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# 'I did not have sex outside of our bubble': changes in sexual practices and risk reduction strategies among sexual minority men in Canada during the COVID-19 pandemic

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**ABSTRACT**

In efforts to prevent the spread of COVID-19, jurisdictions across the globe, including Canada, enacted containment measures that affected intimacy and sexual relations. This article examines how public health measures during COVID-19 impacted the sexual practices of sexual minority men— gay, bisexual, queer and other men who have sex with men—and how they adopted and modified guidelines to prevent the transmission of COVID-19, HIV and other sexually transmitted infections (STIs). We conducted 93 semi-structured interviews with men ($n = 93$) in Montreal, Toronto and Vancouver, Canada, between November 2020 to February 2021 ($n = 42$) and June to October 2021 ($n = 51$). Across jurisdictions, participants reported changes to sexual practices in response to public health measures and shifting pandemic contexts. Many men indicated that they applied their HIV/STI risk mitigation experiences and adapted COVID-19 prevention strategies to continue engaging in casual sexual behaviours and ensure sexual safety. 'Social bubbles' were changed to 'sex bubbles'. Masks were turned into 'safer' sex tools. 'Outdoor gathering' and 'physical distancing' were transformed into 'outdoor sex' and 'voyeuristic masturbation'. These

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strategies are examined in connection to the notion of 'reflexive mediation' to illustrate how sexual minority men are simultaneously self-responsibilising and resistant, self-monitoring and creative.

## Introduction

In March 2020, the World Health Organization (WHO) declared SARS-CoV-2, the virus responsible for the coronavirus disease (COVID-19), a global pandemic. Since then, over 456 million people globally have been infected and 6 million have died (WHO 2022). As of February 2022, approximately 3.1 million infections and over 35,000 deaths had been recorded in Canada (PHAC. 2022). Canada's municipal, provincial and federal governments enacted various measures to try and contain COVID-19 transmission, including lockdowns, curfews and 'stay-at-home' orders. Directives were also issued requiring people to wear masks, physically distance, handwash, test for COVID-19 symptoms and be vaccinated (Public Health Ontario 2021). Recognising the importance of social contact, some provincial public health agencies advised individuals to create 'social circles' or 'social bubbles' early in the pandemic (May-June 2020). These ranged from six people in British Columbia and up to 10 people in Ontario and 12 in Quebec (BCCDC 2021; Ontario Ministry of Health 2020; Quebec Ministry of Health and Social Services 2020). Due to natural ventilation, public health officials also promoted outdoor social gatherings as a lower-risk option (PHAC, 2021a).

Some public health agencies also addressed the impacts of these measures on sexual health. Despite recommendations to masturbate alone or have virtual sex, the British Columbia Centre for Disease Control (BCCDC 2020) acknowledged that '[p]eople can, will and should continue to have sex during the COVID-19 pandemic'. The BCCDC instructed people looking for partners outside of their bubbles to avoid kissing, wear masks and limit face-to-face contact. In July 2020, the BCCDC endorsed glory holes, which allowed for sexual connections without face-to-face contact, generating considerable media attention (BCCDC 2020; Woods 2020). Toronto Public Health (TPH) did not recommend sex with partners outside their households, suggesting engaging in sexting or virtual sex instead (Georgieva 2020). Similarly, the Institut national de santé publique du Québec (INSPQ) endorsed telephone calls or virtual dates as alternatives to physical sexual contact (Macdonald 2020). By November 2020, TPH revised its strict no in-person sex guideline by recommending individuals to use masks and explore sexual positions that prevent face-to-face contact (Paltsev 2020). These instructions were identical to those provided by the Public Health Agency of Canada (PHAC) and BCCDC (Montgomery 2020). In Quebec, the INSPQ continued to advise partners to use caution before meeting each other and follow health standards (Macdonald 2021). These variations in guidelines reflect differences in COVID-19 prevalence and the variety of control measures imposed by different Canadian jurisdictions over time.

COVID-19 has wide-ranging effects on the sexual health and behaviours of sexual minority men — gay, bisexual, queer and other men who have sex with men. Several studies have shown that sexual relations among gay men declined when lockdowns were initially enacted in Australia (Chow et al. 2021; Hammoud et al. 2021) and Belgium (Reyniers et al. 2021). In Canada, many men reported engaging in more virtual sex

during the early months of COVID-19 and limiting encounters with new sexual partners (Grace et al. 2021). Other studies indicated that, between March-June 2020, some men who have sex with men in the USA continued high levels of sexual activities, which often coincided with increased substance use (Stephenson et al. 2021). In the UK, casual sex continued, but most men reported fewer partners (Hyndman et al. 2021).

Beyond examinations regarding sexual frequency and number of partners, studies of how sexual minority men assessed COVID-19 sexual risks and what strategies they implemented to prevent COVID-19 during sexual encounters remain scarce. Research conducted in the early stages of the pandemic found that many men took precautions when engaging in sex during COVID-19. These measures included requesting that partners be tested for COVID-19, temporarily becoming sexually abstinent, limiting sex to regular partners, and screening partners by asking specific questions (e.g. 'Are you showing any symptoms?') (Gaspar et al. 2022; Hyndman et al. 2021; Murphy et al. 2022; Starks et al. 2022; Stephenson et al. 2021; Shilo and Mor 2020). According to Gaspar et al. (2022), these practices mirrored, in some respects, the strategies developed by gay, bisexual, queer and other men who have sex with men to reduce HIV risks, demonstrating their capacity to modify 'top-down and restrictive public health messaging into more pragmatic practices' (Gaspar et al. 2022, 123; Grace et al. 2014). Murphy et al. (2022) also argued that these strategies (e.g. restricting sex to known partners, screening, and temporal spacing of partners/encounters) indicate the use of a 'lay epidemiology' whereby gay men incorporated medical knowledge, enabling them to reconcile gaps 'between public health messages and lived realities' and tailor their sexual practices accordingly (Murphy et al. 2022, 12). Likewise, for Braksmajer and Cserni (2021), sexual minority men's COVID-19 risk reduction initiatives reflected their modification of public health measures and the adaption of their previous experiences with preventing sexually transmitted infections (STIs). Applying lessons from HIV/STI and COVID-19 prevention illustrates men who have sex with men's responsiveness to sexual risks by combining experiential and expert knowledge into practical strategies, demonstrating a 'reflexive mediation between embodied habits and medical opinion' (Race 2003, 377).

In this study, we sought to understand better how urban sexual minority men in Canada changed their sexual behaviours in response to COVID-19 public health measures. Our objective was to provide insights into how diverse gay, bisexual, queer and other men who have sex with men applied knowledge gained from HIV/STI and COVID-19 prevention to inform their protective behaviours, including those that would allow for continued in-person sex during the COVID-19 pandemic. To this end, we drew on respondents' accounts of the impact of COVID-19 on their sex lives, sexual decision-making and negotiations of safety.

## Methods

Data were derived from Engage COVID-19, a mixed-methods study conducted in Canada's three largest cities (Montreal, Toronto, and Vancouver). Embedded within the ongoing Engage Cohort Study (Cox et al. 2021; Hart et al. 2021), Engage COVID-19 examined the impact of COVID-19 on the physical, sexual and mental health of urban sexual minority men in Canada. Data collection for Engage COVID-19 began in

September 2020; participants were already enrolled in the multi-city Engage Cohort Study. Two rounds of in-depth qualitative interviews were conducted, representing a total of 93 distinct interviews at different time points. The first round (November 2020 to February 2021) involved 42 individuals. For the second round (June to October 2021), 51 new participants were interviewed. They were purposively recruited from the larger cohort along four key dimensions: ethno-racial background, age, gender identity and HIV status.

Due to public health restrictions, one-on-one interviews were conducted virtually using MS Teams. The research team developed a semi-structured interview guide in collaboration with community engagement committees in Montreal, Toronto and Vancouver, composed of service providers and members of the gay, bisexual and queer communities. Participants provided written consent electronically before the interviews, which lasted between 30 and 169 min. Interviews were conducted in English or French, depending on the participants' preferences, and were digitally audio recorded, transcribed verbatim, reviewed for accuracy and de-identified. Participants received a CAD$50 honorarium for participation in the qualitative component of the study.

The interview guide had six overarching and interconnected domains: (1) experiences and risk factors for COVID-19; (2) effects of the COVID-19 pandemic on finances and work; (3) access to health services; (4) sexual health and sexual decision-making; (5) psychological impacts, mental health and substance use patterns; and (6) additional issues of concern and closing reflections. Transcripts were entered into NVivo 12 software and coded following thematic analysis (Braun and Clarke 2006).

Our inductive coding and analysis identified semantic and latent themes following three steps. First, a sub-group of authors gained familiarity with the interviews by reading transcripts and discussing the interviewers' reflections after each interview was completed. Second, broader codes were applied to the transcripts, allowing us to organise key components of the interviews into manageable sections (e.g. sexual practices during COVID-19; public health compliance). Third, this sub-group of authors reviewed key themes and refined, named and explained trends in the data. In case of disagreements over codes, a consensus was reached through discussions among this sub-group of authors.

## Findings

Table 1 shows the main sociodemographic characteristics of participants. About 42% were in their 30s, 27% were in their 20s and 13% were in their 40s. Thirty-six per cent of participants self-identified as White, 23% as mixed race, 16% as East/Southeast Asian, 8% as Black, 6% as Latin American and 3% as Middle Eastern and South Asian. The vast majority self-identified as cisgender (81.7%) and 70% self-identified as gay. People living with HIV accounted for 21.5% of the participants.

Across the three cities, participants reported changes to sexual practices in response to COVID-19 public health measures and shifting pandemic contexts, including fluctuations in COVID-19 cases, easing/tightening of restrictions and availability of vaccinations. During the early periods of the pandemic, some men discussed complying with public health restrictions on social interactions. About one quarter (24%)

**Table 1.** Sociodemographic characteristics of study participants ($n = 93$).

| | Montreal ($n = 30$), n (%) | Toronto ($n = 33$), n (%) | Vancouver ($n = 30$), n (%) | $N = 93$ (%) |
|---|---|---|---|---|
| Age in years | | | | |
| 20s | 10 (33.3) | 8 (24.2) | 7 (23.3) | 25 (26.9) |
| 30s | 10 (33.3) | 15 (45.5) | 14 (46.7) | 39 (41.9) |
| 40s | 5 (16.7) | 4 (12.1) | 3 (10.0) | 12 (12.9) |
| 50s | 2 (6.7) | 3 (9.1) | 4 (13.3) | 9 (9.7) |
| 60s | 3 (10.0) | 3 (9.1) | 2 (6.7) | 8 (8.6) |
| Ethno-racial background | | | | |
| Black | 3 (10.0) | 4 (12.1) | 1 (3.3) | 8 (8.6) |
| East Asian/Southeast Asian | 2 (6.7) | 6 (18.2) | 7 (23.3) | 15 (16.1) |
| Indigenous | 1 (3.3) | 0 (0.0) | 1 (3.3) | 2 (2.2) |
| Latin American | 2 (6.7) | 3 (9.1) | 1 (3.3) | 6 (6.4) |
| Middle Eastern | 1 (3.3) | 1 (3.0) | 1 (3.3) | 3 (3.2) |
| Mixed Race/Ethnicity | 8 (26.7) | 6 (18.2) | 8 (26.7) | 22 (23.7) |
| South Asian | 0 (0.0) | 1 (3.0) | 2 (6.7) | 3 (3.2) |
| White | 13 (43.3) | 12 (36.4) | 9 (30.0) | 34 (36.6) |
| Gender identity | | | | |
| Cisgender | 25 (83.3) | 28 (84.8) | 23 (76.7) | 76 (81.7) |
| Non-binary | 2 (6.7) | 1 (3.0) | 3 (10.0) | 6 (6.5) |
| Trans | 2 (6.7) | 2 (6.1) | 3 (10.0) | 7 (7.5) |
| Genderqueer | 1 (3.3) | 2 (6.1) | 1 (3.3) | 4 (4.3) |
| Sexual identity | | | | |
| Bisexual | 4 (13.3) | 5 (15.2) | 3 (10.0) | 12 (12.9) |
| Gay | 23 (76.7) | 22 (66.6) | 20 (66.7) | 65 (69.9) |
| Pansexual | 0 (0.0) | 0 (0.0) | 1 (3.3) | 1 (1.1) |
| Queer | 3 (10.0) | 6 (18.2) | 6 (20.0) | 15 (16.1) |
| HIV Status | | | | |
| HIV-Negative | 23 (76.7) | 25 (75.8) | 25 (83.3) | 73 (78.5) |
| Living with HIV | 7 (23.3) | 8 (24.2) | 5 (16.7) | 20 (21.5) |

reported temporarily abstaining from sex and avoiding sexual contact; a third of individuals (33%) described engaging in temporary monogamy. Over 40%, however, reported continuing in-person sexual relations. To reduce COVID-19 transmission, some of these participants limited sex to regular partners. Others indicated engaging in sexual relations with first-time, sometimes anonymous, partners while using some COVID-19 safety precautions, including: asking for COVID-19 status; accounting for local COVID-19 cases and variants of concern; mask wearing; and physically distant and outdoor sex. When COVID-19 vaccinations became widely available and certain restrictions were lifted, several participants reported increased sexual activities and added 'vaccine sorting' into their sexual practices. Many men indicated applying their HIV/STI risk mitigation experiences and adapted COVID-19 prevention strategies to maintain sexual engagement and safety during the pandemic.

### *Changes in frequency of sexual behaviours and number of sex partners*

Participants' accounts revealed adherence to public health measures and modifications of sexual behaviours during the various stages of COVID-19 restrictions in Montreal, Toronto and Vancouver. First, some single men who were sexually active pre-pandemic temporarily abstained from in-person sexual engagements. Several single individuals, however, described participating in virtual sex. Second, the implementation of COVID-19 restrictions led to a temporary closure of open relationships among a small number of

couples. Third, many participants described continuing sexual relations only with regular partners. The three study sites/cities were all under various public health restrictions and COVID-19 vaccines were not yet widely available when the first round of interviews (November 2020 to February 2021) was conducted. Conversely, there was an increase in sexual activities when COVID-19 infections were lower, some restrictions were relaxed and COVID-19 vaccinations had become widely available during the second round of interviews (June-October 2021). Participants who had received two doses of the COVID-19 vaccine reported resuming sexual engagements.

### *Temporary abstinence*

During the first round of interviews, several single participants indicated that they had temporarily paused in-person sexual relations since the outbreak of COVID-19:

> Just have not done anything for a whole year. (20s, HIV-negative, Mixed Race, Toronto)

> So, I have not seen anyone since March [2020], since the lockdown was officially announced. (20s, HIV-negative, East Asian, Montreal)

Some men ascribed their abstinence to protecting vulnerable people they lived with (e.g. immunocompromised parents), implying that they considered other people's health when deciding to refrain from sex temporarily:

> So, I see my psychiatrist and he always reminds me that if I have sex with other people, I put risk to my [parent who's getting treatments] [ … ]. So, I always remind myself not to have sex with others. (30s, HIV-positive, East Asian, Vancouver)

Although some men did not practise in-person sexual activities, a few participants shared that they participated in virtual sex: 'At the height of the pandemic, there was [ … ] no interaction with anybody. It was all virtual' (50s, HIV-negative, Middle Eastern, Vancouver).

The periods of abstinence described by these men were temporary and coincided with COVID-19 restrictions: 'I was pretty much abstinent from March until late September [2020]' when some lockdowns in Ontario were eased (30s, HIV-negative, South Asian, Toronto). When COVID-19 vaccines became widely accessible, some men resumed their 'normal' sexual practices:

> Before the pandemic, I had a very active sexual life [ … ]. When the pandemic came, it was as if my sex life ceased to exist [ … ]. It also changed when I got my two vaccines. I felt more comfortable seeing other guys [ … ]. It was like a return to normal. (Translated from French, 20s, HIV-negative, White, Montreal)

### *Temporary monogamy*

Some couples practising open relationships before the outbreak of COVID-19 closed their relationships temporarily and became monogamous to reduce their exposure risk: 'I think there was more [ … ] sleeping with other people [ … ] pre-COVID. That's really changed because once COVID hit, the power to ensure mutual health between our partnership [was] foremost priority' (20s, HIV-negative, Mixed Race, Toronto). This pattern of becoming monogamous was also observed during the AIDS crisis (Connell et al. 1989; Siegel et al. 1988).

Another reason for temporary monogamy described was to ensure the health of their partners who were at higher risk due to being older and having health issues:

> Now that cases are getting a little bit to scary levels, I'm concerned that if I get it [ … ], I would be quite worried about my health, especially because my partner's older and he's got some health problems. (20s, HIV-negative, Mixed Race, Vancouver)

Adherence to public health guidelines was also reported as a motivation for temporarily becoming monogamous:

> We can't really sleep with anybody else because of the quarantine rules and mixing of households [ … ]. Because of that, neither myself nor my partner are sleeping with anybody else. (20s, HIV-negative, Mixed race, Toronto)

Participants shared that closing their open relationships was a 'temporary situation' and some had resumed their open relationships since receiving vaccinations: 'Now that we're all vaccinated [ … ], we're starting to have those encounters again' (20s, HIV-negative, Mixed Race, Toronto). However, some men indicated that they delayed resuming sexual relations with others due to concerns about the COVID-19 Delta variant at the time of their interview (August 2021)[1]:

> We're still not confident enough to meet up with other groups yet. We were almost there [ … ] and then all the Delta stuff and [ … ] you know, you can still get infected with the vaccine and everything. We figured it was probably best to wait another month or two and see how things pan out. (20s, HIV-negative, White, Toronto)

### *Sex with regular partners*

Compared to the participants above, almost a quarter of men sometimes reported reducing the number of casual sexual partners, so much so that they referred to their remaining casual partners as 'regular' partners: 'During the past six months, I was just seeing casual regulars' (20s, HIV-negative, Mixed Race, Montreal). Having sex with regular partners made them feel safer:

> There are [ … ] three people I've been intimate with during the COVID-19 period, and they're the same as prior [ … ]. I think because I feel comfortable with them, I know them well [ … ], it's not simply having sex. (40s, HIV-positive, White, Toronto)

For these men, limiting sex to partners they already knew and trusted was essential to managing COVID-19-related sexual risks: 'Especially with COVID, I think it's even more important to limit myself to [the] ones I know' (50s, HIV-negative, Mixed Race, Vancouver). It was also understood as a way of mitigating not only COVID-19 but also HIV/STI risks:

> It was kind of nice to maybe not to worry about [ … ] like STI prevention and stuff like that. Being like, "Ok, we know each other has been tested … " (30s, HIV-negative, White, Vancouver)

Engaging in sexual behaviours with regular partners was further described as maintaining or forming a 'sex bubble', borrowing language from COVID-19 public health messaging around social bubbles:

> I was bubbled with a guy [ … ], he was lovely, and we decided to do that together [ … ]. So, I live alone, and he lives alone [ … ]. It was nice but also COVID-related [ … ]. I would

> trust that [he] would only be seeing me versus seeing lots of other people. (30s, HIV-negative, White, Vancouver)

Some men attributed the idea of sex bubbles directly to public health guidelines: 'It was largely a by-product of the guidelines we were initially given [ … ]. I wouldn't be making these decisions if I didn't have that initial framework' (30s, HIV-negative, South Asian, Vancouver).

In second-round interviews, as vaccine availability grew, some participants reported resuming sexual relations but only with regular partners and with an added check for vaccination status:

> [I] had a lot of guys who were interested, but I said no. My priority is on the regular guys. But [ … ], vaccination was key to my agreement on [the] assessment of their risk. (70s, HIV-positive, White, Toronto).

## *COVID-19 risk mitigation strategies for continued casual sex*

Some participants described continuing in-person sexual relations with first-time, sometimes anonymous, sexual partners despite the pandemic. Our participants' sexual practices evolved along with the pandemic's epidemiological context, requiring them to adapt many public health precautions, including asking for COVID-19 status; accounting for local COVID-19 cases and variants of concern; mask wearing; and physically distant and outdoor sex. A recent inclusion was 'vaccine sorting', which emerged in the second round of interviews after more participants had received COVID-19 vaccines. Many participants indicated how their HIV/STI experiences and knowledge acquired from COVID-19 prevention helped them navigate sexual safety during the pandemic.

### *Asking for COVID-19 symptoms, status, and safety behaviours*

Some men reported inquiring about COVID-19 symptoms and safety behaviours to screen potential sexual partners. For them, such questions 'had become a thing to ask': 'If they had been safe [ … ], how often do they go out, or if they use a mask when they go out' (20s, HIV-negative, Latin American, Toronto). As part of their sexual screening process, some participants also discussed requiring proof of a COVID-19 negative test or whether their potential partners were showing any COVID-19 symptoms.[2]

> If they have proof, I'd be down to go ahead and have sex. If they didn't, I just tell them to get tested because it doesn't really take long to get the results. (20s, HIV-negative, Mixed Race, Toronto)

> I guess I started asking them if they have tested for COVID or if they are feeling fine [ … ]. If I ask for STD, I would ask that [COVID status] and then STD. (20s, HIV-negative, Mixed Race, Montreal)

This reference to 'STD' demonstrates how knowledge about HIV/STI lends itself to COVID-19 risk reduction strategies. Other participants mentioned drawing on their previous experiences of safer sex to understand and negotiate COVID-19 risk:

> Just like you would with an STI, or about HIV or something [...]. It would be literally as an STI. "Oh, I may have been exposed, you might want to get tested," or whatever. (20s, HIV-negative, Mixed Race, Montreal)

> I guess like with having sex, or back then with HIV, they said if you sleep with a guy, you were sleeping with everybody that guy has been sleeping with. And that's the same thing I guess with COVID-19. (50s, HIV-negative, Mixed Race, Vancouver)

These excerpts suggest that some participants had integrated the methods of HIV/STI and COVID-19 prevention and control by incorporating contact tracing into their COVID-19 safer sex practice.

Although some men appeared to have seamlessly incorporated asking about COVID-19 symptoms and status into their safer sex strategies, participants living with HIV expressed some uneasiness about screening potential partners that way:

> It's kind of an awkward situation when it's just a random hook-up. But it's like, "Hey, have you been COVID safe?" And they're like, "Yeah, I do." And you just have to trust that they do. (30s, HIV-positive, Mixed Race, Toronto)

> I think people are very sensitive to [COVID-19] questions. More sensitive than me asking a guy, "Are you negative or positive?" I mean, it's just like asking the same questions, but it'll be in a more medical way like, "Do you have any flu-like symptoms?" They would be really annoyed [...]. That's why I find it even harder to meet someone, even if it's just sex. (40s, HIV-positive, East Asian, Vancouver)

### *Accounting for local COVID-19 cases and variants of concern*

Some participants described factoring local COVID-19 case counts into their risk reduction strategies. In particular, they assumed that lower case counts would reduce their risk of COVID-19 infection:

> I hooked up twice after the pandemic started [...]. They were one-night stands, so definitely random partners. It was when cases were very low, summertime. The risk was still there, but it was quite minimal compared to what it was in the winter months. (30s, HIV-positive, Mixed Race, Toronto)

Another participant shared that he had 'a lot less sex in 2020 because of COVID' but had resumed sexual relations because 'it's summertime [and COVID-19 cases are lower]'. However, he noted that he would likely 'go back to remission again during the winter when the Delta variant's also high up' (20s, HIV-negative, East Asian, Vancouver).

### *Mask wearing*

Mask wearing was another strategy some participants had used when engaging in sex earlier in the pandemic:

> A couple of times I got fucked and were both wearing masks [...] because it was like peak of the pandemic. (30s, HIV-negative, White, Vancouver)

> I met a guy. He came to my place. He told me, "Well, when you want to suck me, you'll take off your mask [...]." But he said, "for the rest, it's really not practical because if I fuck you, it will be exhausting with my mask... I'm going to choke in my mask," and he said, "Let's not do it! I will finish in your mouth." (Translated from French, 50s, HIV-negative, Mixed Race, Montreal)

While these men embraced mask wearing, this measure was not reported as widely adopted within sexual contexts: 'When someone tells me that we can have safe sex by wearing a mask, I don't [think it's] true' (20s, HIV-negative, Mixed Race, Vancouver). Some also described wearing masks during sex as inconvenient, choosing instead to abstain from sex during the pandemic:

> I wasn't hooking up during lockdown. I wasn't hooking up pre-vaccine rollout. But I know people were using masks [...]. Those options were available to me if I was active at that time [...]. And even if I was active, I probably [...] would've abstained from sex altogether. Just because at that point, it's not really sex. That's mechanical choreography. (30s, HIV-negative, Black, Toronto)

Some men further felt that mask wearing during sex overcomplicates an already complex process of safer sex:

> Having safe sex already has a lot of protocols [...]. And then there's masks, and there's like safety stuff. So, I was like, "No, thank you." (20s, HIV-negative, East Asian, Toronto)

### *Physically distant and outdoor sex*

Outdoor sex in public parks has been portrayed in the media as 'risky,' owing to the possibility of being discovered, physically harmed, or arrested (Hennelly 2010). However, in the context of COVID-19 transmission, a small number of participants redefined public sexual encounters as 'safe'. Such reframing may have been adapted from public health recommendations regarding physical distancing and the relative safety of outdoor gatherings (PHAC, 2021a). Outdoor sex was also promoted as a safer sex option during the pandemic by some HIV prevention activists (e.g. Prepster 2020). Some participants indicated adopting this strategy:

> What I started to do a while ago was go and hang out at the cruising areas. Outside, only outside. Not any of the inside washrooms [...]. And that's specifically because of COVID. (40s, HIV-negative, Mixed Race, Toronto)

When cruising outdoors, participants also avoided physical contact by masturbating and watching others, described as a 'socially distanced hook-up' and 'probably a good [COVID-19] prevention strategy' (30s, HIV-negative, White, Vancouver).

The use of glory holes was also described as an additional COVID-19 safety measure, a strategy informed mainly by the BCCDC's (2020) guidelines regarding the safety of glory holes to limit face-to-face contact when having sex during the pandemic:

> I got much more acquainted with glory hole experiences. You know, they seemed safer. No idea whether they are, but sure, we were told they are! (30s, HIV-negative, Mixed Race, Vancouver)

### *Vaccine sorting*

When the second round of interviews was concluded in October 2021, close to 74% of Canada's eligible population had received two doses of the COVID-19 vaccine (PHAC. 2021b). Many participants who reported double vaccination status described resuming sexual engagements because they were now 'less concerned about transmitting COVID' (30s, HIV-negative, Mixed Race, Montreal).

Being vaccinated, however, did not result in relaxed attitudes towards resuming sexual engagements for some participants: 'I'm just going to wait until everything goes back to normal [...]. I've got a couple of regular partners now and I'm just happy with that' (20s, HIV-negative, White, Vancouver). COVID-19 variants also affected sexual behaviour: 'All the stuff about the Delta [variant] started coming out and how vaccinated people are getting re-infected. So, I was right back to: "All right, we're being careful, we're being safe"' (20s, HIV-negative, White, Toronto).

Vaccinated participants reported incorporating 'vaccine sorting' into their safer sex repertoire, asking sexual partners about their vaccination status and only having sex with other vaccinated individuals: 'I'm double vaccinated, and I make sure that the other partners have been as well' (30s, HIV-negative, Black, Toronto). Participants further compared vaccine sorting to HIV prevention:

> It might be similar to an HIV prevention strategy where I'm vaccinated, so it's like I'm on PrEP [...]. It's like talking to someone who's like, "I'm poz, but I'm undetectable" or "I'm on PrEP too." (30s, HIV-negative, White, Vancouver)

Those who implemented vaccine sorting remarked that they simply 'trust[ed] people's word for it' since 'a lot of folks are saying it on their profiles on Tinder and Grindr' (30 s, HIV-negative, Black, Toronto). In contrast, some men described explicitly asking for vaccination proof from new partners:

> If I know them fairly well, I won't ask for actual proof. But if it's someone I don't know very well [...], I would ask for proof of vaccination. (30s, HIV-negative, East Asian, Toronto)

## Discussion

This study provides insights into how the shifting pandemic context influenced sexual minority men's sexual decision-making. Findings show that men have used COVID-19 guidelines and their acquired knowledge of HIV/STI to adapt sexual behaviours and mitigate sexual risks during the pandemic. However, while participants have adapted some HIV/STI strategies, COVID-19 safety seemed to have been prioritised, lowering the assumed priority of HIV/STIs in risk reduction during a concurrent pandemic.

Some participants were still hesitant to engage in casual sexual behaviours at the beginning of the pandemic. However, as some restrictions were relaxed and COVID-19 vaccinations were made widely available, some men reported becoming more open to resuming their sexual activities, provided that they and their partners had received two doses of the vaccines. This practice of 'vaccine sorting' as a risk-reduction strategy specific for COVID-19 shares similarities with the logic of HIV risk reduction 'sorting' strategies, including serosorting (Blackwell 2015; Grov et al. 2015), viral load sorting (Grace et al. 2015, 2021) and PrEP sorting (Martinez and Jonas 2019). Applying experiential knowledge of HIV/STI prevention to COVID-19 provides evidence that sexual minority men are reflexive and 'savvy consumers of sexual health information' (Grace et al. 2014, 324). Similar to HIV/STI prevention strategies, our participants' COVID-19-related sexual risk management practices were developed through an iterative and

collective process involving negotiation, experimentation and sharing information with others (Race 2003).

Incorporating and adapting COVID-19 public health knowledge and directives into techniques of sexual safety reflect a form of reflexive mediation (Race 2003). Instead of just applying health directives in a top-down fashion, developing preventive behaviours required the participants' inventiveness in transforming public health policies into practical tactics (Gaspar et al. 2022; Grace et al. 2014; Race 2003). Using COVID-19 public health information to create various strategies demonstrates how participants cultivated a degree of lay epidemiology (Murphy et al. 2022). This capacity to foster lay epidemiology and become reflexive consumers of COVID-19 public health information cuts across the participants' age, ethnicity, serostatus and gender and sexual identities. Future research, including complementary quantitative analysis, is needed to further understand the extent to which differences in sociodemographic factors (including income and education levels, ethnicity, serostatus and gender and sexual identities) shape sexual minority men's incorporation of COVID-19 risk reduction strategies into their everyday social and sexual lives.

The development of these strategies needs to be understood in the context of neoliberal discourses around disease prevention that invite individuals to self-regulate and self-discipline (Adam 2005). By adhering to COVID-19 public health measures and creating safety behaviours, participants in this study acted according to the ideas of self-responsibility, self-monitoring and self-surveillance (Braksmajer and Cserni 2021). However, we argue that their actions must be conceived as considerably more than this. They were simultaneously self-responsibilising and resistant, self-monitoring and creative. Elsewhere, COVID-19 public health restrictions such as stay-at-home orders have been identified as normalising processes that 'elevate heteronormative, romantic relationships', failing to recognise the complexity of many gay men's sexual lives (Pienaar et al. 2021, 128). These prescriptions were disconnected from the 'sociocultural meanings of sex' prevalent among sexual minority men (Newman and Guta 2020, 2260). Our study demonstrates that despite public health's shortcomings in implementing COVID-19 guidelines that foregrounded the realities of queer sex, gay men leveraged their acquired knowledge from HIV/STI prevention and modified COVID-19 public health measures to continue engaging in sexual behaviours. The creation of these preventive methods exemplifies a form of counterpublic health, in which 'subordinated groups' such as gay, bisexual, queer and other men who have sex with men devise practical and collaborative strategies that are 'remarkably effective' in ensuring sexual health and pleasure (Race 2009, 162; Pienaar et al. 2021; Murphy et al. 2022).

Furthermore, as with HIV, where sexual minority men's adoption of safer sex was motivated by altruistic concerns (Nimmons and Folkman 1999), many participants in this study also considered the health needs of others to make sense of their COVID-19-related sexual safety behaviours. These practices go well beyond the concept of self-protection and convey a sense of communal altruism in and beyond queer communities (Rangel and Adam 2014).

### *Limitations*

This study is not without its limitations. These findings are limited to men living in large urban areas in Canada. Thus, our results may not be generalisable to rural and suburban settings. Furthermore, sexual minority men may have differential abilities to manage COVID-19-related sexual risks depending on their intersectional social locations, which requires further attention for this and future pandemics. Qualitative analysis from our study focusing on the experiences of racialised men (Grey, Tian, et al. 2022) and trans and non-binary people (Grey, Sinno, et al. 2022) during COVID-19 is ongoing. Moreover, given COVID-19 restrictions, the interviews for this study were conducted online, which may have limited our sample to individuals with access to the required technology and a private place in which to be interviewed. Social desirability (Mooney et al. 2018) may have influenced some men not to report sexual activities deemed risky by public health guidelines.

## Conclusion

The analysis presented here points to the importance of further deepening understanding of sexual minority men's ability to adopt and modify public health guidelines on HIV, STIs and COVID-19 for continued engagement in sexual behaviours during the ongoing COVID-19 pandemic. Participants' accounts stand in sharp contrast to the discursive characterisations of gay men as pursuing pleasure selfishly and disregarding COVID-19 public health recommendations (Hakim, Young, and Cummings 2022). Public health institutions and policies should recognise gay, bisexual, queer and other men who have sex with men's capacity to assess and manage COVID-19 and HIV/STI risks within the ongoing COVID-19 pandemic and likely future pandemics.

## Notes

1. The Delta B.1.617.2 variant was a variation of the SARS-CoV-2 virus first identified in India. It was declared a variant of concern by WHO in May 2021.
2. The participants quoted here referred to the polymerase chain reaction (PCR) test, a test that searches for SARS-CoV-2 genetic material. It was the only free COVID-19 test avaiable at the time of their interviews (November 2020-February 2021).

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