living in the German-speaking part of Switzerland and, thus, of capturing the variety of possible strategies and their contextualization.

Eligible participants were adult MSM (i.e. 18-year-old or older) who self-reported as HIV-negative and were able to give an interview in German. We sought variation in terms of sexual orientation; age; dating context (online vs onsite); civil status and partnership status; geographical area and size of municipality they were living in; and nationality and migration background.

For the recruitment, we contacted MSM on the two most frequently-used dating platforms in Switzerland (Romeo and Grindr) (Weber et al., 2019) via outreach and advertising. We put out flyers in specialized sexual health clinics for MSM and in AIDS service organizations. This communication was directed to MSM who were willing to participate in the project website and provided them with written information about the study and the procedures involved. In the first phase, we started by including consecutively the first five MSMs who agreed to participate. Their interviews were to serve the purpose of the project but also for the development of a Virtual-Reality Serious Game (VR-SG; see below).

In the second phase, when the VR-SG was available and integrated into the interview, we placed flyers in gay saunas in major cities in addition to advertising on the dating platforms, bars, sexual health clinics and AIDS service organizations. This assured the participation of MSM who (also) connected with men on-site in gay venues and had sex on the premises. This took place when these establishments reopened following the end of public health measures to contain the Covid-19 pandemic in 2022. We pooled the potential participants and selected the interviewees according to our sampling strategy.

We aimed to achieve saturation in terms of both data saturation (new participants repeated negotiation strategies that were expressed in previous data) and inductive thematic saturation (the strategies were clear and no new concepts emerged) (Saunders et al., 2018). After 25 interviews, we were confident of having approached saturation.[3] However, in the third phase, we conducted four additional interviews with participants we recruited explicitly in order to include MSM who had a migration background (Swiss citizen vs non-citizen) or practiced 'chemsex' (substance use during sex for the improvement of sexual pleasure or to extend intercourse vs no substance use during sex; the substances considered were crystal meth amphetamine [crystal, meth, Tina], GHB/ GBL [liquid ecstasy], ketamine, mephedrone as well as ecstasy [E, XTC, MDMA] and cocaine) (Malandain & Thibaut, 2023; Stuart, 2019) as we aimed to ensure that we did not miss out MSM negotiating their HIV protection in those contexts and under those circumstances. We wanted to make certain that no new negotiation strategies emerged.[4]

Data Collection

Oriented to problem-centered interviewing (Witzel, 2000; Witzel & Reiter, 2021) we designed a flexible interview guide combining different interview styles based on the literature and leveraging previous field expertise. First, we initiated the interviews with an open question about the participants' relationships with men in order to reduce inhibitions and build rapport. We then continued with further narrative-opening questions on the participants' experiences of negotiating their protection and explored in more depth the topics they brought up, using the semi-structured guide. Second, we asked participants to play the Virtual-Reality Serious-Game (VR-SG) we had developed and produced especially for this purpose (for description, see, Gredig et al., 2023). The aim of the game was to immerse participants in situations similar to those they might have encountered in real life in order to stimulate further accounts of partner interactions and, thus, to enrich the interview data with additional narratives. During the interviews, it became apparent that the VR game did indeed prompt the participants to elaborate their experiences more extensively. The virtual interaction had the potential to remind participants of situations they had not mentioned before the game, to bring up topics they had not addressed before and to complement their narratives in the first part of the interview. Third, after the gaming session we asked participants to reflect on their interactions in the game and relate convergent or divergent experiences from real life. Fourth, we ended the interview with a set of brief structured questions to capture sociodemographic characteristics.

In May and June 2020 (first wave) and between May 2021 and June 2022 (second wave), we conducted the interviews face-to-face at times and locations convenient for the participants. This could be at their homes, in rented meeting rooms, or at the

[3] We are aware that the idea of 'saturation' is associated with the uncertainty of predicting 'the unobserved (what would have happened if the process of data collection and/or analysis had proceeded) based on the observed (the data collection and/or analysis that has taken place hitherto)' (Saunders et al., 2018, p. 1903).

[4] Our primary criterion for determining the number of interviews needed was saturation. A look at the literature shows that a data set with 29 interviews is in line with the specific sample size suggestions (Dworkin, 2012; Hennink & Kaiser, 2022; Onwuegbuzie & Leech, 2007).

university. The interviews lasted between 40 and 90 min. During the interviews, we adhered to the restrictions in place at the time of the Federal Office of Public Health regarding the Covid-19 pandemic.

Our team consisted of one female and three male researchers, all of whom conducted interviews. The principal investigator and the research fellow were trained social workers holding a PhD in social work. One research assistant was a trained social worker and doctoral student while the other was a graduate in psychology. The members of the team were familiar with the lifeworld of MSM as they were themselves from a sexual minority group or were close to others who were. They had accumulated many years of former HIV-related research with and for MSM and sex workers. One team member had several years of experience in professional social work practice with sexual minorities. All participants met their respective interviewers for the first time in their lives. As the interviews were also conducted in locations the interviewers had not known before, the team developed, fixed and agreed upon some principles that served as a guide for the interviewers regarding their (feeling of) safety in the interview situations.

Based on the participants' informed consent, the interviews were audio-recorded. The research team transcribed the records manually using the software F4. The transcription was verbatim according to simple guidelines (drawing on Archiv für Zeitgeschichte ETH, 2020). The interview data was pseudonymized (by assigning participants first names in alphabetical order that had no connection to their actual names or other characteristics) and anonymized (by replacing all references to people, establishments or places with neutral functional equivalents, such as "bar x").

Data Analysis

We analyzed the transcripts by performing a content analysis according to Kuckartz (2018). This analytical strategy permits the intertwining of a deductive and an inductive approach to the material: it allowed us explicitly to adopt categories known from previous research and, at the same time, identify courses of negotiation emerging from the data and define new categories inductively. For this, we implemented open coding to break up the data (Strauss & Corbin, 1996), an option offered by Kuckartz (2018, p. 79ff), and used Atlas.ti 9 software to support this process. In a further step, we arranged the categories into groups to form a system of categories. The data from the first ten interviews were coded by the four researchers together. The coding of the subsequent interview data was conducted in teams of two researchers with changing composition. New emerging codes were discussed and defined by the four researchers in the weekly team meetings. This ensured continuous intersubjective coordination of the use and further development of the codes. New emerging strategies as well as the categorization were continuously discussed and defined in the whole team.

Ethics

MSM who were willing to participate were given written online information about the study and the procedures to be followed before an interview were agreed upon. Before the interview, we informed potential participants in writing as well as verbally

about the interview procedure including the VR-SG and obtained a signed informed consent statement regarding the interview and open access to their data. The use of VR in the interview was accompanied by specific considerations as the participants in the VR serious game were expected to experience immersion, which may lead to adverse effects such as motion sickness (see, for example, Stanney et al., 2003), information overload, and possible difficulties re-entering the real world (Behr et al., 2005; Slater et al., 2020). We therefore prevented these potential negative after-effects as far as possible during the VR-SG production. In the video production, we made sure to avoid unexpected movement maneuvers as well as unforeseen events such as visual frights. We also *took care* to prevent the evocation of 'negative' emotions such as fear, disgust or anger. Further, the game provided participants with the option to exit at any time. (For a more detailed discussion, see Gredig et al. (2023). The relevant ethics commission scrutinized our project and declared that, according to Swiss law, this study did not require further formal ethical approval.[5]

Results

Sample

Our sample comprised 29 MSM living in different areas of the German-speaking part of Switzerland with self-reported HIV negative serostatus. In accordance with our sampling strategy, we were able to achieve a highly diverse sample regarding age (ranging from 21 to 80 years with a median age of 37 years), self-declared sexual orientation (gay [18 participants], homosexual [$n=5$], bisexual [$n=4$], pansexual [$n=2$]); dating context (online [24 participants] and private vs on-site in saunas [19 participants]); partnership status (single [$n=19$], in a steady relationship [$n=4$], open relationship [$n=6$]) and civil status (unmarried [$n=23$], in a registered partnership [$n=2$], married to a woman[$n=1$], divorced [$n=1$], widowed [$n=1$]); geographical area and size of municipality they were living (rural/remote area [$n=11$], small urban center [$n=2$], sub-urban area [$n=5$], urban center [$n=11$]); nationality (Swiss [$n=26$], European [$n=3$]) and migration background (Europe [$n=4$], USA [$n=1$]) including a person of color. Furthermore, we also achieved a great variation in terms of socio-demographic characteristics such as education (apprenticeship -ISCED 3- [13], higher technical school -ISCED 6- [$n=5$] and university degrees -ISCED 6,7- [$n=11$], employment (full-time [$n=18$], part-time [$n=8$], retired [$n=1$], studying/in training [$n=2$]), occupational field, and income (ranging from 'less than 26,000 CHF' to '104,001 and more per year' with the median in the category ranging from 78,001 to 104,000 per year). Finally, we were also able to include MSM with experience of 'chemsex' ($n=6$) and without ($n=23$).

[5] Statement of the Ethikkommission Nordwest- und Zentralschweiz on August 15, 2019, regarding the formal request BASEC nr Req-2019-00648.

The Personal Protection Strategies Adopted by the MSM in the Sample

Among the 29 participants, 17 men reported using condoms to protect themselves from HIV and STIs and one reported using condoms during a first encounter with a new partner. Consistently, these men reported the intention to negotiate in order to have a condom used with their non-steady partners. This applied also to the participant who reported using PrEP in combination with condoms to protect him. Nine men reported that they used PrEP without a condom: of these, five men reported that they intended to negotiate sex without condoms with non-steady partners, while 4 said they were open to condom use. Fifteen participants combined their strategy with regular testing, among them was one who had experience of testing together with his non-steady partner.

Negotiation Strategies

Our participants' accounts provided evidence that they negotiated their protection from both HIV and other sexually transmitted infections (STI) when they contacted a potential non-steady sex partner or were addressed by a man interested in having sex with them for the first time. Depending on the personal protection strategy they themselves and their potential partners had adopted, the negotiation of protection from HIV, from other STIs or a combination of both moved to the forefront. Although they did not appear completely separate in the reported interactions, it was possible to distinguish the negotiation strategies analytically according to whether they were used to negotiate protection from HIV or from other STIs, although they occurred—in different sequences—in one conversation.

From the participants' accounts, we identified 17 strategies which these MSM or their non-steady partners used to negotiate their protection from an HIV infection.

We were able to cluster these single strategies and assign them to three categories which we defined as (1) subject-centered strategies; (2) strategies leveraging sexual arousal; (3) strategies centered on risk communication. Table 1 provides an overview of these. The strategies displayed in white boxes had been identified in previous studies and were confirmed by our data. The categories in light grey boxes emerged in our analysis and were added to the range of negotiation strategies known from previous research on condom negotiation.

Strategies used to negotiate HIV protection

We present and define the broader categories as well as the individual negotiation strategies and illustrate them with quotes from the interview data.[6]

[6] From a methodological perspective, is it important to recall that the participants shared their experiences through narratives. Thus, we interpreted narratives on situations, actors, courses of action and actors' conversations as they were enacted in these narratives which were produced in the interview situation looking back to the past. (The actors and conversations we work with are neither observed nor are registered actions and conversations.) Thus, in a strict sense, when the participants reported on their action and the conversations they had had in the past, they necessarily constructed a 'narrated self'. Their partners were 'narrated partners' and the conversations we interpreted were 'narrated conversations' (Lucius-Hoene &

Table 1 Overview of strategies used to negotiate the protection from HIV among the MSM in our sample

Category of negotiation strategies	Negotiation strategy
Subject-centred strategies	Asking explicit questions
	Being authoritative
	Asking questions to understand
	Presenting arguments
	Using visual cues to demonstrate intention
	Interpreting normative cues
	Acceptance of conditions / actions of the partner
	Tacit agreement / non-verbal consent
Strategies leveraging sexual arousal	Seduction
	Reference to loss of / gain in pleasure through condom use
Strategies centred on risk communication	Calming the partner
	Providing risk information
	Deceiving
	Dramatizing life-threatening consequences
	Seeking information

Strategies displayed in white boxes had been identified in previous studies and were confirmed by our data; Strategies in light grey boxes emerged in our analysis and ad to the range of knownstrategies

Subject-Centered Strategies

The negotiation strategies grouped in this category have in common that they are anchored in the intention and determination of the men who deploy them. However diverse these strategies may be in their appearance; they seem to be based solely on the will and decision of their users. They express and are geared to asserting the men's decision—sometimes made long in advance, sometimes ad hoc—without resorting to other elements, such as giving reasons, asking for comprehension, or mobilizing moral justification. They are centered on the person's will and conviction (i.e., are subject-centered) and proceed openly and directly or indirectly and covertly.

This category comprises eight strategies: asking explicit questions, being authoritative, asking questions to understand, presenting arguments, using visual cues to demonstrate intention, interpreting normative cues, acceptance of conditions/action of the partner, and tacit agreement/non-verbal consent.

In this order, strategies are first mentioned that serve in a direct, verbal or non-verbal way to persuade the potential partner to adopt the strategy preferred and intended by the respondents themselves. This is followed by negotiating strategies which participants use to communicate to a partner that they are moving towards meeting their partner's intention and, for example, following his wishes or demands. Finally, there are strategies acting out the person's will.

Deppermann, 2004). In our report, however, we present the participants without permanently commenting that these were 'narrated' characters and present them simply as 'participants', 'MSM' or introduce them with their pseudonym in order to maintain readability. We also present the strategies we identified without commenting that these were 'narrated strategies'.

Asking Explicit Questions Participants ask about their partner's preferred protection strategy in order to be able to respond to their partner's wishes. Manuel[7] told us (109): *'I do it like this: I always tell people: "I have PrEP*, *would you prefer us to fuck without a rubber or with a rubber?"'*

This strategy was used both by participants who wanted to use a condom and by those who wanted to have condomless sex.

Being Authoritative Participants use their authority, claim to know more, or insist on the protection strategy they have adopted. Boris, for instance, reported (37): *'That's just not on*, *sorry*, *I'm not discussing it.'* Pio, who insists on the use of condoms, told us (277): *'And*, *um*, *then I'm a bit*, *let's say*, *I insist*, *I say: "Shut up*, *either with one or not at all*," *then it's plain and simple.'*

In contrast to participants who insisted on condom use, like Boris or Pio, other participants used this strategy, for example, to strictly reject condom use, for example, because they were using PrEP.

Asking Questions to Understand Participants ask questions to understand the protection strategy their partner has adopted—whichever it may be—as, for example, Manuel, who reported (251): *'So then I ask: "Where did you get that idea?" Or: "What are you uneasy about?"'*.

Presenting Arguments Some respondents present arguments with the aim of convincing and bringing about change in the partner, as seen with Zoran who takes PrEP and does not want to use condoms (159): *'When I'm the initiator and I don't know someone*, *I always ask: "Is this okay?" and there are men who know they don't want something. Perhaps also because it can be a bit uncomfortable or when someone said: "You know*, *this is the only thing I still fear a bit." Then I said*, *"Okay*, *then it's clear*," *and then I have myself under control.'*

Using Visual Cues to Demonstrate Intentions We identified a strategy based on indirect / non-verbal communication such as using visual cues to demonstrate intentions, negotiate condom use or communicate that condom use is not negotiable. Igor (142) reported: '*But condoms are always there—ready to use. Because that way I'm sending a signal.*' Typically, this strategy was only used by participants who wanted to assert condom use as HIV protection or accompanying PrEP use.

Interpreting Normative Cues Participants interpret visual cues as an indication of the intended method of protection as understood by the community. Respondents assume that the meaning of these cues is shared and understood in the same way in

[7] All proper names are pseudonyms. The numbers in brackets refer to the section in the transcript.

the community. These cues are predominantly sought in chats to pre-screen potential partners. This is what Jan told us, referring to online profiles (261): '*So where it says PrEP, I assume they fuck without a rubber.'*

Accepting conditions/Action of the Partner Some participants explicitly accept their partner's preferred protection strategy. For example, Manuel said (109): *'And when the other person says: "I only want to with a rubber," then I agree to his wish.'*

In our sample, the acceptance of the partner's conditions was underpinned by different motivations: Some participants were willing to comply with their partner's wish to use condoms so that their partner could feel safe during sex. Other participants compromised and accepted their partner's conditions or wishes if, for example, these partners seemed very attractive to them or were considered a 'fuckbuddy'.

Tacit Agreement/Non-verbal Consent This strategy consists of giving non-verbal consent to the action initiated by the partner. As illustrated in Fabian's quote (66): *'There have been situations where, where it, now I'd say, stupid- nearly happened. And, and that you noticed that the other person isn't saying no either, he's not resisting and then you just penetrate him.'*

In our sample, we found examples of consent to condomless sex, as illustrated here, but also examples of consent to condom use contrary to the original intention.

Strategies Leveraging Sexual Arousal

These negotiation strategies have in common that they take advantage of their partner's sexual desire, stimulate further excitement or promise increased pleasure in order to assert the implementation of their own personal protection strategy.

This category consists of two negotiation strategies: seduction and reference to loss of/gain in pleasure through condom use.

Seduction Participants excite their partner to distract him and obtain his consent. Excitation can be instigated verbally, with a tendency to be implemented but tends to be implemented non-verbally and physically. This was illustrated by Willi, who was the target of seduction (127): *'Then the kissing started, just slowly. Is just a bit of petting and then at some point, yes, then he slipped and found, now he wants me inside him and then began to slowly slide on top of me and that was one of those moments where first of all I just thought: "Oh, actually we should get condoms now," and at the same time somehow in the moment, you're so in it, I had the feeling: "Yes, when we- then we'd have to break off."'*.

In our sample, there were participants who allowed themselves to be seduced into condomless sex, even though they would otherwise want to protect themselves by using a condom. Other participants use this strategy intentionally to enforce their personal protection strategy—be it condom use or condom avoidance.

Reference to Loss of/Gain in Pleasure Through Condom Use MSM claim that sexual sensitivity is limited, or inversely, increased by condoms. Holger intends to use a condom and serves as an example for making the promise of increased pleasure when using a condom in order to convince his partner (130): '*And then you can sometimes manipulate these tops a bit*, *I can make them horny by explaining to them that when they have their dick in your throat*, *that they can then really come in your throat and so on. You can achieve that in a conversation.'*

According to our participants, this strategy is also used in reverse—namely to convince the partner to have condomless sex.

Strategies Centered on Risk Communication

The strategies in this category have in common that they focus on communication regarding the potential risks of HIV infection and ways to prevent. They revolve around requesting the information needed to weigh the risk they run or giving information to remind, demonstrate or downplay risks in the perception of the partner, to influence the partner's emotions and decisions in order to assert their own preferred protection strategy.

This category consists of a cluster of five strategies: calming the partner, providing risk information, deceiving, dramatizing life-threatening consequences and seeking information.

Calming the Partner Participants try to impact their partner's emotions, to calm him down and to assure him that even without using a condom there is no risk of HIV infection. They target the partner on an emotional level to influence their thought processes. As Otis told us *(93*): *'And then I just wanted to reach for a condom and he said something like: "No*, *leave it off*, *I think it's hornier if someone comes inside me*,*" and then I said: "(...) only with a condom*, *or else I won't fuck you." Well*, *then he begged me again: "No*, *come on*, *just once*, *nothing will happen*, *I'm negative."'*.

This strategy was used solely by participants who were on PrEP and aimed to have condomless sex.

Providing Risk Information Participants try to convince their non-steady partner of the protection strategy they have adopted themselves by providing information considered hard facts.

Elias reported (58): *'Once I had someone I knew. Who said to me very clearly "with a condom". And then during the act he wanted it without one*, *and then I said: "But you're*, *you said the last time you were tested was*, *er*, *four or five months ago." Then he said: "Yes*, *but I don't have many [partners]." And it was clear to me with a condom. Or else it wouldn't happen.*'

This strategy was used both by participants who used PrEP and aimed to have condomless sex as well as by participants who only wanted to have sex with a condom.

Providing risk information is a strategy also identified in previous research.

Deceiving Participants use deception to induce their partner's compliance with their personal protection strategy. For our participants, deception could take two forms:

Some of our participants deceive their potential partner regarding the protection measures which are available or could be used. Fabian, for example, intended to insist on using a condom and not giving his partner any leeway for a discussion on condomless sex. He therefore did not disclose that he was taking PrEP (112): *'I don't communicate that in some way right at the beginning: "Well, I'm on PrEP." Depending on the way the conversation develops, I might say it at some point.'* Yves, for example, shared his experience with partners who claimed that they could not use condoms because of an intolerance. He reported (363): '*…then there are other people who say: "Ah no, only without one for me," "Ah no, I have a latex allergy." This excuse is often used.'*

Deception also takes the form of feigned consent. In order to have sex, men pretend to be in agreement with their partner's protection measures. When it comes to applying the strategy, however, they withdraw their pledge. Theo, for example, reported such an experience (212): *'When we were agreeing: he said: "Yes, that's fine, okay." (...) and there I had to assume, when he says: 'Yes, that's okay", I have to assume he agrees to it. (...) And then afterwards when he was here, then he started, and I say: "So, do you have a rubber with you?" He says: "No, we're doing it without one!"'*.

Dramatizing Life-Threatening Consequences Using another strategy, participants draw their partner's attention to long-term maximal negative consequences that could occur if their partner does not agree to their preferred protection strategy. Christian made this clear (40): *'I say: "In principle I'm practicing safety because I'm not tired of living," I always say. I'd like to live longer. I still want to be able to experience enjoyment.'*

This strategy was only used by participants who intended to have sex with a condom.

Seeking Information Finally, we observed the strategy of constantly gathering information to appraise one's risk and to decide whether to insist on one's own protection strategy (re-examining). For example, Uriel reported (209): '*Then I just started to move on to the subject: "How long have you been taking PrEP?" and "Which type do you take then?" or "Which, w…, there are different types. Which one do you have? Can you show me it?"'*.

This strategy was mostly used by participants who use PrEP and would generally prefer condomless sex. Information seeking is then used to assess the risk of other STIs. However, this strategy is also used by participants who basically do not pursue a specific goal (with or without a condom) and are guided by their partner's wishes. In certain cases, there is a need to obtain information about the potential partner and their behavior.

Actions Breaking up the Flow of the Negotiation or Bypassing Negotiations

During the analysis focusing on negotiation strategies, we also identified elements which were closely related to the negotiation strategies but were of a different nature than the strategies. While relevant for the further course of the interaction between the partners, these 'actions' are not intended to obtain their partner's cooperation or accept a particular protection. Instead, they mark the conclusion of the interaction. Some actions are used to break the flow of communication and interaction regarding the protection strategy—often as a consequence of failing to reach agreement—and directly enforce change or protection. We identified: breaking off the negotiation (before sex), pushing the partner away, changing to practices perceived as lower risk and breaking off sex. Some actions are used to create a situation that corresponds with the actor's wishes without previous negotiations. We identified: being taken by surprise and holding on to the partner (which we consider a form of violence or harm).

Versatility

Within the Swiss context, the identified negotiation strategies demonstrated versatility. As shown above, the participants in our sample approach potential non-steady partners with different goals. Some were determined to use condoms, while others had no intention of using condoms. With two exceptions, our analysis showed no specificity of strategies for the aim pursued in this respect. The one exception was the use of visual cues: the strategy to place condoms visibly to encourage their use reported only men who aimed at condom use. The second exception was 'dramatizing live-threatening consequences', which was only used by participants who wanted to assert condom use. The remaining strategies were used for various aims and diverse situations that do not prove to be specific and, thus, are not fixed in the dimension of their 'direction' (Peasant et al., 2015). So, seduction, for example, was shown to be used to assert condom use as well as to avoid it. Our analysis did also not reveal an inherent relationship between the socio-demographic characteristics of our participants, such as age, and the negotiation strategies they used.

Negotiation as a Complex Process

While focusing on specific negotiation strategies, analysis revealed that the participating MSM combined several strategies from within the same category as well as across several categories to influence their potential partner and to respond to or to adjust to their partner's moves. In the negotiation process, they combine strategies and form patterns.

Furthermore, MSM used the strategies we identified during encounters on site (such as in saunas) and also during online dating and subsequent in-person sex dates. Regarding online dating, we identified three typical stages in negotiating HIV protection using the arenas embedded in the logic of action on the relevant platforms: when strolling through the profiles, during the chat, and during the in-person date.

Discussion

This study was conducted in Switzerland, in a context in which MSM had been addressed by specific prevention campaigns and services since 1987 (Kocher, 1993) and the discussion about the non-transmission of HIV under effective ARV had been publicly discussed early on (Vernazza et al., 2008). MSM are using risk reduction strategies (Gredig et al., 2014, have adopted PrEP and use PrEP as a condomless option of protection against HIV (Gredig et al., 2016), in a country having experienced an increase in STI over a longer period. This makes our study the first (ever) to examine the strategies MSM use to negotiate their HIV protection with non-steady partners in the era of practices of risk reduction strategies, the 'u=u' paradigm, increasing PrEP use, increasing risk of STI and online dating also to be found in other countries. Previous studies focused on 'condom negotiation' between partners meeting in person on-site and often neglected MSM.

By including MSM who were dating both online and in gay saunas, we were able to identify 17 negotiation strategies and group them into three overarching categories: (1) subject-centered strategies; (2) strategies leveraging sexual arousal and (3) strategies centered on risk communication. Beyond confirming the strategies identified in previous research, our study identifies a range of strategies not described before: It expands the category of subject-centered strategies to include 'asking explicit questions', 'asking questions to understand', 'presenting arguments', 'acceptance of conditions/action of the partner', and 'tacit agreement/non-verbal consent'. Among the strategies leveraging sexual arousal, it extends 'reference to loss of' to include 'gain in pleasure through condom use' and it adds 'dramatizing life-threatening consequences' to strategies centered on risk communication.

Thus, in these respects, this study posits an elaborate range of negotiation strategies. At the same time, it seems to us that the suggested systematization of the strategies along the three dimensions 'direction' (promoting vs rejecting condom use), 'directness' (direct vs indirect), and 'verbalism' (verbal vs nonverbal) (Peasant et al., 2015) also fits this expanded range of negotiation strategies presented here.

However, in contrast with earlier findings, we did not identify any strategies which referred to the person's relationship with their partner (Noar et al., 2002). This may not be surprising, however, as we studied MSM who were negotiating with a non-steady potential sex partner. In this constellation, it is not possible to refer to the relationship and bring it into the equation.

Further, our study draws attention to the close connection between negotiation strategies and 'actions' which directly enforce a prevention strategy or protection or bypass negotiations.

Our findings support the idea that negotiation strategies—at least those identified in the research—have multiplied and currently go far beyond 'condom negotiations'. Negotiations about what should or should not be done to protect against HIV have become far more open. This reflects the fact that MSM currently have more than one effective protection option (condom use, PrEP combined with condom use or PrEP alone). Further, they may choose among popularized specific risk reduction strategies which do not minimize risk and are less effective (Jin et al., 2009). 'Condom etiquette' (De Bro et al., 1994) has lost its binding vigor. The context in which

MSM meet with other MSM has gained new dimensions (such as PrEP) and, has thus increased in complexity as have negotiations about HIV protection.

By specifically interviewing MSM who practice online dating, we were able to establish that HIV protection negotiation during online dating takes the form of a multi-tiered process. The strategies described here already come into play in online communication before the partners meet. Some MSM have developed online strategies that come to bear even before an interaction starts, when reading and interpreting clues on an online profile. In this respect, this study confirms the findings by Kavanagh (2016). During a chat, the full range of verbal strategies aiming at condom use or condomless sex are applied. When a date in person then takes place, the maximum range of strategies come into play, including non-verbal strategies. Future research on negotiation strategies used by MSM should take this into account.

Our study describes negotiation strategies MSM are currently using and thus contributes to the differentiation of the concept of negotiation strategies. In further research, the identification of negotiation strategies among MSM should be advanced. Achieving saturation in the range of strategies MSM use when negotiating HIV protection would pave the way to incorporating 'negotiation strategies' in a tangible way into models explaining HIV protection behavior, such as the Information-Motivation-Behavioral Skills Model (Fisher & Fisher, 2002) and would support the extension of the model (see, for example, Nöstlinger et al., 2010; Gredig et al., 2020). In addition, research should also explore the HIV protection negotiation strategies used by other (key) populations.

Limitations

Our sample comprised 29 men who were very diverse in many respects. However, we suspect gaps in a few areas: We had no participants who had only completed compulsory schooling. In the context of the Swiss education system, however, this is not exceptional. The number and diversity of participants with a migration background remained comparatively low. German as an interview language may have been an obstacle for MSM who had themselves immigrated. However, this does not apply to members of the second generation of immigrants. Other barriers must have held them back from participation. However, in the demographic context of German-speaking Switzerland, it seems appropriate to have one man of color in the sample. Furthermore, we were unable to interview any men who use substances regularly or intensively.

There was also the potential for self-selection bias, whereby MSM who are more marginalized or reluctant to discuss their sexual health were underrepresented. It is also worth noting that all but one of the participants generated a 'narrative identity' (Lucius-Hoene & Deppermann, 2004) as skilled, self-determined negotiator with strong agency (Helfferich, 2020). Thus, it is possible that experiences and the negotiation strategies of men with fewer skills and with unfavorable experiences are missing. Further, given the focus on MSM living in German-speaking Switzerland and the presumed contextual influence on negotiation strategies, caution should be exercised in transferring the findings to other contexts.

The interviews took place after the second main wave of the Covid-19 epidemic in Switzerland. Due to the public health measures to contain the Covid-19 pandemic, our participants had fewer non-steady partners in the year before the interview. Their statements referred to encounters that could have taken place a few months before. However, this was not likely to have led to bias, as the interview did not focus on their last encounters and the interviewees generally considered and reflected on experiences they had had over longer periods of time in the past.

Conclusions

We are cautious about recommending a direction for specific further developments of prevention offers as we believe that development processes should be guided by a methodological framework, based on an assessment of concurrent practice and participatory in nature (see, for example, Gredig & Sommerfeld, 2008) and not be created by researchers sitting alone at their desk. Nevertheless, we hope that our study will enrich prevention practices in a more general way by reminding prevention professionals that HIV protection requires not only a decision in favor of a proven effective protection option, but also the communication skills necessary to implement it when interacting with a (non-steady) partner before and during sex. Our findings could therefore motivate prevention professionals to reflect on the extent to which negotiation skills and strategies are being addressed in prevention offers. In a context in which public health is pursuing an 'HIV combination prevention' approach—combining behavioral, biomedical, and structural prevention to address both the immediate risks and underlying causes of vulnerability to HIV infection (Hankins & de Zalduondo, 2010)—MSM are systematically offered access to various effective options for protecting themselves against HIV. In Switzerland, for example, health insurance has been covering the costs of PrEP only since 2024, while this has been the case elsewhere for several years. This lowers the barriers to access and will most likely encourage the use of this option. Therefore, MSM with varying safety needs and different HIV protection strategies are likely to meet when dating. There is evidence that conflict about HIV protection may arise, and stigma has developed (Belluz, 2014; Dubov et al., 2018; Protiere et al., 2023). Against this background, consideration could be given to widening the focus of prevention offers to empower MSM to adopt an effective personal protection strategy, while making them aware that other members of the MSM community might pursue different (safer sex) choices. In the framework of person-centered HIV prevention, an aim could be to enable MSM to clearly communicate their need for protection and empower them to stand up for their needs and assert the protection strategy they had adopted. This requires communication skills and the ability to set boundaries. However, MSM who claim these skills for themselves should be able to accept that others do too, with regard to *their* needs, personal protection strategies, desires, etc. This means that within the MSM community, they must expect to encounter dissent and be able to accept decisions made by others that are incompatible with their own and in doing so, show respect for one another. In consequence, competencies such as skills in building consensus for HIV protection, including the ability to take on other perspectives, empathize and show

respect might need to be further developed. Our findings support the view that HIV protection arises from dialogue, that the quality of the relationship—even in one-off encounters with non-steady partners—influences the decision on protection and the implementation of a protection strategy. They suggest that prevention can be successful if it strengthens relationship skills. In this way, our findings may contribute to the refinement of prevention needed to "end Aids" (UNAIDS, 2014, 2024b) as a public health threat by 2030.

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Declarations

Conflict of interest The authors report no conflict of interest.

Ethical Approval On formal request BASEC nr Req-2019-00648, the competent ethics commission, Ethikkommission Nordwest- und Zentralschweiz, declared on 15 August 2019 that, according to Swiss law, the research project on which this article is based did not require further formal ethical approval. Written informed consent was obtained from all participants included in the study including consent for publication in a scientific journal.

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