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'Why aren't you on PrEP? You're a gay man': reification of HIV 'risk' influences perception and behaviour of young sexual minority men and medical providers

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ABSTRACT

Public health models and medical interventions have often failed to consider the impact of reductionist HIV 'risk' discourse on how sexual minority men interpret, enact and embody biomedical knowledge in the context of sexual encounters. The aim of this study was to use an anthropological lens to examine sexual minority men's perception of HIV risk and experience within the medical system in order to examine the influence of risk discourse on their health, behaviour and social norms. In-depth interviews ($n = 43$) were conducted with a racially, ethnically and socioeconomically diverse sample of young sexual minority men and explored HIV-related beliefs and experiences, as well as their interactions with healthcare providers. Findings suggest that the stigmatisation of behaviours associated with HIV appears to be shaped by three key forces: healthcare provider perceptions of sexual minority men as inherently 'risky', community slut-shaming, and perceptions of risk related to anal sex positioning. Stigmatising notions of risk appear to be embodied through sexual health practices and identities vis-à-vis preferred anal sex positions and appear to influence condom use and PrEP initiation.

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Background

In the USA, sexual minority men comprise a disproportionately high proportion of people living with HIV (Mayer et al. 2021). Although there was a 7% decrease in HIV diagnoses among sexual minority men overall between 2014 to 2018, that decrease was driven predominately by white sexual minority men, who reported a 15% decrease in new infections over that time. Rates of new diagnoses remain high in sexual minority men of

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colour and young sexual minority men, who comprised 71% and 25%, respectively, of new infections among sexual minority men in 2018 (CDC 2020a,b).

Young sexual minority men are placed at higher risk for HIV acquisition by a myriad of interrelated biopsychosocial and structural factors. Biologically, condomless receptive anal intercourse—in the absence of prevention—is associated with HIV seroconversion at higher rates than other sexual behaviours (Patel et al. 2014). Other key biological factors that influence seroconversion risk include the presence of other sexually transmitted infections and high transmissibility associated with acute HIV infection (CDC 2019). Psychosocial vulnerabilities include increased rates of substance use disorders, depression, anxiety, and stress caused by stigma and prejudice, all of which are associated with increased 'risky' sexual activity (Safren, Blashill, and O'Cleirigh 2011).

Pre-exposure prophylaxis (PrEP) in the form of oral antiviral medications used to prevent HIV infection among HIV-negative individuals, is an effective biomedical means of HIV prevention (Grant et al. 2014), but low uptake and adherence persist among sexual minority men in the USA (CDC 2020a,b). Low uptake can be attributed to a variety of factors, including stigma and cost (Jaiswal et al. 2018). Furthermore, many sexual minority men lack access to LGBTQ competent health care and experience stigma and discrimination within the medical system (Bonvicini 2017; Morris et al. 2019). LGBTQ discrimination in particular is robustly linked to poorer HIV-related outcomes, including HIV testing, HIV care engagement, and PrEP uptake (Furukawa et al. 2020; Quinn et al. 2019). Disclosure about sexuality and sexual behaviour can also be fraught (Griffin et al. 2020b; Rossman, Salamanca, and Macapagal 2017), as anticipated stigma specifically involving anal sex can lead to increased anxiety and decreased disclosure to physicians (Kutner et al. 2021).

Increasing perception of HIV risk is often characterised as a method to decrease 'risk behaviours' (e.g. condomless sex) and increase protective behaviours (e.g. testing, PrEP uptake). Although it is paramount to recognise the multitude of factors that increase sexual minority men's odds of acquiring HIV, it is important to recognise how the current framing of 'risk' is potentially problematic. Frequently, these notions rest on the assumption that 'risky behaviour' is the result of limited health knowledge (MacKellar et al. 2007) and often lack a nuanced appreciation of what constitutes risk in the era of PrEP (Calabrese, Mayer, and Marcus 2021). By failing to distinguish between individual and contextual factors, the term 'risk' offers an imprecise description of sexual behaviour which ultimately obscures the complexities of HIV transmission (Marcus and Snowden 2020). Continued reliance on socially constructed notions of risk decontextualises the reality of disease transmission and in turn imposes blame on sexual minority men as a collective entity(Junge 2002). Against this background, the study presented sought to examine the ways in which discourse concerning HIV risk underlies how sexual minority men and medical providers in New York City interpret and enact these understandings.

Methods

Study sample

The Health-Related Beliefs Sub-Study was a mixed-methods study designed to examine medical mistrust, HIV-related beliefs and experiences with sexual health care.

This sub-study was nested within the P18 Study, a prospective cohort study which explored the syndemic development of HIV, substance use, and mental health in a racially/ethnically and socioeconomically diverse sample of emerging adult sexual minority men and transgender women. Briefly, eligible participants (assigned male at birth, HIV-negative, 22–23 years old at time of enrolment, residing in NYC, and with recent sexual activity with a man) attended biannual study visits for 3 years, where they received HIV/STI testing and completed computer-based and interviewer-administered assessments. Further details are available in previous publications (Halkitis, Kapadia, and Ompad 2015; Halkitis et al. 2013).

Data collection

All HIV-negative parent study participants were invited to enrol in the mixed-methods Health-Related Beliefs Study. Information regarding the quantitative part of the study is available elsewhere (Jaiswal et al. 2021). The analysis presented here used qualitative methods to enable participants to attribute meaning to their lived experiences and talk openly about sensitive or stigmatised topics (Lincoln and Guba 1985). Semi-structured qualitative interviews were conducted between July and November 2018 by trained research staff. The interview guide included questions regarding sexual health, HIV and PrEP and interactions with healthcare providers and systems, including the following: 'How do you go about managing your sexual health?', 'Do you have a healthcare provider that you're able to talk to about sex?', 'Do you have a sense if a lot of people are using PrEP?' and 'Can you tell me about how people are thinking about PrEP and condoms?' Interviews varied in length from 30 to 75 min, with most lasting 50–60 min. All participants provided written informed consent, and all activities were approved by the New York University Institutional Review Board.

Data analysis

All interviews were audio recorded and transcribed by a professional transcription service. To ensure data integrity, the researchers developed a coding scheme, applied it to the data, and used it to discern patterns, themes and subcategories. Upon completion of coding, codes/subcodes were organised, extracted and re-examined in order to identify relationships between the codes. Four of the authors (J.J., A.C., K.H., K.D.) developed the codebook and participated in coding; analyses were closely reviewed by the first and second authors to discuss differences and to assess theme validity. During the analyses, the authors used multiple techniques to establish trustworthiness, including credibility and confirmability, in the analysis. For example, the research team utilised peer debriefing and periodic external audits with researchers not involved in data collection (Lincoln and Guba 1985). All qualitative data was organised using Atlas.ti 8. Participants were assigned pseudonyms to protect confidentiality.

Results

Sociodemographic sample characteristics are shown in Table 1. Participants were 25–27 years old. The sample was intentionally selected with attention to racial and

Table 1. Sample characteristics of sub-study participants ($n = 43$).

	n (%)
Age (mean, SD, range)	25.86 (0.74), 25–27
Race/ethnicity	
White	11 (25.6)
Black	11 (25.6)
Hispanic/Latino	12 (27.9)
Asian	9 (20.9)
Education	
High school/GED or less	9 (20.9)
Some college	8 (18.6)
Bachelor's or Master's degree	26 (60.5)
Total annual income, past year	
<$15,000	8 (18.6)
$15,000–24,999	9 (20.9)
$25,000–44,999	14 (32.6)
≥$45,000	10 (23.3)
Missing	2 (4.7)

ethnic representativeness. The majority of the sample had a Bachelor's or Master's degree and an annual income above $25,000.

Three main themes were identified in the data: (1) sexual minority men become alienated from medical practice through the reproduction of risk discourse; (2) stigmatising notions of risk are manifested through community-based slut-shaming; and (3) risk discourse becomes enacted and embodied. First, problematic notions of HIV risk become actualised in medical practice when healthcare providers view sexual minority men as inherently 'risky' or 'at risk' based on their sexuality. Participants described clinicians equating sexual minority male identity with HIV, ultimately leaving them feeling alienated and stigmatised. Second, these notions of HIV risk were also apparent and reinforced at the community level in slut-shaming around perceived 'promiscuous' sexual behaviour. Although many participants endorsed stigmatising ideas about sexual behaviour, others were critical of these community norms. Finally, specific understandings of HIV risk were enacted by participants vis-a vis—their perceptions of risk-related anal sex positioning. Participants largely perceived bottoming (i.e. being the receptive partner) as significantly more risky than topping, which influenced decision-making around condom use and how they thought about PrEP. Overall, these themes suggest notions of HIV risk are mutually produced and reinforced at structural, community, and individual levels.

Sexual minority men become alienated in medical practice through reproduction of risk discourse

Many participants described frustration with health providers' association of sexual minority men with HIV and felt that providers reproduced these stereotypes rather than saw their patients as individuals with varying experiences and needs. Many reported experiencing discomfort and stigmatising attitudes from clinicians when discussing factors that place someone at increased risk for HIV. Although some providers reportedly discouraged patients from initiating PrEP, citing concerns about risk compensation, others shamed patients for not taking it. Participants expressed frustration

with healthcare providers mentioning HIV when it was not clinically relevant. Anthony described one such experience:

> Basically, when [the nurse] found out that I was gay, she gave me a dirty look, and she said – she literally looked at me and she said, 'Well, I hope you don't have HIV.' I went in there because I had allergies. So, I was totally confused … it was because she saw on my chart that you know, my preference was with a male … [I was] just like, 'Never again. I'm not coming here.' [Anthony, 26, Latinx]

Malik described how his sexual identity influenced his provider's perception of his risk of acquiring STIs, leading to unfounded assumptions:

> I had a – what was it called – like a staph – it was like an infection on the staph bacteria. And they wanted to know if [the infection] was anywhere else. And when he was asking me if it was anywhere else, he was kinda implying like, 'Is it somewhere else that I don't know about, like anywhere else in your body?' And I'm like, 'No, it's not.' … it made me feel like even if there was – even if there was somewhere else on my body, I kind of would be afraid to tell you, because I would be afraid of the next assumption that you would make. … I just felt that because he was – he knew that identified as gay or bi – I identify as bi, but to some people it doesn't matter – But, because I was a gay man, it just felt like he was like, 'Let me make sure I ask these questions.' [Malik, 25, Black]

Christopher explained how he believed the link between sexual minority men and HIV risk within the medical community accelerated societal stigma:

> Because everywhere on out – including medical professionals – were under the impression that the only way to catch this HIV/AIDS disease was to A, first, be a homosexual forgetting what you're calling it – HIV, human immunodeficiency virus, human – which means anybody that was born from either that gender was born from either Y or X chromosome – human. So, it doesn't say. It's not Gay HIV … It's not at all, nor is AIDS anywhere in there signalling or targeting only homosexuals. Even medical professionals, that's part of what really shot the stigma all the way to the moon, I feel. [Christopher, 25, Black]

Participants reported a lack of consensus among health providers regarding the utility of PrEP. Some described negative interactions with providers during which their identity was intrinsically linked to risk and they in turn felt pressured to initiate PrEP. Charley recounted:

> It's always linked with 'Oh, you have a very high number of partners. Even if you're not engaging in anal activity, you should be on PrEP.' And I say, 'I just don't think it's for me.' And then it's usually – I don't know. I just get all these negative – implied negative feedback that at this point, I'm just very annoyed about … It's implied like almost 'What's wrong with you? Why aren't you on PrEP? You're a gay man. You're supposed to be on it.' And then like part of why I don't wanna take it, too is I don't wanna take a drug every day just because of my sexual orientation. And yet, I feel like that's what's being pushed by the medical community. [Charley, 25, white]

In contrast, Alex recounted how his friends describe their providers perception of risk preventing their access to PrEP:

> There's a narrative around the use of PrEP that – if you're taking this drug – you're having sex with a ton of men nonstop. I have been in conversations with friends on PrEP … and it's always been like, 'I went to my doctor and my doctor told me they wouldn't prescribe me PrEP because that's a drug for men who are going to sex parties and I'm

not going to sex parties. I'm just having sex with men and I want to be safe.' They're like, 'No, you don't need that drug.' [Alex, 25, Latinx]

Perceptions of risk become stigmatised through community slut-shaming

HIV risk perception also shaped community norms about 'slut-shaming', a term many participants used. Promiscuity, seemingly defined by participants as having condomless sex or multiple sexual partners, was viewed negatively and linked with HIV risk, and therefore stigmatised. Two sub-themes were identifiable in this respect: (1) the endorsement of slut-shaming stigma, and (2) a rejection of slut-shaming stigma. Although some participants endorsed the use of PrEP as an effective means of HIV prevention, others shamed peers by assuming that taking PrEP signifies 'inherent risk'.

Endorsement of 'slut-shaming'

Many participants slut-shamed their peers during interview. Some expressed concern that PrEP initiation would lead to condomless sex. Behaviours that participants identified as 'risky', such as an increased number of sexual partners, were labelled as deviant or careless. Some participants identified others' PrEP use as posing an inherently higher level of risk, often stating they would avoid such individuals for fear of acquiring other STIs.

Sebastian echoed the sentiments shared by other participants regarding PrEP's role in promiscuity, framed as a dangerous trend.

> The stereotype right now is [people on PrEP are] promiscuous, they're out being hoes, they're out having sex without condoms, they're just using that as an excuse not to use condoms. They're out there, proudly boasting about it, like it's something that – 'Yes, I got PrEP, girl, and it's free', or this, that, that they're – it's, right now, seen as a trend. That's what I'm seeing. It's being seen as a trend and something that gives them subconscious piece of mind. They're going out there, doing their thing, and doing what they wanna do, thinking, 'I'm taking this pill; I'm good.' So, that's pretty much right now what the overall perception of PrEP is in the gay community, from what I've seen or heard … I feel like [PrEP] has also influenced people in a negative way. [Sebastian, 25, Latinx]

Other participants believed that preventing HIV was a matter of personal responsibility, and perceived 'promiscuous' behaviour as a failure to meet this responsibility. Matthew, explained:

> People don't want to have sex with you if you have HIV. I think it's as simple as that … I know this sounds bad, but I have this friend who's HIV [positive] – I have two friends who are HIV-positive and one of them he just was going through a really shitty time in his life and that's why he contracted it. The other one, I'm a little bit more judgemental of. I think he's a little irresponsible and he was a prostitute and I think he got it doing that and I think he was more irresponsible, and I judge him a little bit more for having it than my friend, [friend's name]. [Matthew, 26, white]

Rejection of 'slut-shaming'

Some participants were critical of the stigmatisation of 'risk behaviours', characterising these sentiments as judgemental. They expressed discontent with such discourse,

seeing these ideologies as rooted in historical homophobic discourse and evidence of internalised homophobia. Peter described some of the stereotypes associated with PrEP initiation and how stigmatising notions of risk can affect social standing:

> I think, stereotypically, people will first of all think [people on PrEP are] sexually active, those people are whoring around all the time so that's why they're on PrEP … So, you are sexually active, you want to protect yourself, you don't want unnecessary risk, which is totally acceptable and understandable. I don't really think this is a reason why people should stigmatise on other people's reputation. Because this is just one way that you chose to make your life, and you chose to protect yourself. I don't really think it's necessary for people to say, oh just because he uses it just means that you're a risky person because you're just having sex all along. [Peter, 26, Asian]

Participants believed slut-shaming to be perpetuated by the sexual minority male community itself. Nick, for example, stated that behaviours defined as 'unsafe' are stigmatised by the same men who participate in these 'risky' encounters:

> I guess gay men slut-shame, too … I've talked to some people and allegedly, apparently one of the guys that – the guy that I started going to therapy for – apparently, I put out too soon. If you do unsafe sex stuff on the first time that you meet them, apparently you are a whore and not marriage material, so that's what I've also heard … how common of a perception [it is,] I don't know. But I'm sure there's gay men out there who think – who link it like, 'You're on PrEP, therefore you're loose, therefore you're not marriage material.' [Nick, 24, Asian]

Participants often discussed how slut-shaming occurred within the community. Leo said:

> I think more people believe that if you have multiple partners, you're considered a slut. You sleep around a lot, which is, I don't know, maybe somewhat true, maybe not true. But if somebody likes to have different partners, let them do what they want. I don't care. You can sex with who you wanna have sex. It doesn't bother me because I'm not sleeping with you at the end of the day, so why should I care who you sleep with? [Leo, 25, Black]

Some participants situated risk stigmatisation within broader homophobic discourse. Sean, for example, described how PrEP stigma and slut-shaming are interrelated phenomena that reveal pre-existing tensions around sex and sexuality:

> I feel like [PrEP] brings out how people already feel about sex and safe sex or unsafe sex practices, and I don't think any of it is actually [about] PrEP. It is PrEP-specific, but I think it's kind of indicative of how somebody already feels and acts about talking about sex and safe sex and whatever that means to them … I feel like somebody who's already more inclined to slut-shame or say stuff like that like, 'All gay men just want to have sex', whatever, may be more inclined to think that PrEP is just a party drug, which is what people are saying. [Sean, 25, white]

Asked if he thought slut-shaming was preventing PrEP uptake, Alex explained:

> I think it's that. I think it's fear and judgement imposed by communities – both outside and inside of the gay community … It's also the slut-shaming, obviously – Sorry to just use that language again, but it is what it is. It's coming from people who don't have a lot of sex or do have a lot of sex but think that acknowledging that you have a lot of sex is not something that is desirable in I think more PC culture. Letting people know that you're fucking a ton isn't the most attractive thing to people. [Alex, 25, Latinx]

Risk discourse becomes enacted and embodied

Risk discourse underpins the ways in which sexual minority men navigate sexual encounters, having potential implications for condom usage and PrEP initiation. Participants described how these perceptions becomes enacted in practice. Many participants linked varying levels of risk certain sex positioning (e.g. participants perceived 'bottoms' as higher risk and 'tops' as inherently lower risk). Below, Josh described his decision-making in the context of HIV risk perception:

> I rationalised the decision not to use the condom, and it was like, 'Oh, he's on PrEP, so it's okay. And I'm topping, so there's no risk.' And I mean, parts of that may be true, but like [only] to some extent. [Josh, 26, white]

Similarly, Ash shared how risk perception informed their sexual script. Ash noted how power dynamics within sexual encounters patterned their perception of HIV risk as it related to sexual positioning:

> … Statistically and scientifically, as a top you are less likely to contract [HIV] … I mean, if I am to top, I am wearing a condom and I am always – if penetrative sex is happening, I am always the insertive one, and so it's on my body so I'm in control of that situation. [Ash, 25, white, non-binary]

When asked how he thought people generally perceived PrEP and condom use, Nate explained that he viewed people who topped as the partner who would most likely prefer condomless sex. Below, he explained how his association of sexual positioning and risk impacted on his PrEP use:

> I think from the sexual perspective, having a condom or not having a condom might be the difference to the people who tends to be, likes to be on the top position … And while for me, the chance getting HIV in my opinion, it would be relatively low because I never bottom before, so it just causes all the benefit. [PrEP] might not be worth it for me to take that every day [Nate, 25, Asian]

Below, Sebastian explained how he believed PrEP use was correlated with a decrease in perceived HIV risk and in turn condom use, particularly among receptive partners. He likened PrEP to a form of birth control, for whom the user is protected from an unwanted outcome:

> I would personally believe, based on my observations, that people that are on PrEP don't wanna use condoms. That's the whole reason why – the receptive partners or the bottoms, they're looking at it more as like, 'Girl, this is my birth control.' [Sebastian, 25, Latinx]

Discussion

This study contributes to knowledge of PrEP-related experiences and interactions among sexual minority men and posits that perceptions, identities and behaviours are shaped in the context of risk discourse. Current framing of sexual minority men's susceptibility to acquiring HIV has resulted in many men feeling stigmatised by healthcare providers' perceptions of risk. These stigmatising notions of 'risk' are reproduced and reinforced in healthcare settings, compounded through slut-shaming in gay and queer communities, and ultimately enacted and embodied at the individual level.

Historically, public health and medicine have viewed sexual minority men's health from a deficit perspective. Research has utilised concepts of risk to inform the development of programmes and interventions, with the underlying assumption that altering risk perception will ultimately lead to a decrease in 'risky' behaviours (Junge 2002). Terms such as 'unsafe sex', despite failing to properly articulate who or what is not safe, are widespread in public health discourse and have led to an imprecise understanding of the surrounding factors that contribute to HIV transmission (Marcus and Snowden 2020). Failure to comply with public and community health recommendations has resulted in those who do not comply to be labelled as ignorant, irrational or deviant (Nichter 2001). By labelling those who are associated with risk as 'risky', such discourse informs social relationships and distributions of power (Lidskog and Sundqvist 2013).

This critique of risk discourse does not deny the validity of biological and epidemiological means used to define which behaviours are categorised as risky; rather, it seeks to recognise that risk itself is a socially constructed concept that shapes attitudes, actions and perceptions through institutional and societal control (Tansey and O'Riordan 1999). Rather than being seen as a framework through which people seek to reduce vulnerability in line with medical recommendations, risk can instead be seen as a cultural and subjective phenomenon that shapes, and is shaped by, societal beliefs and values (Adam 2005; Tansey and O'Riordan 1999). Such an understanding is particularly relevant in the context of sexual minority men's health. Rather than seeing HIV risk as linked to structural inequality, sexual minority men are often viewed as posing a risk to their partners, themselves and society more broadly (Calabrese, Mayer, and Marcus 2021; Junge 2002).

The data presented here signal how risk discourse underpins perceptions, behaviours and vulnerability at both the community and individual level, as well as how research can take a different approach to understanding sexual minority men's health. Specifically, the conflation of population-level risk with individual behaviour decontextualises sexual encounters, discursively constructs stigma, and dominates sexual minority men's healthcare experience. Farmer's critical epistemological approach, which seeks to take biosocial lens to evaluate how biomedical knowledge is created and utilised, is useful in thinking about how to move away from a risk-based model (Farmer 1996). Rooted in social constructivism, which understands knowledge as a social and cultural construct through which individuals make meaning, we used this reflexive approach to examine how the historical framing of risk has shaped sexual minority men's experience in healthcare settings and in sexual relationships. By reconsidering risk through this perspective, future programming could better account for how moral, cultural and behavioural factors influence HIV prevention and PrEP uptake within the context of the lived daily experiences of individuals (Adam 2011; Kippax et al. 2013)

Risk reification negatively influences patient-provider interactions among sexual minority men

Participants in this study reported feeling stigmatised by health providers' perceptions of HIV risk and its explicit links to gay and queer men. Within provider–patient

interactions, the provider holds a position of power through which they can manipulate and enact sociocultural constructions of risk (Lupton 1999; Worthington and Myers 2003). Notions of risk thereby become mechanisms of social control, leaving patients disempowered from decision-making regarding their health (Mill et al. 2010). Identifying ways to reframe risk and empower sexual minority men in healthcare interactions is paramount to mitigating the effects of stigmatising risk discourse (Fisher et al. 2018; Fuzzell et al. 2016; Kutner et al. 2021).

These findings align with previous qualitative studies, which have found that sexual minority people often express discomfort and concern when discussing sexual health with their clinicians (Hedrick and Carpentier 2021; Fuzzell et al. 2016). The sexual orientation-related stigma sexual minority men experience from health providers (Griffin et al. 2018; Furukawa et al. 2020) may in fact be associated with increased frequency of 'risky' behaviours (Emlet et al. 2017). Furthermore, stigmatising notions of anal sex as an inherent risk factor for HIV may result in internalised and anticipated stigma, leading to decreased healthcare utilisation by sexual minority men (Kutner et al. 2021).

Medicalised risk discourse shapes stigma among sexual minority men

Within this sample of sexual minority men, there was no consensus regarding endorsement or rejection of the stigmatisation of risk-associated behaviours, e.g. 'promiscuity'. A recent study showed that a 'myth of promiscuity' is often perpetuated among sexual minority men, leading many to believe that PrEP users engage in risky behaviours at a high rate (Schwartz and Grimm 2019). Experienced stigma derived from slut-shaming discourse can lead to feelings of rejection, in turn increasing minority stress (Feinstein 2020), which may be a factor in predicting HIV transmission (Burton, Clark, and Pachankis 2020; Pachankis et al. 2020). Sexual minority men's discourse regarding sexual behaviours, including slut-shaming as endorsed by some participants in this study, has been shown to decrease open communication regarding risky behaviour among peers (McDavitt and Mutchler 2014).

Risk perceptions becomes embodied and enacted

Participants linked specific anal sex positioning to varying levels of perceived HIV risk, which in turn appeared to inform behaviours concerning condom use and PrEP. Although there is an increased risk of HIV acquisition for receptive anal sex in the absence of other prevention methods (Patel et al. 2014), our findings highlight the need for tailored safer sex messaging to sexual minority men who top. In this study, participants who identified as tops regarded themselves as being at lower risk, which appeared to influence how they thought about condom use and PrEP. Although risk perceptions are indeed informed by population-level statistics, this discourse may inadvertently lead to increased vulnerability among those who see themselves as being at 'low risk'. Condomless insertive anal sex still presents a significant risk factor for HIV transmission and safer sex messaging should acknowledge that while topping is often of comparatively lower risk, it is not risk-free. As a result, future interventions should account for how risk discourse underlies the meaning making and social relationships among sexual minority men (Race 2012).

Limitations

The study is not without its limitations. The sub-study was conducted in the context of a parent investigation in which participants received HIV testing and counselling. As such, participant's awareness and knowledge of HIV and PrEP may not be reflective of other sexual minority men in the USA. Additionally, the study took place in New York City, where PrEP messaging and service access have been strong. Finally, while the parent investigation recruited sexual minority men who were assigned male at birth, some participants transitioned during the multi-year study and later identified as trans women or non-binary. Transgender participants were retained in both the parent and sub-study to honour their time and experiences. The number of trans participants in the study was insufficient to make meaningful claims about their experiences and we caution strongly against conflating sexual minority men and trans women, as each population should be considered in its own right.

Clinical recommendations and future research

Patient centred approaches are paramount in providing a comfortable and inclusive environment for sexual minority people in a clinical setting, and in turn could prove useful for mitigating the harmful effects of stigmatising risk discourse (Griffin et al. 2020a; Haider et al. 2017). Specifically, health providers should non-judgementally ask patients how they make decisions about condom use and sexual positioning in order to understand how patients' decision making about sexual behaviour, and then engage in shared decision-making with patients to discuss HIV prevention strategies that are consistent with the patient's values and goals. This is important for sexual minority men, who often experience health communication barriers that specific to their sexual orientation (Fisher et al. 2018; Fuzzell et al. 2016; Kutner et al. 2021), and may be especially important for sexual minority men of colour, for whom healthcare provider communication may be a facilitator of PrEP uptake (Jaiswal et al. 2021). A tailored, patient-centred approach also can help patients better understand that HIV risk is complex and related to factors beyond sexual position.

The language that health providers use to speak about sexuality orientation and risk can act as facilitator or barrier to communication and perceived LGBTQ competence (Fisher et al. 2018; Halkitis, Maiolatesi, and Krause 2020; Rossi and Lopez 2017). Future research is needed to illuminate how clinicians think about and act upon notions of risk, particularly with regard to individuals and communities who are most structurally vulnerable. Given that sexual minority men of colour are placed at particular risk for HIV, an intersectional approach could help inform how racism and classism, in addition to sexual minority status, impact risk communication and management (Overstreet, Rosenthal, and Case 2020). By taking into account sexual minority people's perspectives, future public health interventions and medical recommendations could prove to be less stigmatising and thus more effective (Race 2012).

Conclusion

Stigmatising notions of risk have shaped how sexual minority men live within their bodies and communities. This study's findings demonstrate how medicalised risk

discourse can perpetuate and augment HIV- and sexuality-related forms of stigma. In order to provide affirming and non-judgemental care, it is imperative to contextualise the lives of often marginalised individuals. By considering how risk discourse shapes sexual minority men's identities and experiences within healthcare systems, findings from this study demonstrate how biomedical knowledge becomes enacted and embodied at the structural, community, and individual levels. These findings offer actionable insights as to how HIV prevention interventions can deliver culturally sensitive and effective care and messaging to vulnerable populations that are disproportionately affected by bigotry, inequity and ultimately the ongoing HIV epidemic.

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