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A qualitative evaluation of the acceptability of shigellosis prevention recommendations among gay, bisexual, and other men who have sex with men

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Abstract

Background: Shigellosis is diarrheal disease caused by highly infectious *Shigella* bacteria. *Shigella* can spread in multiple ways, including sexual contact. Gay, bisexual, and other men who have sex with men are particularly at risk for shigellosis.

Methods: To evaluate the acceptability of three CDC-developed behavioral recommendations for the prevention of sexually transmitted shigellosis, virtual in-depth interviews were conducted among twenty-six gay or bisexual men in March–May 2021.

Results: Participants had a median age of 25; 65% were Non-Hispanic White, 12% were Hispanic White, 12% Asian, 4% Hispanic Black, and 8% multiracial/other. Respondents indicated willingness to engage in certain prevention behaviors (e.g., washing hands, genitals, and anus before and after sex), but were less willing to engage in behaviors that were viewed as outside social norms or difficult to practice (e.g., dental dams for oral-anal contact; latex gloves for fingering or fisting). Respondents thought recommendations may be more feasible if knowledge of shigellosis was greater; however, some perceived that the severity of shigellosis is low and did not warrant the effort of engaging in prevention behaviors.

Conclusions: Educational efforts to increase awareness of shigellosis and other enteric diseases spread through sexual contact are needed and public health practitioners should consider the acceptability of how realistic it is for individuals to engage in certain prevention behaviors. Rather than recommending behaviors that do not have buy-in, it may be more efficacious to focus recommendations on adopting behaviors reported as acceptable to the target audience.

Summary:

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Gay and bisexual men were interviewed to evaluate recommendations for preventing sexually transmitted shigellosis and found that while some prevention behaviors seemed feasible, participants were unwilling to engage in behaviors outside of the social norm.

Keywords

Shigella; sexual behavior; MSM; infectious disease

Introduction

Shigella, the bacterium that causes the diarrheal disease shigellosis, causes ~450,000 infections and 6,000 hospitalizations yearly in the United States (1). Shigellosis is a highly infectious disease, requiring a very low infectious dose to spread through fecal-oral contact. *Shigella* spreads when hands have been contaminated by the feces of a person sick with shigellosis (2, 3). In the United States, person-to-person contact is the most common mode of *Shigella* transmission. The spread of *Shigella* through food, water, and fomites is less common (2, 4). Person-to-person transmission can occur through both non-sexual and sexual contact (2, 3).

Populations at increased risk for contracting shigellosis include young children (particularly in childcare settings), gay, bisexual, and other men who have sex with men (collectively referred to as MSM), persons experiencing homelessness, people living in crowded conditions, those living in poverty, and international travelers (2, 5–7). While shigellosis is primarily treated through supportive therapy such as hydration, antibiotics may also be prescribed for more severe infections or for persons at higher risk of infection and transmission (2).

Outbreaks and clusters of shigellosis among MSM have been reported in North America (6, 7, 9–11) and around the world (12–15). These outbreaks are of particular concern as they often involve highly resistant strains of *Shigella* (11, 14–16). Antibiotic-resistant *Shigella* has been identified as a serious public health threat and can result in illness that is difficult to treat (17). Sexual behaviors reported by MSM infected with shigellosis include direct oral-anal contact, using drugs or alcohol immediately prior to having sex, attending sex venues, and having casual or multiple sex partners (7, 9, 13, 18). MSM living with HIV infection are also at higher risk of acquiring shigellosis (7). Studies have shown that knowledge of shigellosis among MSM is low; MSM do not perceive themselves to be at risk for acquiring a sexually transmissible enteric infection (STEI) such as shigellosis and shigellosis is not perceived as a serious health concern (19–21).

CDC has developed recommendations for the prevention of shigellosis (8), including recommendations specifically for sexually active people (22). These recommendations include: wash hands, genitals, and anus before and after sexual activity; use a condom or dental dam when engaging in anilingus (“rimming”); use latex gloves when fingering or fisting; avoid having sex with a partner for at least two weeks after symptoms resolve if you or your partner has recently had diarrhea or a diagnosis of shigellosis; wash sex toys before and after each use and wash hands after touching used sex toys.

Although some work has been done examining knowledge and attitudes of MSM related to shigellosis and other STEIs, no evaluation has been conducted to assess how acceptable these recommendations are to MSM or their willingness to engage in them in the event of illness with shigellosis.

Materials and Methods

To evaluate the acceptability of three behavioral recommendations for shigellosis prevention, in-depth interviews were conducted virtually among MSM from March 1–May 31, 2021. Participants were recruited through Facebook advertisements, which targeted people using demographic characteristics (e.g., located in the United States, male, etc.) and key words (e.g., LGBTQ+). Upon clicking the advertisements, potential respondents were directed to a project webpage where they completed an online survey and were screened for eligibility. The online survey assessed interest in participating in virtual in-depth interviews about shigellosis prevention and assessed demographic and behavioral data. Eligibility criteria for participation included: 1) ability to speak and read English; 2) U.S. residency; 3) 18 years of age or older; 4) self-reported biological male sex; 5) reported sexual contact with another male at least once in the past year; and 6) reported engaging in anilingus (“rimming”) at least once in the past two years. Purposive maximum variation sampling was used to obtain a diverse group of respondents (23). From the pool of eligible respondents, the final sample was selected to maximize diversity by age, race or ethnicity, location of residence, income, educational status, marital or relationship status, and frequency of sexual activity.

In-depth interviews were conducted via Zoom among selected respondents and all interviews were audio recorded. Interviews were guided by a semi-structured interview guide that included questions on sex-related hygiene behavior and perceptions of, and willingness to engage in, the behaviors recommended by CDC for the prevention and control of sexually transmissible shigellosis discussed above. The recommendation to “wash sex toys before and after each use and wash hands after touching used sex toys” was only asked if there was time left in the interview; therefore, not all participants were asked this question and results of this paper focus on the three other recommendations. Interviews were conducted by an experienced moderator with previous experience working with gay and bisexual men and sexual health-related topics. Interviews took an average of 60 minutes and respondents were compensated with $40 for their time.

Audio recordings for the interviews were transcribed verbatim and all transcripts were reviewed for accuracy and corrected by the primary coder. Thematic coding was used to analyze transcribed data. The primary coder and a secondary coder coded five transcripts together. During these coding sessions, inductive codes were applied to segments of text, resulting in the development of a preliminary codebook. The primary coder then independently coded all remaining interviews deductively using the codes from the preliminary codebook. The codes were discussed with the secondary coder until 100% agreement between coders was reached. MAXQDA qualitative software was used to facilitate the coding process for all data and document management (MX20). This activity was reviewed by CDC and was consistent with applicable federal law and CDC policy.[1]

Results

Demographic characteristics

From March 1–May 31, 2021, 30 interviews were conducted. Of the 26 men interviewed that met inclusion criteria for the evaluation, 85% identified as gay, 12% identified as bisexual, and 4% reported another sexual identity. The racial and ethnic makeup of respondents was 65% non-Hispanic white, 12% Hispanic white, 12% Asian, 4% Hispanic Black, and 8% multiracial. Respondents had a median age of 25 years (mean: 29 years, range: 19–60 years), and all respondents had at least some college education (Table 1). Most respondents lived in urban (50%) and suburban (38%) areas. Slightly less than half the respondents were in a relationship (42%). The median number of sexual partners in the past year was 4 (mean 8, range: 1–50). Respondents were asked about what types of sexual contact they had with men in the past 24 months; 96% received oral sex, 88% performed oral sex, 77% had anal sex where they inserted their penis into their partner's anus, 73% had anal sex where their partner inserted his penis into their anus, 73% performed anilingus on someone, 69% received anilingus, 62% were fingered or fisted by someone, and 50% fingered or fisted someone.

Pre-sex Hygiene Behavior

Personal Hygiene—Respondents were asked what hygiene behaviors they typically engaged in before sex. The most common pre-sex behaviors reported were showering, which included showering overall, focused washing of genitals and anal area with soap and water, and douching. These behaviors were done to help respondents feel more comfortable and cleaner, prevent defecation accidents, and "to create a more positive and pleasant experience for me and whomever I will be with" (ID 13).

Partner's Hygiene—Most respondents wanted their partners to engage in the same behaviors they did – showering and douching— especially if they were to be the receptive partner for anal sex. One stated, "it's sort of like a mutual respect kind of thing" (ID9). Multiple respondents indicated that they would not have sex with someone they didn't think was clean, and that they informally screened potential partners based on hygiene. Although most respondents preferred their partners to be showered and clean, some stated that showering was not a priority, "Because a little bit of man smell is good" (ID23).

Recommendation 1 – Wash hands, genitals, and anus with soap and water before and after sexual activity (Table 2)

When asked about the feasibility and their willingness to engage in recommendation 1, most respondents perceived it favorably. The major themes that emerged included showering as an established practice, contextual factors, and risk assessment. Many respondents perceived this recommendation as already part of most people's pre-sex routines. As one respondent said, "Well, … you're not asking anyone to do anything terribly exotic. I mean wash your hands, wash your butt, … it's not rocket science" (ID2). Respondents expressed that washing hands, genitals, and anus before and after sex are generally viewed as a social norm

[1]45 C.F R. part 46, 21 C.F R. part 56; 42 U S C. Sect. 241(d); 5 U S C. Sect. 552a; 44 U S C. Sect. 3501 et seq

among gay and bisexual men: “Because I mean honestly it just seems kind of like good practice. Completely removed from the whole *Shigella* issue it just seems natural to me.” (ID 5).

Various contextual factors were raised as facilitators and barriers. Access to a shower could vary when sexual encounters occurred away from home: “Depending where you are before the encounter, it would be probably really easy or really hard. If you’re in a bar, probably really hard…If you’re home, easy” (ID7). The partner or encounter type also plays a role. For example, some respondents indicated it would be easier to follow the recommendation with a regular partner versus a “hookup,” saying, “having a partner it’s easier to like plan out your sexual encounters with them [….] So I feel like this would just be one more step to put in which would not be hard in the grand scheme of like the prep and the hygiene practices that I do in my life” (ID 24). Finally, some respondents indicated that the type of people they would choose as partners would already be “clean” and that, “There’s no reason to get clean to get dirty” (ID5).

While recommendation 1 was generally viewed as an established practice, knowledge of shigellosis factored into risk assessment. Some respondents indicated that they would be willing to follow recommendation 1 when they had the ability to do so as a strategy to reduce their risk of shigellosis, saying, for example, “I will be 100% willing to do it just because it doesn’t even, it benefits me to not be sick and it will benefit also my partner in that aspect” (ID 26).

Recommendation 2 – use dental dams and cut-open condoms during anilingus (“rimming”) and using latex gloves during anal fingering or fisting (Table 3)

When asked about recommendation 2, most respondents did not find it to be feasible or realistic. Major themes included sexual norms, access to materials, the sexual experience, partner type, and risk assessment. Respondents described this recommendation as “ridiculous” (ID4, ID6), “absurd”, “stupid” (ID4), “weird” (ID7), and “unsexy” (ID24). One respondent stated, “It ruins the fun of it and it’s like, I just think, it’s just like a weird perception. Like if someone had like any of these objects I would feel like they would, they were like my doctor instead of like a partner” (ID6). Some respondents likened it to their experience with lack of condom use in the gay community. One respondent explained, “people already have difficulty wanting to use a condom so I can’t see people taking it a step further” (ID21).

Two major themes that appeared as barriers were access to materials and the sexual experience. Accessing and purchasing materials was seen as a burden: “I mean, I’m going to hook up, not to like the first grade. I’m not bringing my crayons. And like also, I have to purchase all of that? No, thank you” (ID 7). Aspects of the sexual experience also influenced respondents. Multiple respondents felt that skin-to-skin contact is an important part of sexual activities like anilingus and anal sex, saying, “I’m willing to take the risk to eat my boyfriend’s ass unobstructed. Because I very much enjoy doing that” (ID18). Additionally, several respondents felt like they would rather not engage in rimming or fingering at all than use these barrier methods, which would make sex more like, “a science experiment” (ID12) and saying, “…gay men do not have sex for the purpose of uh, procreation, we’re having sex

for the pleasure that is involved in it and once you remove the element of pleasure, then the whole purpose of sex is gone" (ID22).

Other factors that influenced respondents included partner type and low perceived risk for shigellosis. Some respondents felt that if their partner asked them to take these precautions, they would be more willing to follow the request than with a stranger. Others felt that they would be more willing to follow the recommendation with a hookup or casual partner since they would not have the same level of trust as with their partner. Shigellosis was also perceived as uncommon and not as severe as contracting other STIs, with one respondent remarking, "I think that because I've never heard of this condition before I, and I don't know how prominent it is, I'm not particularly worried about getting it" (ID24).

Recommendation 3 – wait to have sex or sexual contact for at least one week, ideally for several weeks, after diarrhea has gone away (Table 4)

Respondents had mixed responses with regards to recommendation 3. Major themes included the time required to implement, sexual alternatives, confidence in 'diagnosing' shigellosis, risk, and partner type. The major barrier to implementation was the time required. Many respondents were willing to consider waiting a week but viewed several as too long. Some indicated that it would be more feasible to refrain from anal intercourse, particularly if they could engage in other sexual activities, such as mutual masturbation. However, many other respondents expressed that one week was too long, let alone several, to abstain from sex. One respondent expressed his doubts, saying, "especially for people who are under 30, they want to engage in sexual acts. .... I think it would be, not strange but, like...no, I would say strange like wait, like several weeks before engaging in any kind of sexual activities if you don't have any more diarrhea and you feel completely fine" (ID 6).

Respondents were not confident in their ability to self-diagnose shigellosis and expressed they would be more likely to follow a doctor's recommendations. Difficulties to self-diagnosis included various unrelated reasons one could have diarrhea, such as from diet and medications. Respondents expressed that they would not wait to have sex every time they experienced any diarrhea. Risk assessment also played a role, with some being more willing to wait to have sex if someone was, "really, really sick" (ID29). They did not want to get or spread diarrhea, describing a desire to keep their partners safe. Contextual factors that might negatively impact adherence included having access to a lot of opportunities for sex, alcohol consumption, and willpower. One respondent explained, "On the weekend, you're out with your boys and like, you're getting a little intoxicated and your willpower just doesn't like stay the same" (ID7).

Discussion

For some of CDC's recommendations to prevent the spread of shigellosis through sexual contact, respondents identified barriers. While the recommendation to "wash your hands, genitals, and anus with soap and water before and after sexual activity" was viewed as feasible, recommendations to "use barrier methods when rimming and fingering or fisting" and to "wait at least two weeks to have sex after symptoms resolve" were not. Barriers included low risk perception of shigellosis, level of planning of the sexual encounter, partner

type, negative effect on sexual experience, and social norms. Overall, respondents did not indicate willingness to follow all CDC's recommendations to prevent the sexual spread of shigellosis, few had prior knowledge of shigellosis, and most did not perceive it to be a concern.

While respondents expressed willingness to consider engaging in some of the recommended behaviors, some behaviors were not perceived as acceptable. Respondents felt positively about engaging in 'normal' activities such as showering before sex (wash hands, genitals, and anus before and after sexual contact), but using barrier methods when rimming and fingering or fisting was viewed as unfeasible and even ridiculous by some respondents. They felt waiting to have sex would require a higher level of knowledge about *Shigella* in the gay and bisexual community. However, increasing knowledge may have limited utility in encouraging gay and bisexual men to engage in prevention behaviors that are viewed as more difficult or outside of the social norm. Perceived social desirability and norms of a community are a key consideration for engaging in risk behaviors or prevention behaviors such as condom use (24, 25). Most respondents had never heard of using a dental dam in this context, making it far more socially unacceptable than using a condom. These results suggest that the most important factor for not wanting to use a dental dam or glove was that the perceived risk of becoming sick with shigellosis was not high enough to overcome the potential decrease of sexual pleasure. Diarrhea may not be enough of a deterrent compared with the burden of following some of the recommendations, as diarrhea was seen as treatable and limited in severity. The same trade-offs have been reported in other studies about other STIs, such as gonorrhea or chlamydia (26, 27). Even if knowledge of shigellosis improved, it might still be low on the list of health concerns compared to other infectious diseases.

Respondents identified multiple barriers and contextual factors that influenced their perception that most of the behavioral recommendations were unacceptable. They identified times when engaging in any of the recommendations would be unfeasible, predominately during hookups or other spontaneous encounters. Harm reduction approaches that seek to reduce risk of shigellosis as much as possible may be more successful in promoting engagement in preventative behaviors. While discussing the recommendation to "wait to have sex or sexual contact for at least one week, ideally for several weeks, after diarrhea has gone away," many respondents expressed confusion about whether all sexual contact should be avoided. They also suggested that it would be more feasible to avoid anal sex and engage in mutual masturbation or oral sex than to wait several weeks after diarrheal symptoms resolve to have any sort of sex. CDC's recommendations to prevent the sexual spread of COVID-19 and monkeypox (28) give detailed suggestions to decrease the risk of transmission in the event of engaging in sexual activity. Gay and bisexual men may be more likely to follow guidelines that give an idea of which sexual activities are the riskiest and outline safer alternatives; therefore, research should be done to further assess risk of each sexual activity with regards to transmission of *Shigella*. Nuance can be added to address these contextual factors that make engagement in preventative behaviors more difficult.

While increasing knowledge of shigellosis alone may not result in behavior change, knowledge was identified by participants as a substantial barrier to following these recommendations. Most respondents had not heard of *Shigella* prior to the interview and,

even after learning about it during the interview, did not perceive it as a concern. This is consistent with other studies that have found low knowledge and concern about STEIs and *Shigella* among gay and bisexual men (19–21). The American Men's Internet Survey found that though 56% of participating MSM knew diarrheal diseases could be transmitted through sexual contact, only 31% felt they were at higher risk of contracting an STEI (21). Another online survey of gay and bisexual men conducted in the United Kingdom (UK) found that 27% of respondents had heard of *Shigella* but only 17% knew it could be spread through sexual contact (20). This evaluation adds to the literature showing that there is a knowledge gap among gay and bisexual men that could be addressed/narrowed by increased education and messaging regarding person-to-person sexual transmission of *Shigella*.

There were several limitations in this evaluation. While maximum variation sampling was conducted in an attempt to assemble a diverse group of respondents, respondents were predominately white with higher levels of education. Therefore, the perspectives shared by respondents may not reflect perspectives of all gay and bisexual men. The results of this evaluation are not generalizable. Time was limited for interviews and therefore the last recommendation to wash sex toys was only asked if time allowed for it. Due to this, not all participants were asked about these behaviors, and it was not discussed in this paper. Interviews were also conducted during the early phases of the COVID-19 pandemic, which was a time where attention to hygiene was heightened. This could have impacted respondent perceptions of feasibility and buy-in of certain behaviors. As the interview included discussions of sensitive behaviors, responses could have been affected by response bias.

This is an opportunity to further tailor messaging and consider how we can increase knowledge of STEIs and adherence to prevention behaviors. Willingness to follow these recommendations varied, particularly for recommendations that respondents felt were outside of typical social norms. Additionally, regardless of knowledge level, individuals may not be willing to follow CDC's recommendations in their entirety due to the perceived low severity of shigellosis. It is important to continue educational efforts for *Shigella* and other STEIs, particularly among gay and bisexual men. Another approach that might be effective in this high-risk population would be broad messaging around washing hands, genitals, and anus before and after sexual contact to prevent the spread of STEIs, a highly acceptable and feasible behavior among gay and bisexual men. A harm reduction approach that adds more nuance to CDC's recommendations and suggests alternatives may be beneficial to increasing levels of engagement with protective behaviors.

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Table 1.

Self-reported demographic characteristics of respondents (n = 26)

	Mean	Median	Range
Age	29	25	19 – 60
Number of Sexual Partners, past 12-months	8	4	1 – 50

	N	%
Sexual Orientation		
Gay	22	85
Bisexual	3	11
Another sexual identity	1	4
Race/Ethnicity		
Non-Hispanic White	17	65
Hispanic White	3	12
Asian	3	12
Hispanic Black or African American	1	4
Multi-racial *	2	8
Relationship Status		
Single	15	58
In a relationship	11	42
Yearly Household Income		
$0 – $19,999	6	23
$20,000 – $59,999	9	35
$60,000 – $99,999	6	23
$100,000 or more	2	8
Prefer not to answer	3	11
Education level		
High school Graduate	3	12
At least some college	7	27
4-year college	12	46
At least some postgraduate work	4	15
Community		
Urban	13	50
Suburban	10	38
Rural	3	12
Type of sexual activity engaged in during the past 2 years †		
I had anal sex as a top	20	77
I had anal sex as a bottom	19	73
I rimmed someone	19	73
Someone rimmed me	18	69

	N	%
I performed oral sex on someone	23	88
Someone performed oral sex on me	25	96
I fingered or fisted someone	13	50
Someone fingered or fisted me	16	61
Prefer not to answer	1	4

*Multiracial category includes two individuals who selected both “White” and “Pacific Islander/Alaska Native.”

†Wording comes directly from screening questionnaire. Participants were able to choose all that applied.

Table 2.

Recommended Behavior: Washing hands, genitals, and anus before and after sexual activity

Theme	Exemplar Quote
Established Practice	• Um, 'cause just washing in, um, using water and soap is one of the most basic things that people do, is one the most basic things that I do, is, and the simplest forms of hygiene practice that I practice, before and after sex, so I find it an easy recommendation to follow. (ID17) • Um, well, pretty easy, I think I do it more without thinking like when I look at this stuff. I definitely do it, but I hadn't even thought of, you know, I hadn't even thought about that, when you asked what kind of hygiene you do because it's just so automatic to me. Like if I've been touching somebody genitals, I'm going to wash my hands as soon as we're done, so. (ID5) • Mostly because it's something that I already do so, it kind of, of like justifies my existing behavior but, um. I also think that, at least for my lifestyle I don't think it's that difficult to like, make sure I do this before any sort of activity or anything. (ID14)
Contextual Factors • Access • Partner Type	Access • It's very simple to follow the recommendation, I mean, assuming you're, (laughs) I guess assuming it's not just some hookup you've done on the damn corner or on a bus stop where you're not, you don't have access to uh, hm, soap and water but uh, those days are long gone for me. (ID22) Partner Type • Just because, like I said before, having a partner it's easier to like plan out your sexual encounters with them …. So I feel like this would just be one more step to put in which would not be hard in the grand scheme of like the prep and the hygiene practices that I do in my life. (ID 24)
Risk Awareness	• I think I mostly do anyway, but I guess, yeah, having the knowledge that, if this is a widespread problem I might be more likely to follow through and make it more... consistent. (ID19) • Well, first off, I don't want to get sick. Second off, it's not too hard. As long as there's the ability to do it, I would do it. When I say the ability, like what I was saying about the bar, that makes it hard. I think when you're in a relationship it's actually probably easier. (ID 7)

Table 3.

Recommended Behavior: Use a dental dam for rimming, a glove for fingering or fisting

Theme	Exemplar Quote
Sexual Norms	• It ruins the fun of it and it's like, I just think, it's just like a weird perception. Like if someone had like, any of these objects, I would feel like they would, they were like my doctor instead of like a partner. (ID6) • Yeah, I mean I've used condoms, but like a dental dam I don't think I've ever used and I definitely never like stopped a hook up and said, 'Well, let me put my glove on' like, it's just not a thing, um, yeah. (ID9)
Access to Materials	• Again I, I think it would depend on the situation that you're in if you happen to find latex gloves around or, if you have them on hand um, that, I'm gonna go with more not feasible. (ID27)
Sexual Experience	• I would probably say let's not even bother, um, because the pleasure factor from it is all gone, so- and since, you know, gay men do not have sex for the purpose of uh, procreation, we're having sex for the pleasure that is involved in it and once you remove the element of pleasure, then the whole purpose of sex is gone. (ID22). • …There are parts of sex with another guy that when you start using things like dental dams and latex gloves and all this other stuff and the amount of um, man to man contact, skin to skin contact, taste, smell, whatever that you're inhibiting, you just reduce the whole allure of the sexual contact by a great amount. (ID22)
Partner Type	• I think I think in my current relationship, yes, but maybe not for me, generally, like, I think, I think if I was hooking up casually with someone I would probably be more willing to follow these guidelines, than, if I, If I was in this monogamous relationship where like maybe there are like, there's more like trust that needs to be upheld in a way. (ID14) • I feel like- 100% honest I feel like if I was single I would be using it, but since I only have like one sexual partner, I will not be partaking in that because I feel like, I guess, it should be done even though you have a sexual partner because you don't know if that sexual partner will be your whole life, so I feel like it could be something I can talk with him and see what we can come to conclusion, but I feel like it, definitely it's something that I would look into it. (ID26)
Risk Perception	• Guess like I, like I understand that it's like it's, it's, it's like an STI or a condition that you can get when having unprotected sex, even with your partner. I think that because I've never heard of this condition, before I, and I don't know how prominent it is, I'm not particularly worried about getting it. (ID24)

Table 4.

Recommended Behavior: Wait at least 2 weeks after symptoms resolve to have sex

Theme	Exemplar Quote
Sexual Alternatives	• Well, I guess what I'm trying to say is as far as waiting for that, you know, waiting a week for anal, absolutely, that that's not a problem at all. Several weeks, depending on how many weeks, that might be kind of a challenge, but again I don't think it would be that much of- big of a deal because if somebody had *Shigella*, I probably would say well let's do something else, you know. (ID5)
Time Required to Implement	• I mean, even like it's unrealistic for both like if I tried to tell one of my sexual partners like, oh, I can't have sex with you for three weeks until after my diarrhea has cleared, they'd be like, what the fuck is wrong with you? Like three weeks? Like, you know, they would want to take their chances. They would think I'm being over, you know, over cautious. Um, yeah, it just seems like unnecessarily, um... I'm sure- I'm sure, I believe it, that it is best practice to have this waiting period and to refrain from sexual activity while having diarrhea but, um, you know. People are horny. (ID4)
Self-Diagnostic Confidence	• Diarrhea is, for many people, a very frequent thing, ….I just don't have it people being willing to put their sex life on hold like that. …. [And] I think a lot of sexual partners, if they knew about their partner's diarrhea status, like I don't think they would really care, they probably'd just be like 'oh you douched right?' and then, you know, you're fine. (ID4).
Risk Awareness	• I guess I think it's situational, too, and how like it was, and what it was, and like how sick someone really was I guess, in my opinion (ID29) • Um, just because I mean, I would want to like keep my partners like safe, if I could, if I had the option to. (ID3)
Contextual Factors	• Like if you're surrounded, like if you're at work, you're working, you're going home, you're tired. On the weekend, you're out with your boys and like, you're getting a little intoxicated and your willpower just doesn't like stay the same. (ID7)