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An ethics of intimacy: online dating, viral-sociality and living with HIV

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Abstract

There has been considerable academic interest in how people living with HIV use the internet for online dating and sex seeking. Most of this work has focused on the relationship between internet use and the risk of viral transmission. Drawing on an analysis of HIV dating websites and interviews with women living with HIV, this article moves beyond this and connects the use of dating websites with the changing dynamics of what constitutes a 'normal' life with HIV in the 'post-AIDS' era. The use of these websites is situated within a broader ethics of intimacy in which people living with HIV are told they are able to develop 'normal' sexual/romantic relationships, yet their right to do so is contingent on them pro-actively protecting others from infection. The disclosure of an HIV positive status and the selection of HIV positive partners are explored as key mechanisms for preventing the spread of the virus while enabling people 'living with HIV' to form intimate relations, 'sharing the virus' in other ways – practices conceptualised here as 'viral-sociality'. Throughout the discussion attention is drawn to how sexual relations, clinical encounters and HIV-related criminal prosecutions intersect in this field, such that the most private aspects of 'living with' the virus can at the same time be the most public.

Keywords: internet, dating, HIV, intimacy, disclosure, ethics.

Introduction

In 2009 I interviewed a group of HIV positive women about how they used the internet in relation to their health. The first woman I interviewed, whom I shall call Amy, described herself as '*not very good at computers*'. Despite this self-reported lack of computer literacy, Amy told me that she did use the internet in relation to living with HIV. However, instead of focusing on what I had been expecting – such as researching symptoms, medication, side-effects and so on – Amy spoke enthusiastically and with a great deal of humour about her experiences of online dating.

When I asked subsequent interviewees how they used the internet in relation to HIV and their health, I frequently received animated responses, such as Amy's, on its use for dating. On one level, this is unsurprising. Research on the experiences of women living with HIV has documented romantic and sexual relations as major concerns (Squire, 2003; Doyal & Anderson, 2005; Ridge et al., 2007). The internet has become a popular technology for the initiation of romantic and sexual relations (Baker, 2000; Ellison et al., 2006; Lawson & Leck, 2006; Whitty & Carr, 2006; Whitty et al., 2007). And the implications of internet use on the risk of viral transmission for men who have sex with men (MSM) has proven to be a topic of considerable academic interest (Benotsch et al., 2002; Tashima et al., 2003; Bolding et al., 2005; Davis et al., 2006; Ross et al., 2006; Jenness et al., 2010).

Yet, to date, there has been little to no research on the online dating practices of women living with HIV. Moreover, with a few notable exceptions (Race, 2010), the majority of existing work on online dating and HIV has centred on the relationship between internet use and risk. While the starting point for this article was how Amy and other research participants spoke of their use of online dating to initiate romantic and sexual relationships, my concern

here is with neither romance nor risk of viral transmission. Instead, I am interested in the role that these technologies play in what has been referred to as the ‘post-AIDS’ era (Dowsett & McInnes, 1996) – a context in which HIV is being turned into a chronic, rather than terminal, illness, due to the availability of highly active anti-retroviral therapy (HAART) as a treatment, but not a cure, for the virus. More specifically, I focus on how HIV dating websites are used to negotiate the formation of intimate relations in a paradoxical field in which people living with HIV are positioned as being able to have ‘normal’ (read ‘healthy’ and ‘full’) sexual, romantic and family relations, yet are seen as both ‘a risk’ to prospective partners and ‘at risk’ from them. I sketch out how dating websites are used to manage some of the tensions that emerge in relation to this and suggest that they facilitate a very particular form of sociality – conceptualised here as ‘viral-sociality’.

Viral-sociality describes practices of explicitly seeking out, forming and maintaining romantic and/or sexual relations between people living with HIV (or other sexually communicable conditions) and others who also already have the virus; preventing the literal spread of the virus to uninfected others, while sharing it with each other in different ways – through, for example, mutual understanding, providing emotional support, helping with medical decisions. In developing the concept of viral-sociality, I build on that of ‘biosociality’ as proposed by Paul Rabinow (1996) and subsequently developed by others, such as Nikolas Rose (2007). However, while the concept of biosociality describes the interactions, solidarities and identities that have emerged as a consequence of biomedical (and particularly genetic) technologies, viral-sociality highlights a specific form of biomedically informed sociality that has emerged in relation to ‘living with HIV’. Consequently, rather than being a matter of individual choice or preference, viral-sociality is premised on the particular ethics of intimacy that sits at the heart of the broader ethical

regime of ‘living with HIV’. An ethics of intimacy in which the ability of people with HIV to have the ‘normal’ sexual/romantic relations promised in the post-HAART era is contingent on them engaging in ‘positive prevention’ (Ridge et al., 2007) – taking responsibility for not infecting others as an essential component of any intimate relationship.

The article is based on forty-seven interviews carried out with HIV positive women (originally from thirteen sub-Saharan African countries, but living in the UK at the time)¹ and people working in the HIV field (primarily online information providers and those working in community groups). African-born women are the second largest group (after MSM) to be diagnosed with HIV in the UK,² and while there has been considerable interest in researching the use of internet technologies by people living with HIV, very little of this has focused on either women or people who have immigrated to new countries or are living abroad on a more temporary basis. The interviews were conducted as part of a broader study on health-related internet use by women of African origin whose experiences of HIV spanned the UK, where the virus is increasingly treated as a chronic manageable condition, and countries where access to ARV treatment is more precarious and, for many, a diagnosis of HIV remains synonymous with AIDS.

Interviewees were primarily recruited through three public sector HIV specialist outpatient centres (henceforth referred to as ‘clinics’) in London. The interviews were semi-structured with questions focused on the various ways in which people use the internet in relation to their health. Unexpectedly, from the first interview one of the key areas of internet use that emerged was that of online dating, and explicit questions on this were subsequently included in later interviews. Most interviews were audio recorded and transcribed verbatim; in a few cases the interviewee did not want to be recorded and simultaneous notes were taken. In

addition, two focus groups were conducted at different community groups to validate the findings from the interviews and add any areas of interest not covered. Finally, online dating websites and other relevant documentation (e.g. professional guidelines, patient information sheets, news reports etc.) were analysed. Ethical approval for the study was received from the Outer North East London Ethics Committee. All the names used are pseudonyms.

The article is structured as follows. First, an overview of dating websites designed specifically for people living with HIV and other sexually transmitted infections is presented. Drawing on the concept of ‘regimes of living’ (Lakoff & Collier, 2004), these websites are contextualised as part of the broader regime of ‘living with HIV’ and used to illustrate the ethics of intimacy underlying the formation of sexual/romantic relations in this regime. Next, the key role that disclosing an HIV positive status to past, current and future partners plays in this ethics of intimacy is outlined. This is followed by a discussion of the preference expressed by interviewees for sexual/romantic partners who were also HIV positive. In the fourth and fifth sections, the notion of viral-sociality is developed through an analysis of the reasons interviewees gave for using the internet for meeting prospective partners.

Dating websites and the ethical regime of ‘living with HIV’

There are many online services that facilitate the initiation of romantic and sexual relationships, ranging from general purpose social networking sites to specialist dating ones. A number of these services target specific communities, for example: *JDate* (<http://www.jdate.com>) for Jewish singles; *Shadi* (<http://www.shadi.com>) aimed at people originally from South Asia; and the extensively researched gay community networking platforms, such as *Gaydar* (<http://gaydar.co.uk>) and *Manhunt* (<http://www.manhunt.net>) (Light et al., 2008; Mowlabocus, 2010). The websites analysed in this article fall into a

distinct category of specialist dating websites – those designed for people living with HIV and other sexually transmitted infections (STI). For example: *Pozmatch* (<http://www.pozmatch.com>), *Positive Singles* (<http://www.positivesingles.com>) and *HIV Match* (<http://www.hivmatch.co.uk>).

While these websites differ in terms of service and price they have many features in common, both with each other and with other dating sites. Typically this includes: a homepage containing basic information about the service (such as pricing, number of users, success stories, assurances of anonymity); a picture of homogenously happy, often, but not always, multi-racial, healthy-looking people; and a search facility which allows users to seek profiles based on specific criteria. When a search is carried out, the profiles of users that match the criteria being looked for are returned. These profiles normally contain information on age, location, gender, marital status, last online, a picture (if available) and a small section of self-description. In addition, private messaging and instant chat services are provided as well as a mechanism for indicating interest without writing an actual message, such as ‘winking’ or ‘sending a kiss’.

Even though the structure and functionality of HIV dating websites is similar to that of other dating websites, there are clear indicators that these services are aimed specifically at people living with HIV. Most obviously, they include advertisements for HIV/AIDS products and/or services, but a closer look at the profiles of users provides more subtle indicators – they often contain information on when and how the virus was contracted, and make explicit or oblique references to health status and, for example, to adopting a ‘positive approach’ to life (e.g. ‘*we only get this one life it should be lived up no matter what*’). In the case of heterosexual women’s profiles, the desire to find a stable partner and have children is frequently

mentioned, with motherhood (past or future) emerging as a recurring theme. This pattern is not limited to online services, but is evident in women's profiles listed in the classified advertisements of magazines such as *Positive Nation* (<http://www.positivenation.co.uk>).

Although early work on online dating frequently fixated on the apparent *absence* of the body in this type of interaction, the presentation of the body on dating websites has become an increasingly prominent topic of research (Whitty et al., 2007). It has been shown, for instance, that instead of presenting their physique in an 'ideal' light, users of online dating services tactically balance positive and negative aspects of their bodily image (Ellison et al., 2006; Toma et al., 2008; Hancock & Toma, 2009). Furthermore, in his research on how gay men use the internet as a means for organising sex, Kane Race argued that erotic interests and other details are 'entextualised' in various ways in online profiles (Race, 2010, p.10). One example of this would be that, in some cases, instead of explicitly stating that they were HIV positive, men's profiles would specify 'safe sex only', to be read as a code for a positive status (Davis et al., 2006; Race, 2010).

In the case of the HIV dating profiles discussed above, physical attributes (such as height, weight, hair and eye colour) are often, although by no means always, presented. However, it is not primarily erotic interest that is 'entextualised' in the profiles, but rather a particular enactment of what constitutes a 'normal' life *with* HIV, which in the case of heterosexual women centres on expectations regarding romance, relationships and motherhood.

These forms of online self-presentation and relationship-seeking can be read, as has already been done in relation to HIV romance narratives (Squire, 2003), as a challenge to the attribution of sickness and disease to an HIV positive status, and as such working in

opposition to the enactment of HIV *as* disease. Instead, I suggest that these websites do not challenge expectations and norms imposed on people living with HIV, but form part of the enactment of an ethical regime of ‘living with HIV’. By referring to ‘living with HIV’ as a ‘regime of living’, I am drawing on the work of Andrew Lakoff and Stephen Collier (2004), in which they define ‘regimes of living’ as configurations of ethical reflection and practice that occur across sites in which specific ways of living are problematized and enacted as ethical projects. In this case, the mode of living problematized is how to have a ‘normal’ life post an HIV positive diagnosis in a context where – through an assemblage of policy discourses, changes to clinical care, pharmaceutical drugs and other practices – HIV is being decoupled from AIDS, and repositioned as just another chronic condition (Clarke, 1994; Rosengarten, 2009).

Thus, people diagnosed with HIV are told they can live a ‘normal’ life with all the rights and responsibilities implied by that normality, including being able to form romantic and sexual attachments. And yet, the ability to ‘live’ this normality is contingent on a number of factors, such as the availability of treatment and high levels of care, being able to adhere to treatment regimes, managing stigma and discrimination. Moreover, due to its status as a communicable virus, people living with HIV are not living with *any* chronic illness – they are living with a virus that can be transmitted through bodily fluids that makes them, at least potentially, a threat to those close to them, most notably sexual partners and, in the case of women, their unborn children.

When viewed in this light, the use of HIV dating websites provides an interesting case in which to explore a tension that lies at the heart of the contemporary ethical regime of ‘living with HIV’. Namely, that people living with HIV are encouraged to develop ‘normal’

sexual/romantic relationships, yet in order to do so ‘ethically’ they need to take active measures to prevent spreading the infection – ‘positive prevention’ (Ridge et al. 2007). In what follows, I explore some of the complexities and paradoxes that emerge when these two imperatives meet in practice. The approach taken for doing so is to focus on the two main reasons interviewees gave for why they chose to go online to look for partners: *disclosure* and *selection*; using HIV dating websites as a medium for disclosing a positive status and selecting partners who were also HIV positive.

‘It’s your decision’: Disclosing an HIV positive status

When someone is diagnosed with HIV in the UK, questions of disclosure in terms of who needs to be told, when and how, become matters of paramount personal and professional concern. A key aspect of this concern centres on contacting and testing the sexual partners of the person diagnosed. Not only do doctors and nurses counsel newly diagnosed patients through this process, encouraging them, if relevant, to bring their partner in to have a test, but specialist sexual health advisers are assigned to work with them (Greene et al., 2003). These healthcare practitioners come from a range of professional backgrounds, such as nursing, counselling, or social work, and their explicit purpose is to work with people affected by sexual health issues. An important element of a health adviser’s role is to work with newly diagnosed patients to notify partners and trace sexual contacts (see the Society for Sexual Health Advisers (SSHA) website: <http://www.ssha.info/>). In addition, community groups provide advice on issues of disclosure in face-to-face counselling sessions, through information booklets distributed in clinics and online, and disclosure is a popular topic in HIV-related internet forums (Rier, 2007).

The question of the appropriate ethical and legal path to follow vis-à-vis the disclosure of an HIV positive status has long been a central issue in the fight against AIDS and, under the leadership of Jonathan Mann, the World Health Organisation's global AIDS program framed the decision to disclose an HIV positive status as a human rights issue, stressing that people diagnosed with HIV should not be forced to disclose their status (Mann & Kay, 1991). However, despite the fact that official discourses around disclosure of an HIV status emphasise the right of the person diagnosed to make decisions pertaining to disclosure, how this right is applied in practice is far from simple.

On the one hand, people diagnosed with HIV are told that it is *their decision, their right*, to decide when, where, and whom to tell about their HIV status. Yet, in the interests of public health, they are at the same time strongly advised by the healthcare practitioners on whom they are dependent on for treatment and care to disclose their HIV status to past, current and future sexual partners. However, it is not only the rights and responsibilities of patients that are at stake here. Healthcare professionals are expected to balance their duty to care for, and respect the confidentiality of, specific patients with their responsibility to minimise the spread of infection as a pressing public health concern (Cline & McKenzie, 2000). The ethical tension that arises in this context is reflected in the British HIV Association (BHIVA) guidelines, in which the statement: 'a health care worker has a legal responsibility to maintain confidentiality of patient information unless the patient has consented to disclosure', is directly followed by a second one stating: 'a health care worker may disclose information on a patient (either living or dead) in order to protect another person from serious harm or death' (Fakoya et al., 2008, p.706).

Moreover, a failure to disclose an HIV positive status to sexual partners carries a very real risk of criminal prosecution (Weait, 2007). While not a common occurrence, there have been a number of such prosecutions in the UK (Weait, 2007; Dodds et al., 2009), with these cases receiving widespread media attention, in which the people living with HIV in question have often been brutally demonised (Persson & Newman, 2008). It has been suggested that one of the reasons HIV positive gay men prefer meeting partners online is because they find it easier to disclose over the internet and in doing so avoid the risk of criminalisation (Dodds et al., 2009). No equivalent study has been carried out on women living with HIV, but the participants of this research spoke of similar motivations for using the internet to seek out romantic and sexual partners: namely that it is 'easier' to disclose online and that this minimised the risk of inadvertently transmitting the virus and the possibility of criminal prosecution.

Even in circumstances where people living with HIV have every intention to disclose their positive status to their sexual partners, it remains for many an extremely difficult thing to do. HIV is still highly stigmatised and people with the virus not only run the risk of being discriminated against (for example, in terms of employment), but many fear that disclosing to partners, friends and family members will result in them being ostracised or otherwise abused by those closest to them (Doyal & Anderson, 2005; Ridge et al., 2007; Elford et al., 2008). In instances where people are dependent on others – such as family members taking care of children left behind in order for their parent(s) to work in the UK, as was often the case in the interviews I conducted – disclosing an HIV positive status is perceived as not only a risk to the person with the diagnosis, but also to those they care for.

Thus, people living with HIV enter sexual relations with the knowledge that they could infect their partner with the virus; they are ‘a risk’ to those they engage with intimately. However, in addition to being ‘a risk’, they are also ‘at risk’ in numerous ways. These latter risks range from being infected by other strains of HIV, through to the pervasive threat of criminal prosecution, fears over stigmatisation and moral judgement. People living with HIV are faced, therefore, with a dilemma: disclosing your HIV positive status to sexual partners is considered the right thing to do, and in disclosing you minimise a range of risks for both you and your partner; yet disclosing an HIV positive status begets a whole host of other risks. It brings with it not only the possibility of rejection, but also the threat of violence and the fear that knowledge about an HIV positive status will spread beyond its intended audience.

Dealing with the difficulty of disclosing an HIV positive status was a much discussed topic in my interviews, where interviewees spoke at length of their experiences (often, but not always, negative ones) of doing so. In the rare cases where the women I interviewed spoke of having deviated from the expectation of prompt disclosure to their partners, they expressed feelings of being ‘*judged*’ by healthcare practitioners and often went to some lengths to justify to me their reasons for non-disclosure. It would be overly simplistic, however, to blame this sense of moral judgement on the insensitivity of said practitioners. As already mentioned, healthcare professionals are themselves grappling with managing tensions between respecting an individual’s rights and taking responsibility for protecting the public.

Despite disclosure being framed as an extremely difficult thing to do, in the majority of interviews it was consistently described as an individual choice and right (echoing the rights-based discourses in information leaflets and community groups). Moreover, with a few exceptions, interviewees said they believed that in relation to *sexual partners* full disclosure

was the responsible, morally right, thing to do (mirroring the findings of other research on 'positive prevention' (Ridge et al., 2007)). And yet, as discussed in the next section, disclosure was seen as only one aspect of an appropriate ethics of intimacy, and was not deemed as solely sufficient for preventing the spread of infection.

‘Someone positive like me’: Protection through partner selection

The women I interviewed expressed deep concern about transmitting HIV to a negative sexual partner and spoke of disclosure as a moral obligation necessary to prevent this. But telling existing or potential partners of an HIV status did not always translate into expected ‘safe sex’ practices, namely the use of condoms. For example, when Kerry was diagnosed with HIV she did what was expected of her – she told her partner about her diagnosis and attempted to bring him in for a test. Not only did he not want to go for the test, but refused to use condoms:

When I found myself HIV positive they did advise me to bring my partner to have a test [pause] and to talk to him about it. When I did I found it a bit strange because, I think it is some black mentality, when I did, I tried to explain to him that we should go for a test; that was my way. I wanted to talk to him about it, but he never wanted to go and when I tried to protect him by using protection he explained to me that where he come from they don’t believe in losing sperm.

In our interview Kerry spoke of her partner’s attitude with concern and disapproval, but she also expressed a certain amount of confusion regarding the risks of her *actually* infecting her sexual partners. In particular, she was perplexed about how she could have the virus *and* an undetectable viral load and how she could have given birth to an HIV negative child. Moreover, she was unclear on exactly what type of sexual contact could result in her transmitting the virus. Kerry’s confusion was not, however, simply a consequence of a poor understanding of HIV. For many experts seem to be similarly confused, or at least in conflict, on this very same topic – a point aptly illustrated by the controversy surrounding what has become known as the ‘Swiss Statement’ (Vernazza et al., 2008).

In January 2008 the *Bulletin of Swiss Medicine (Bulletin des Médecins Suisses)* published a consensus statement by the Swiss National AIDS Commission. It stated that ‘after 6 months’ treatment, if the virus is undetectable in the plasma and in the absence of another sexually transmitted infection the risk of transmitting HIV is negligible’ (Garnett & Gazzard, 2008). Unsurprisingly, this has become a point of contention and controversy. Although the authors of the ‘Swiss Statement’ apologised for any misleading interpretations of it, they also insisted that they held by their original aim in issuing it, which was to counter the discrepancy between what some doctors were telling their patients in private and what they were prepared to say in public. In other words, this was not merely a medical statement, but an explicitly political one. For, in Switzerland, people with HIV can be prosecuted for having unprotected sex with *consenting* HIV negative partners. Thus, part of the purpose of this statement was to use it as evidence in court to prove that if someone was receiving treatment they could *not* transmit HIV. And, in February 2009, it was used successfully to do just that (Bernard, 2009).

In addition to the lack of official consensus on what counts as effective HIV prevention in the post-HAART era, the very nature of intimate relationships has been raised as a barrier to ‘safe sex’. Even in cases where uncontroversial methods of protection, most commonly condoms, are used by serodiscordant couples – couples with different HIV statuses – issues abound (Van Der Straten et al., 1998; Palmer & Bor, 2001; Kalichman et al., 2002; Stevens & Galvao, 2007; Walque, 2007). Research that draws on social theories of risk management, as developed by Anthony Giddens and Ulrich Beck, has stressed the complexity of managing risk in the context of intimate relations and HIV. In this, it has been suggested that intimacy in the form of sex without condoms can override concerns regarding infection (Rhodes & Cusick, 2000, p.5). Interestingly, in these circumstances it is often the HIV negative partner

who wants to forego using protection (Ridge et al., 2007). Intimacy and risk management do not, it seems, blend well together, as has been vividly illustrated in research on the subculture of 'barebacking' and the active pursuit of HIV infection ('bug chasing') among gay men (Dean, 2009). This was reiterated in my research where participants, such as Kerry, spoke of the difficulty of negotiating condom use with HIV negative partners even when these partners were aware of the women's positive status and especially if they wanted to have children together.

Thus, even though patients diagnosed with HIV are told that the disclosure of their positive status is *their* decision, a matter of their own *individual* responsibility and integrity, in practice they have to navigate through a field strewn with multiple rights and responsibilities aligned with different agencies and moralities – clinical, public health, financial, criminal, and so on. Furthermore, despite the emphasis placed on disclosure as crucial for preventing the spread of the virus, disclosure does not always manifest straightforwardly in the intended protection (Kippax & Race, 2003; Richters et al., 2003; Slavin et al., 2004; Ridge et al., 2007). This gap between disclosure as prevention in theory and disclosure as prevention in practice means that many people living with HIV choose to develop intimate relations with people who are also HIV positive – referred to as serosorting (Bolding et al., 2005; Davis et al., 2006; Dodds et al., 2009; Race, 2010) – as a complementary risk minimisation strategy.

Disclosure and selection: Mediating the ethics of intimacy

In our interview, Amy spoke about how, with some help, she had set up a profile on an HIV dating website. Although she was hoping for a serious relationship, none had developed by the time of our interview. Nevertheless, Amy remained optimistic that if she persisted the internet would help her find a suitable partner and she used it, in her own words, because

'...you can disclose. I can advertise myself and say I am HIV positive, looking for someone like me.' Very similar sentiments to Amy's were expressed by other interviewees, such as Cara below:

I really wanted a partner. Because you can get other people who want you, but you don't want to infect them and you don't want to tell them you are positive, but at least if you get somebody on the internet he tells you already that he is positive so if you meet you are not worried that you are going to infect somebody else. At least you are meeting someone positive like you.

In cases such as these, online dating services were seen as technologies for enabling sexual/romantic relations *and* adhering to the ethics of intimacy implicit in the regime of 'living with HIV' *while* minimising some of the key risks engendered by that adherence. Yet, using the internet in this way was far from risk free.

Last year Amy met a man online who told her he was an American engineer working in Nigeria. For a period of time they stayed in contact, first through the dating website and then over the telephone. Once they switched to speaking on the phone Amy developed suspicions that he might not be who he claimed to be; he had what sounded like a Nigerian accent. They continued to be in touch, but the more they spoke the wavier Amy became. By the time he asked her to lend him money she was already *'thinking this person was not the right person.'* Although he insisted that he would come to London and pay her back, Amy became convinced that this was an attempt at fraud and cut off all communication. Despite this experience, Amy still felt that using dating websites was preferable to telling men she was

HIV positive face-to-face. After all, she said, in the worst-case scenario she could close her profile and open another.

Although interviewees turned to dating websites in order to manage the difficulties and risks of adhering to the ethics of intimacy by disclosing an HIV positive status and selecting HIV positive partners online, it is important to stress that this use does not dissolve these risks. Instead, drawing on Bruno Latour's concept of 'mediation' (Latour, 2002, 2005), I suggest that these HIV dating websites act as 'mediators' of the ethics of intimacy. Rather than being simple intermediaries that fulfil a specific function (Latour, 2002, p.250), the use of these websites transforms the risks of initiating sexual/romantic relations in ways that are neither predictable nor controllable. So, for example, the risks associated with face-to-face disclosure of an HIV positive status – such as violence, rejection, discrimination – are transformed into the risk of being a victim of dating fraud (a problem on the increase (Rege, 2009), mentioned by a number of interviewees).

Women who turn to HIV dating websites delegate the burden of disclosure to these technologies in order to minimise certain difficulties and risks; and in this process they encounter new agencies and new risks that intersect with and reshape those already at play. For example, in most instances interviewees felt they were more or less in control of how they managed disclosure on websites since they could choose whether to upload a photograph and judiciously select the information they put on their profiles. However, in order to be able to do so, they had to disclose information (such as an e-mail address and demographics information) to website providers in order to activate their accounts. Hence, what is disclosed and to whom shifts. Additional agencies, such as web managers, search algorithms and online

fraudsters, and the different risks and costs associated with them, now have to be taken into account.

Nonetheless, these new risk and costs were often, as in Amy's case, perceived as preferable to those associated with face-to-face disclosure or having sexual relations with someone who was HIV negative. Yet, negotiating the transformation of risks that came about through mediating the ethics of intimacy in this manner involves effort and incurs its own costs. For one, it requires hopeful users to gain access to the internet and learn how to use new services. In some instances, this means relying on the assistance of others, such as family members or friends. Moreover, using these services often involves what is for some people a significant financial expenditure, as even in the cases where participants have a personal computer and internet access at home, only a few dating websites are free.

Furthermore, using online dating services for disclosing an HIV positive status transforms the risks associated with the first *moment* of disclosure through stating one's status upfront. This is only one potentially 'risky' disclosure out of many. Once someone has been met online, multiple moments of disclosure unfold over time and across different mediums. For example, real names, physical address, telephone numbers, likes and dislikes, and so on. This process often, though not always, follows a similar technologically mediated trajectory in which interactions move, more or less slowly, across different technical devices. After having met someone on a website, interactions usually move to personal e-mail addresses, through to phones, and finally to face-to-face meetings, initially in a public place. This typically progresses over a period of time (sometimes a very long time) during which levels of disclosure increase in parallel with the participants' deciding if they want to continue the relationship.

For example, Queenie met her HIV positive boyfriend, with whom she now lives, on an HIV dating website. As she describes below, after meeting online they stayed in contact via phone for over a year before eventually moving in together:

At first I didn't pay for it I just signed it up and put the whole profile thing and just left it, I thought I will just wait and see what happens. I never logged in to chat to anyone or that. I just knew if someone was interested they would email me and I would get the email and reply to them. And that's what I did for like, I think a few months, three months or so before I actually met him. And we just got to know each other, it was just over the phone because I was in [name of city] then and he was in [name of another city] and we would speak for ages.

In Queenie's case she was happy about how things had worked out, but the experiences of many others were not so straightforward or successful. Often, due to various suspicions, or sometimes simply deciding that the person in question was not suitable, the contact would end. The point at which this regularly happened was when a shift was made from text to voice communication, where participants said they felt they got a better feel for the person. Sometimes, very small markers were used to gauge this, such as whether the person gave them a landline number or only a cell phone to contact them on (the former or both was considered preferable).

Although many factors influence the commencement and relative success of a relationship in this context, what is significant here is that the practice of an upfront disclosure of an HIV positive status plays a key *initiator* role. The HIV-related literature provided to patients

stresses that disclosure is a process and frames the actual imparting of information about one's HIV positive status as the culmination of that process (Petronio, 2002; Greene et al., 2003). The use of HIV dating websites mediates the ethics of intimacy in part by reversing this order. Instead of being an end point, disclosing one's HIV status is turned into the starting point for the subsequent sharing of information and the formation of a relationship. Indeed, in some cases it is a fundamental basis for any further relations, which has significant consequences both for the person with whom the relationship is formed and for the nature of the relationship.

Viral-sociality: Mutual responsibility and sharing the virus in other ways

Emma was married when she was diagnosed with HIV, but when her husband went for a test his result was negative. At the time of our interview, though still legally married, they had decided that it was no longer possible for them to live together. As Emma put it:

We're not talking about it, but it's something we've agreed on that it can't work. That it can't work for him. It's out of my mind now. People are different. You know. It's maybe something I can't [pause] I can't just [pause] uhm [pause] deal with him anymore.

Talking about how her HIV diagnosis had affected their relationship was visibly upsetting for Emma, but she was adamant that she now wanted to be in a relationship with someone who was also HIV positive: *'I want somebody with the same stature [sic] ... it is difficult, but uhm it's something I would prefer.'*

Homophily, the tendency to seek people with similar characteristics and preferences to oneself, is a well-documented aspect of online dating (Fiore & Donath, 2005), which has been discussed in some depth in relation to MSM who use the internet for serosorting (Bolding et al., 2005; Davis et al., 2006; Dodds et al., 2009; Race, 2010). Similarly, many, although of course not all, of the women I spoke to said, like Emma, that they preferred to date HIV positive men. However, when someone expressed a preference for a positive partner, it was by no means the only criteria upon which a decision to pursue further interaction was based. In addition to various personal preferences (ethnic background, language, education, religion, physical appearance etc.), many interviewees said they specifically sought ‘*responsible*’ or ‘*good*’ partners. For example, throughout our interview Emma stressed that she wanted to meet HIV positive men who were both ‘*responsible*’ and ‘*healthy*’: ‘*So I spoke with one of the nurses if they’ve got, you know, a particular website that it’s very good to meet people that are responsible, you know what I mean ...*’.

The notion of a ‘*responsible*’ person is clearly multifaceted and culturally contingent, but, in this context, a key constituent of the responsibility interviewees alluded to was the acknowledgement of and adherence to accepted HIV prevention practices (disclosure, condom use etc.) and, where applicable, treatment. Thus, being responsible meant adhering both literally and figuratively to the regime of ‘*living with HIV*’ in order to live as healthy and ‘*normal*’ a life as possible and hence be able to be a ‘*good*’ mother, wife, citizen etc. While the use of online dating services was not considered the only indicator of such responsibility, it was deemed significant in that the people who used these websites were acknowledging their status and proactively disclosing to potential partners. When seen from this perspective, disclosing one’s status on an HIV positive dating website serves, firstly, as a means of constituting *oneself* as an ethical person, and secondly, as a way of measuring the

ethical standards of *others*. Hence, while Emma asked the nurse about a website for meeting people who were ‘responsible’, others felt that simply using these websites were positive indicators of prospective partners’ responsibility and, crucially, their adherence to *doing* HIV in the appropriate way.

Yet selecting a partner who is *both* HIV positive *and* responsible (in the sense outlined above) is linked to how being in a relationship *as an HIV positive person* not only implies being in a relationship *with someone who also has HIV*, but being in a relationship *with the virus*. This entails two different aspects of ‘living with HIV’. Firstly, it means dealing with the issues of infectivity, criminalisation, stigma and discrimination discussed at some length earlier in the article. Secondly, it means *sharing* a life with HIV, in the sense of living with HIV *together*. This can be seen in the way in which Queenie spoke of her relationship with her HIV positive partner where she described it as mutually supportive, both emotionally and practically – they attended the same clinic, reminded each other to take medication and regularly discussed HIV:

At least I have someone to speak to. That is what I really needed, someone that was in my situation that could understand what I was going through, that I could actually relate to. You see my dad, I know he loves me, I know he cares for me, but it’s kind of different when he isn’t actually in your shoes.

The relevance of the use of HIV dating websites cannot, therefore, be equated simply with the pursuit of romance and/or sex *and* avoiding transmitting the virus. The use of these services for disclosing information and selecting partners is also crucially linked to enacting a particular mode of ‘living with HIV’ premised on certain ethical, emotional and practical

expectations – mutual disclosure, mutual responsibility, mutual medical adherence, living with and sharing the virus *without* infecting others. And it is precisely this combination of sharing while not sharing that is encapsulated in the concept of viral-sociality.

Here, I have focused on how the selection of partners is linked to the enactment of responsibility in relation to ‘living with HIV’ and, in particular, ‘positive prevention’. There are, however, multiple factors at play in what comes to count as a ‘responsible’ or ‘good’ partner in this context. Some especially notable ones that, like those discussed above, cut across the interviews, related to the gendered racialization of the virus. For instance, in relation to the quotations shown earlier, Kerry attributed the reason for her partner’s resistance to condoms to ‘*some black mentality*’ and Emma regularly mentioned how ‘*ignorant*’ a great deal of people from Africa (both men and women, but particularly men) were about HIV. This theme, in which African men (regardless of their specific cultural, religious, national or ethnic background) were framed as unable to accept and behave appropriately with regards to HIV, recurred in research interviews. In some cases this was expressed so strongly that the use of HIV dating websites to select ‘responsible’ partners included references to race and/or ethnicity as a marker of the prospective partners’ ethical integrity.

Very similar sentiments have been expressed by African women living with HIV in other research, in which African men were often spoken of as being uninformed, untruthful or in denial when it came to HIV (Ridge et al., 2007; Doyal, 2009). While not the focus of this article, this is a complex issue that is clearly implicated in partner selection and online dating that deserves further exploration in relation to the enactment of both ‘African’ masculinity and femininity in the HIV field; echoing media portrayals of ‘monstrous’ African masculinity

in relation to criminal prosecutions of HIV infection (Persson & Newman, 2008) and the broader, much criticised, stereotype of the 'promiscuous black African male' (Doyal et al., 2009, p.1904).

Conclusions

The internet has been foregrounded as a technology that people affected by different health conditions use to support each other, raise awareness, fundraise and lobby for social change. Analyses of online content pertaining to different conditions, such as bipolar disorder and Huntington's disease (Rose & Novas 2005), have been explicitly used to explore different aspects of biosociality. In this article I have focused on how women living with HIV use dating websites to seek out and meet sexual/romantic partners, conceptualising these practices and their outcomes as viral-sociality.

Starting with an analysis of HIV dating websites, I suggested that these services (in terms of presentation, content and use) form part of a broader enactment of 'living with HIV' in the 'post-AIDS' HAART era. In this mode of 'living with HIV', the virus is compared to other chronic conditions, such as diabetes or hypertension, and patients are told they can live 'normal' lives, including being able to form sexual/romantic relations. However, the ability to enact this normality is contingent on a number of factors; key among these, in the case of forming sexual/romantic attachments, is adherence to a particular ethics of intimacy in which people living with HIV are required to engage in 'positive prevention'. Thus, rather than the use of these dating services signalling a rupture from earlier assumptions and expectations around the sexual practices and moral obligations of people living with HIV to protect others from the virus, they are presupposed by this legacy.

In this article I have focused on the tension underlying living a ‘normal’ life with HIV while adhering to an ethics of intimacy that is not only extremely difficult to put into practice, but is fraught with complexity and inconsistency. One of the key dimensions of this ethics of intimacy is that people with HIV are expected to disclose their positive status to sexual partners as a means of protecting them from infection. However, even though disclosure of a positive status is framed as an individual right, in practice decisions on disclosure come about through a multiplicity of, sometimes contradictory, rights and responsibilities. While, on the one hand, people diagnosed with HIV are told that disclosure is their decision, on the other hand, disclosure to sexual partners is enacted, both legally and ethically, as an imperative for HIV positive people in order to prevent them transmitting the virus to uninfected others.

Despite the emphasis placed on disclosure, in many cases simply disclosing to a current or prospective partner does not result in the adoption of the expected protection mechanisms (Rhodes & Cusick, 2000; Kippax & Race, 2003; Stevens & Galvao, 2007). As a consequence, when applied in isolation, disclosure of an HIV positive status provides only a very partial form of protection. In order to circumvent this inadequacy and to avoid the many risks implied in having sexual relations with an HIV negative partner, many participants expressed a strong preference for HIV positive partners. When analysed in this context, participants’ emphasis on the internet as a technology that facilitates disclosure and selection is more than a matter of individual agency or preference. It is also a means whereby people living with HIV navigate the numerous, often contradictory, agencies and responsibilities at play in the ethical field in which the regime of ‘living with HIV’ operates.

Drawing on the concept of mediation developed by Bruno Latour (Latour, 2002, 2005), I have argued that dating websites are used to mediate the risks and complexities of this ethics

of intimacy while enabling people living with HIV to put the ethical expectation of protecting others into practice. However, in delegating disclosure to these websites, the HIV positive women I interviewed did not simply circumvent these risks; rather, their use of these services transformed them in unexpected ways. Furthermore, in addition to emphasising the ethics of disclosing an HIV positive status, many interviewees expressed a strong preference for HIV positive partners and spoke of using dating websites as a means of meeting them.

While the need to disclose an HIV positive status is accepted as an essential component of positive prevention, it is often not deemed a sufficient mechanism for preventing the infection of sexual partners. Therefore, to ensure they do not spread the virus, some people with HIV actively seek out HIV positive partners – a phenomenon known as ‘serosorting’. In proposing the notion of viral-sociality, however, I have argued that seeking out partners who are also living with HIV is not solely about avoiding spreading the virus. It is also, crucially, about sharing the virus in other ways; living with the virus *together*. Thus, viral-sociality is both a manifestation of the success of attempts to normalise HIV and an indication of its failure to do so. Indeed, the use of dating websites premised on a *shared* HIV infection draws attention to the paradoxes underlying the enactment of HIV as just another chronic illness. For, insofar as HIV dating websites are designed to enable the formation of relationships specifically between people already living with HIV, they facilitate a mode of normalisation that is not the antithesis of exceptionalism, but is enacted through it. Even though these websites were usually presented by interviewees in a positive light (as making disclosure and partner selection easier, and thus helping them to form sexual/romantic relations); these services are needed because HIV continues to be stigmatised and its transmission criminalised. This creates a situation in which the formation of positive identities and subjectivities (romance,

mutual respect, health and family life) is *built on* the supposedly negative, stigmatised ones of viral transmission and patienthood.

Although I have focused on the use of HIV dating websites, disease-specific online dating services are not limited to HIV or other sexually communicable conditions. There are dating websites for people with diabetes (<http://diabeticdate.com>), people with various disabilities, including those linked to chronic illnesses (<http://www.enableromance.com>), and cancer survivors (<http://www.cancermatch.com>). The forms of sociality enacted through the use of these websites will of course differ from that of viral-sociality, but the very existence of these sites raises further questions about the role that dating and forming relationships plays in different emergent paradigms of 'living with' rather than 'coping' or 'dying' with disease.

Notes

¹ Forty-one women were interviewed during the course of 2009. Interviewees came from thirteen different countries: Angola, Burundi, Democratic Republic of Congo, Gambia, Ghana, Kenya, Nigeria, Sierra Leone, Somalia, South Africa, Uganda, Zambia and Zimbabwe, and had diverse cultural and linguistic backgrounds. All of the interviewees were black African, and had been living in the UK for differing lengths of time and had different immigration statuses. Some were European passport holders or permanent residents; others were on student or work visas, were asylum seekers or had other unresolved immigration statuses.

² At the time of writing, according to the latest figures from the Health Protection Agency approximately 15,400 of the 69,250 people diagnosed with HIV in the UK are African-born women. This is less than the number of MSM (29,800) and over double the number of African-born heterosexual men diagnosed (7,300). For latest figures and detail about these statistics see the HIV section of the Health Protection Agency website: <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV>.

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