HIV/AIDS, Hepatitis and Sexually Transmissible Infections in Australia Annual Report of Trends in Behaviour 2004

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Publication details:
Working Paper No. 4/2004
NCHSR Monograph
1445-7881 (ISSN)

Publication Date:
2004

DOI:
https://doi.org/10.26190/unsworks/1216

NCHSR

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Annual Report of Behaviour

Edited by Paul Van de Ven, Patrick Rawstorne, Carla Treloar & Juliet Richters

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ISSN 1445-7881
Monograph 4/2004

The National Centre in HIV Social Research is funded by the Commonwealth Department of Health and Ageing and is affiliated with the Faculty of Arts and Social Sciences at the University of New South Wales.

Design and layout by Judi Rainbow
Printed by Centatime Print Specialists, Rosebery

Contents

Figures

Tables

Acknowledgments

The behavioural data reported in this annual summary are the collective effort of researchers, funding organisations, collaborators and participants. Our thanks to:

ACON
ACON Northern Rivers
AIDS Action Council of the ACT
AIDS Council of South Australia
Albion Street Centre
Alcohol, Tobacco and Other Drugs Service, Cairns
Australian Federation of AIDS Organisations
Australian Hepatitis Council
Australian Injecting and Illicit Drug Users League
Australian Research Centre in Sex, Health and Society, La Trobe University
BC Centres for Disease Control, Vancouver
Centre for Health Promotion Research, Curtin University
Commonwealth Department of Health and Ageing
Department of Human Services, South Australia
GayWay/AIDS Vancouver
Health Department of Western Australia
Health Promotion Unit, Central Sydney Area Health Service
Hepatitis C Council of New South Wales
Kirketon Road Centre
LMS Consulting
Multicultural HIV/AIDS and Hepatitis C Service (NSW)
National Association of People Living with HIV/AIDS
National Centre in HIV Epidemiology and Clinical Research, University of New South Wales
New South Wales Health Department
New South Wales Users and AIDS Association
Northern Territory AIDS Council
People Living with HIV/AIDS (NSW)
People Living with HIV/AIDS (Victoria)
Queensland AIDS Council
Queensland Alcohol and Drug Research and Education Centre
Queensland Health Department
Queensland Intravenous AIDS Association
Queensland Positive People
Tasmanian Council on AIDS and Related Diseases
Twenty-Ten
Victorian AIDS Council/Gay Men's Health Centre
Victorian Department of Human Services
West Australia Substance Users Association
Western Australian AIDS Council
Youthquest!

We also thank the management and staff of venues and sexual health and medical centres across the country, and the many thousands who participated in the research projects.

Preface

This report is the sixth in the annual series to review behavioural data relevant to HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia. Specifically, these data relate to behavioural risk of transmission of human immunodeficiency virus (HIV) and behaviours related to the social aspects of treatment and care. Where available, data relevant to other sexually transmissible infections and viral hepatitis are also presented.

Unless stated otherwise, all data provided in this report are from the five-year period 1999 to 2003 inclusive. In this way, this annual report builds on the previous reports by comparing data from the past year with data from the previous four. Data pertaining to trends over time in behaviour relevant to risk of HIV transmission over a period extending from 1984 to 1995 can be found in *Valuing the past … investing in the future: Evaluation of the National HIV/AIDS Strategy 1993–94 to 1995–96* (Feachem, 1995) and its *Technical Appendices 3* (Crawford et al., 1995), *4* (Crofts et al., 1995) and *5* (Smith et al., 1995). Data from periods after the Feachem evaluation were presented in the five earlier reports in this series, commencing with *HIV/AIDS and related diseases in Australia: Annual report of behaviour* (National Centre in HIV Social Research, 1999).

As in previous years, this report is published as a companion to *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2004* (National Centre in HIV Epidemiology and Clinical Research [NCHECR], 2004). Some of the tables in this report provide data that overlap with or duplicate those in the NCHECR report. We acknowledge the contribution of the National Centre in HIV Epidemiology and Clinical Research to this report.

We also acknowledge the contribution of researchers at the Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University.

We thank a large number of organisations and people involved in health throughout Australia for their help and support. Their contribution to this report is very gratefully acknowledged.

Summary

This report brings together monitoring information from the period 1999 to the end of 2003 about practices that may risk transmission of human immunodeficiency virus (HIV) and about practices related to the social and behavioural aspects of the treatment and care of people living with HIV or acquired immune deficiency syndrome (AIDS). Where available, data relevant to other sexually transmissible infections and viral hepatitis are also presented.

This report builds on data from *Valuing the past … investing in the future: Evaluation of the National HIV/AIDS Strategy 1993–94 to 1995–96* (Feachem, 1995) and the five earlier reports in this series starting with *HIV/AIDS and related diseases in Australia: Annual report of behaviour* (National Centre in HIV Social Research, 1999). Data are organised around a number of themes or topics:

1 Sexual practice
2 Living with HIV
3 Drug use
4 Hepatitis C
5 The current climate

With regard to **sexual practice**, the most detailed information in this report comes from studies of homosexually active men, the population most affected by HIV in Australia. Limited data were available regarding other populations, namely people living with HIV, first-year university students, and women in contact with gay and lesbian communities. The data from other populations have been greatly augmented by the Australian Study of Health and Relationships and an updated summary of key findings from a representative sample of the Australian population is included in Section 1.2.1.

From the mid-1980s there was a decrease in the practices that risk transmission of HIV and an increase in protective behaviour, particularly condom use, among homosexually active men and other populations. These changes happened quite early (that is, by the middle to late 1980s) and were mostly sustained through to the mid-1990s. There was little evidence of anything other than stability in these practices from the early 1990s to around 1995 (Feachem, 1995).

However, as indicated by data detailed in this and previous reports, there is evidence of increases since 1996 in some regions in the proportion of homosexually active men reporting any unprotected anal intercourse in the previous six months. For the period covered by this report (1999 to 2003), the increases in the proportion of men in regular relationships reporting any unprotected anal intercourse were in general of the order of 5 to 10 per cent (see Table 1.1.5b); for example, from around 51 to 56 per cent in Sydney Gay Community Periodic Survey data (with parallel increases reported in the Sydney-based Health in Men study and in Brisbane Gay Community Periodic Survey data). It is important to point out that much of the unprotected anal intercourse within regular relationships was safe with regard to HIV transmission as it occurred within seroconcordant relationships.

Summary

Changes from 1999 to 2003 in levels of unprotected anal intercourse in casual sexual encounters were uneven across the country. There was, nonetheless, evidence of an increase among men with casual partners in Sydney from around 26 per cent in 1999 to 33 per cent in 2003, based on Gay Community Periodic Survey data (see Table 1.1.4b). Such increases have also been documented in Melbourne and Brisbane. There were indications in the Sydney data (from the Health in Men study and from the Gay Community Periodic Survey) that rates of unprotected anal intercourse with casual partners may have reached a plateau, although one or two more years of data will be required to confirm this. In most studies, HIV-positive men were more likely to engage in unprotected anal intercourse than HIV-negative men, although some of this unprotected anal intercourse was safe with regard to HIV transmission as it occurred between HIV-positive partners (see Table 1.1.10).

Data based on surveys conducted from 1999 to 2003 indicate that the overwhelming majority of homosexually active men had had a test for HIV, consistent across most of the areas studied (see Table 1.1.7 and Figure 3). Declining trends in the proportion of men ever tested for HIV (based on Gay Community Periodic Surveys in Melbourne and Brisbane between 1998 and 2002) were no longer evident for the period 1999 to 2003.

Recent HIV testing ('in the previous six months') among HIV-negative gay men was quite uneven (see Table 1.1.8). Data from two Sydney-based studies, Health in Men (2001 to 2003) and Gay Asian Men (1999 to 2002), indicated a decrease in recent HIV testing whereas data from the Periodic Surveys in Sydney and Adelaide (1999 to 2003) indicated an increase in recent HIV testing. No trends were evident in other studies.

The proportion of younger gay men (under 25 years of age) 'ever tested for HIV' was steady in most areas (see Table 1.1.9 and Figure 4). However, Brisbane and Sydney Asian Gay Community Periodic Survey data confirmed a downward trend in HIV testing among younger gay men in both of these communities.

The Health in Men cohort of HIV-negative gay men in Sydney allows estimates of HIV incidence in the population from which the participants are drawn, namely the Sydney gay community. Based on the first three years of data collection (2001 to 2003), HIV incidence was recorded at approximately 1 per cent overall (see Table 1.1.13).

As noted in the section on **living with HIV**, retrospective accounts of the seroconversion of homosexually active men indicated that a number of seroconversions continued to be attributed to regular relationships. However, infection is now more frequently being attributed to casual sex (see Section 2.8).

Information relating to the uptake of therapies and other treatment-related issues is also provided in this section. HIV-positive homosexually active men in Australia took up combination antiretroviral therapy very quickly. However, over time, there has been a significant decline in the proportion of people currently taking combination therapy, notably among Positive Health participants in both Sydney and Melbourne, and among Sydney, Melbourne and Brisbane participants in the Gay Community Periodic Surveys (see Table 2.3.1 and Figure 5). Whereas around 65 to 85 per cent of HIV-positive men were using combination antiretroviral therapy in 1999, only 55 to 70 per cent were doing so in 2003.

The need for adherence to antiretroviral therapy regimens was generally well understood and the available data indicated a high level of commitment to adherence (see Section 2.6) despite the adverse side effects experienced by many of those on antiretroviral therapy. Over time (see Table 2.4), there was a tendency for a greater proportion of participants in

the Positive Health study to report side effects, so much so that by 2002 nearly all participants in both Sydney and Melbourne experienced some side effects. In 1999, about 60 per cent of Positive Health participants reported experience of lipodystrophy, and this increased to approximately 70 per cent in 2002. The increase in the proportion of Positive Health participants experiencing diarrhoea or nausea was even more pronounced, from approximately 50 per cent in 1999 to approximately 75 per cent in 2002.

Findings from the Northern Rivers regional arm of the Side Effects and Lipodystrophy Project (see Section 2.5) speak to experiences of side effects from antiretroviral treatment, low energy levels, depression and other mental health problems reported by some HIV-positive people. A recurring theme was lack of HIV-related health and community support services. Many participants reported some degree of lipodystrophy and their experiences were both similar to and different from those of the participants in the urban arm of the project.

Measures of contact with the HIV epidemic ('knows anyone with HIV' and 'ever knew anyone who died following AIDS'—see Table 2.9) indicate that HIV-positive men in Sydney had continuing high levels of contact with the epidemic. The exception was HIV-positive gay Asian men, whose values on these indicators were substantially lower. HIV-positive men in other parts of Australia had high levels of contact with the epidemic, although somewhat less in some places than their Sydney counterparts. Information from various studies showed that, in terms of 'knowing anyone with HIV', HIV-negative men had fairly high levels of contact with the epidemic but over time there was a downward trend in some places (notably Adelaide).

Until the end of 2003, the National Centre in HIV Social Research had obtained some data on **drug use**, especially 'recreational' drug use among homosexually active men. The data indicate high levels of drug use, particularly among men who are attached to gay community (see Table 3.1.1). From recent data collection, approximately 50 to 80 per cent of gay men (depending on location) reported the use of at least one non-prescription drug in the previous six months. Based on Periodic Survey data, use of at least one drug increased significantly in Brisbane, and use of more than one drug increased significantly in Sydney, Melbourne and Brisbane.

While drug use among homosexually active men is common, injecting drugs is very much a minority practice (see Table 3.1.2). The available data suggest stability in injecting drug use on the whole, although findings from the Periodic Survey in Sydney indicate a decline between 1999 and 2003.

The Barriers and Incentives research project documented barriers and incentives to drug users' access to and use of treatment. Key findings from analyses of three groups (those currently in treatment, in treatment in the past, and never in treatment) are summarised in Section 3.2. People who were currently in treatment or who had been treated in the past were generally older and had a longer history of drug use, had injected drugs (rather than using other modes of administration), had used opioids rather than stimulants, and were more likely to be hepatitis C-positive.

The Access to Needle and Syringe Programs project compared drug injectors in South East Health (formerly the South Eastern Sydney Area Health Service) who used needle and syringe program (NSP) services to acquire injecting equipment with those who did not (see Section 3.3). Use of NSPs was associated with longer injecting history, more frequent

injecting, use of heroin (rather than stimulants), less frequent reuse of own needles or syringes, and greater likelihood of having been tested for hepatitis C, hepatitis B and HIV.

Substantial proportions of HIV-positive people and gay-community-attached men have ever been tested for **hepatitis C** (see Table 4.1). HIV-positive gay men are generally more likely than their HIV-negative counterparts to have been diagnosed with hepatitis C infection. Among HIV-positive people who are co-infected with hepatitis C, few have taken medical treatments specifically for hepatitis C.

Section 4.2 summarises findings from a study of the effects of clinical markers (such as blood levels of alanine aminotransferase or ALT) on people with hepatitis C infection. These clinical markers generally had little effect on participants. The social consequences of living with hepatitis C, such as potential social limitations and isolation, were more significant and had greater impact on people with hepatitis C than did clinical markers of disease progress. However, a small proportion of the participants were concerned with ALT results, possibly related to greater illness or more advanced disease.

Many years have elapsed since Australia first responded to HIV, and the current climate is very different from that at the advent of the epidemic. In general, the majority of homosexually active men have sustained a 'safe sex culture' even though sustaining safe sex over such a long period is difficult. People have aged and the young have become sexually active. Many have become accustomed to living with the epidemic—they no longer live with a constant sense of crisis. The announcement at the 11th International AIDS Conference in Vancouver in July 1996 of the comparative success of new combination antiretroviral therapies added to this sense of post-crisis. New therapies have lessened the burden on most people living with HIV and AIDS: there are fewer deaths and, despite often serious side effects, less debilitating illness among many people living with HIV/AIDS.

Based on data from Gay Community Periodic Surveys, there has been a recent and significant increase in awareness among gay men of the availability of post-exposure prophylaxis (see Table 5.1.1). Relatively few gay men indicated that they had received post-exposure prophylaxis themselves, though larger proportions knew others who had done so. Interview data from persons who had taken the prophylactic treatment provided a strong sense of relief and a determination to avoid risk exposures in the future (see Section 5.1).

A study involving sexually adventurous gay men in Sydney (see Section 5.2) highlights high levels of unsafe casual sex among some of these men. Use of 'recreational' drugs for sex was not universal in this group. However, some sexually adventurous men used drugs for sex, to maximise pleasure and for 'disinhibition', yet with an overall desire to remain in control.

Two studies involving young gay men (see Sections 5.3 and 5.4) confirm the importance most of these men place on safe sex. A number of difficulties for young gay men are made clear, including fear and anxiety around HIV testing and homophobic abuse.

Access to and use of the internet has flourished in recent years. Findings from the Cruising and Connecting Online study (see Section 5.5) confirm that gay men use the internet for socialising as well as finding sex partners. In terms of education and health promotion, the evidence suggests a number of potential avenues for HIV prevention work among internet chat site users.

Sexual practice

1

During the period covered by this report (1999 to 2003) much of the work of the National Centre in HIV Social Research (NCHSR) was concerned with documenting sexual practice among homosexually active men, the population most affected by HIV in Australia. The Centre has also concerned itself with other populations at comparatively lower HIV risk, including young people and the general population. In this report a distinction is made between regular and casual sexual partners. This distinction is important because the meanings of sexual behaviour change depending on whether such behaviour occurs within a regular or committed relationship or in a casual encounter. Moreover, strategies for safe sex take into account the context (regular partner or casual encounter) of sexual practice. Among homosexually active men, many of whom have both regular and casual partners, the distinction is especially relevant.

1.1 SAFE SEX BEHAVIOUR AMONG HOMOSEXUALLY ACTIVE MEN

With respect to homosexually active men, information in this report comes from both national data (2000 Male Out Survey) and state-based data. In the 2000 Male Out Survey (Van de Ven et al., 2001)—as in the earlier studies, Male Call 96 (Crawford et al., 1998) and Project Male Call in 1992 (Kippax et al., 1994)—two groups of men could be identified. One group included men who were attached to gay community, and are referred to as gay-community-attached (GCA). The other group consisted of men who were not attached to gay community, many of whom did not identify as gay but instead as bisexual or heterosexual and many of whom, unlike most of their gay-identified counterparts, have sex with women as well as men. This group is designated non-gay-community-attached (NGCA). Men in the Male Out study were classified as gay-community-attached or not on the basis of their responses to a set of questions relating to their social life. In the 2000 Male Out Survey, two questions relating to social life—number of gay friends; amount of free time spent with gay men—were used to classify men into the two groups. As the gay-community-attached men differed significantly from those who were not attached to gay community with respect to many of the indicators included in this report, 2000 Male Out Survey data are given for each group separately.

In general, data from state-based studies such as the Gay Community Periodic Surveys, the Health in Men cohort of HIV-negative men and the Positive Health cohort of HIV-positive people are based mainly on men recruited from gay communities.

The most complete state-based data are from Sydney, where Health in Men was available as a source of information from 2001 (Mao et al., 2002) and Positive Health sexual practice data from 2001. Gay Community Periodic Surveys funded by the New South Wales Health Department have been carried out in Sydney every six months since February 1996. Results from the Sydney Periodic Surveys have been reported in the form of six-monthly updates as well as published summary reports (Prestage et al., 1999; Hull, Van de Ven, Prestage et al., 2003). For the purpose of this report, Sydney Periodic Survey data have been aggregated in

order to report on an annual basis. Data were also available from Asian Gay Community Periodic Surveys conducted in 1999 (Prestage et al., 2000) and 2002 (Mao et al., 2003).

For logistical reasons, the latest round of data collection for the Positive Health study was extended into 2004. Data from 2003 to 2004 were not available at the time this report was prepared and will be reported next year.

Surveys based on the Periodic Survey questionnaire were also carried out in Melbourne in February 1998 (Van de Ven, Prestage et al., 1998a), February 2000 (Aspin et al., 2000a), February 2001 (Rawstorne et al., 2001), February 2002 (Hull, Van de Ven et al., 2002) and February 2003 (Hull et al., 2003a), Queensland in June 1998 (Van de Ven et al., 1998b), June 1999 (Van de Ven, Prestage, Kippax et al., 1999c), June 2000 (Aspin et al., 2000b), June 2001 (Rawstorne et al., 2002b), June 2002 (Hull, Rawstorne et al., 2002) and June 2003 (Hull et al., 2003b), Perth in October 1998 (Van de Ven et al., 1999a), October 2000 (Brown et al., 2001) and October 2002 (Hull, Brown, Van de Ven et al., 2003), Adelaide in November 1998 (Van de Ven et al., 1999b), November 1999 (Van de Ven, Prestage, Kippax et al., 2000), November 2001 (Rawstorne et al., 2002a) and November 2003 (Hull et al., 2004a), and Canberra in November 2000 (Aspin et al., 2001) and November 2003 (Hull et al., 2004b). Queensland Gay Community Periodic Surveys covered Brisbane and the Sunshine Coast and Gold Coast from 1998 to 2003. Cairns was included from 1999. (In the tables and figures, Queensland Periodic Survey data are referred to as 'Brisbane'. Most of the participants were recruited in Brisbane but data from the Sunshine and Gold coasts, and Cairns, are included.)

Data for gay-community-attached men and non-gay-community-attached men in the 2000 Male Out Survey (August–September 2000) (Van de Ven et al., 2001) are provided for both the whole of Australia and for selected cities in order to provide some comparison with results gathered from other parts of Australia. Nationwide information relating to people living with HIV comes from HIV Futures II of 1999 (Grierson et al., 2000) and HIV Futures III of 2001 (Grierson et al., 2002). The latest round of data collection for HIV Futures was in 2003 and 2004 and these data were not available for inclusion in this report.

In each of the surveys for which data are included in this report, men were asked about sexual practice in the six months prior to each survey. Key indicators in this area are:

- the percentage of men with regular and/or casual partners
- the percentage of men who engage in unprotected anal intercourse (with either regular and/or casual partners)
- the percentage of men who engage in unprotected anal intercourse with casual partners
- the percentage of men who engage in unprotected anal intercourse with regular partner(s)
- mean scores on a scale of esoteric practices for men who engaged in (a) any unprotected anal intercourse, (b) unprotected anal intercourse with regular partner/s and (c) unprotected anal intercourse with casual partners.

A sizeable proportion of homosexually active men report having sex with both regular and casual partners.

Tables 1.1.1 to 1.1.6 show the percentages of men who engaged in the above practices over the period 1999 to 2003. Information enabling an assessment of change in behaviour over the whole of this period is now available for Sydney, Melbourne, Brisbane, Perth and Adelaide men.

1.1.1 PERCENTAGE REPORTING REGULAR, CASUAL AND BOTH REGULAR AND CASUAL PARTNERS

As mentioned above, sexual behaviour often depends on the context, in particular the relationship between the people involved in the behaviour. Table 1.1.1 shows the percentage of men who reported that they had regular or casual partners, and those who reported both regular and casual partners, in the six months prior to the survey. These percentages are derived from responses about sexual behaviour with regular and/or casual partners. These are not mutually exclusive categories, since those who had sex with both regular and casual partners were also counted as having had sex with each category of partner.

For regular partners, the samples of gay-community-attached and non-gay-community attached men showed a high degree of consistency in the percentages reported in Table 1.1.1. Around 60 to 70 per cent of gay men reported sex with a regular partner in the six months prior to each survey, a slightly lower proportion among Gay Asian Men in Sydney in 2002. Over time, there were no significant trends for regular partners apart from Periodic Survey data from Sydney and Brisbane, which indicated a decline in the proportion of men with regular partners.

The picture for casual partners was one of fairly consistent percentages (around 65 to 75 per cent) for both samples. Over time, there were no significant trends for casual partners apart from Periodic Survey data from Brisbane, which indicated a decrease in the proportion of men with casual partners, and Adelaide, which indicated an increase in the proportion of men with casual partners.

Around 40 to 50 per cent of men reported sex with both regular and casual partners in 2003. This is fairly consistent with previous years for both gay-community-attached and non-gay-community-attached men. However, from Periodic Survey data, the proportions have decreased in Sydney and Brisbane, and increased in Adelaide.

Sexual practice data became available from Sydney HIV-positive men in the Positive Health cohort study in 2001. Consistent with past findings, smaller proportions of HIV-positive men in 2002 reported regular/casual partners than, say, their HIV-negative counterparts in Health in Men. Therefore, in drawing conclusions throughout this report, it is important to differentiate between studies whose samples comprised HIV-negative participants only (Health in Men), HIV-positive participants only (Positive Health), and those which included HIV-negative and HIV-positive as well as men who did not know their serostatus (e.g. Periodic Surveys). (Note: See Table 1.1.10 for a breakdown of some sexual practice data by serostatus.)

Table 1.1.1: Percentage of men who reported (a) regular partners, (b) casual partners and (c) both regular and casual partners[1]

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) Men with regular partner/s										
Australia										
Male Out: GCA			1181	76.0						
Male Out: NGCA			651	63.6						
Sydney										
Health in Men					450	68.2	845	75.0	1175	71.8
Positive Health					265	49.4	235	62.6		
Periodic	3343	66.6	2916	64.0	2862	64.2	2884	63.0	2541	59.6
Male Out: GCA			223	74.4						
Male Out: NGCA			78	65.4						
Gay Asian Men	319	65.8					457	56.5		
Melbourne										
Periodic			1578	63.8	1830	65.5	1877	63.6	2064	62.9
Male Out: GCA			258	74.4						
Male Out: NGCA			103	67.0						
Brisbane										
Periodic	1225	62.2	1285	62.5	1570	61.7	1787	59.3	1510	59.4
Male Out: GCA			99	80.8						
Male Out: NGCA			62	61.3						
Perth										
Periodic			1035	65.6			790	63.3		
Male Out: GCA			93	77.4						
Male Out: NGCA			49	53.1						
Adelaide										
Periodic	463	63.5			565	65.7			834	61.3
Male Out: GCA			78	74.4						
Male Out: NGCA			42	66.7						
Canberra										
Periodic			350	61.4					255	62.7
(b) Men with casual partner/s										
Australia										
Male Out: GCA			1181	71.7						
Male Out: NGCA			651	66.1						
Sydney										
Health in Men					450	80.0	845	77.6	1175	78.9
Positive Health					265	57.0	235	67.7		
Periodic	3343	70.3	2916	72.8	2862	73.3	2884	71.5	2541	70.0
Male Out: GCA			223	75.3						
Male Out: NGCA			78	74.4						
Gay Asian Men	319	75.2					457	76.8		
Melbourne										
Periodic			1578	71.2	1830	66.1	1877	67.6	2064	69.2
Male Out: GCA			258	69.8						
Male Out: NGCA			103	66.0						

… / continued

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(b) Men with casual partner/s (continued)										
Brisbane										
Periodic	1225	73.6	1285	70.8	1570	71.6	1787	69.8	1510	69.9
Male Out: GCA			99	70.7						
Male Out: NGCA			62	67.7						
Perth										
Periodic			1035	66.0			790	62.5		
Male Out: GCA			93	71.0						
Male Out: NGCA			49	65.3						
Adelaide										
Periodic	463	61.8			565	66.4			834	72.4
Male Out: GCA			78	74.4						
Male Out: NGCA			42	71.4						
Canberra										
Periodic			350	64.3					255	70.6
(c) Men with both regular and casual partners										
Australia										
Male Out: GCA			1181	52.5						
Male Out: NGCA			651	39.2						
Sydney										
Health in Men					450	49.6	845	54.9	1175	52.7
Positive Health					265	29.4	235	41.7		
Periodic	3343	42.1	2916	42.4	2862	42.7	2884	40.9	2541	37.5
Male Out: GCA			223	52.0						
Male Out: NGCA			78	42.3						
Gay Asian Men	319	47.3					457	43.8		
Melbourne										
Periodic			1578	42.6	1830	39.0	1877	39.4	2064	40.1
Male Out: GCA			258	49.6						
Male Out: NGCA			103	39.8						
Brisbane										
Periodic	1225	42.4	1285	41.6	1570	40.9	1787	38.4	1510	39.9
Male Out: GCA			99	55.6						
Male Out: NGCA			62	38.7						
Perth										
Periodic			1035	39.5			790	35.6		
Male Out: GCA			93	52.7						
Male Out: NGCA			49	30.6						
Adelaide										
Periodic	463	35.6			565	40.2			834	40.6
Male Out: GCA			78	50.0						
Male Out: NGCA			42	47.6						
Canberra										
Periodic			350	34.3					255	38.8

[1] Based on responses to questions about sexual behaviour with regular and/or casual partners
GCA = gay-community-attached NGCA = non-gay-community-attached

1.1.2 PERCENTAGE ENGAGING IN ANY ANAL INTERCOURSE

Table 1.1.2 shows the percentage of men who reported that they had engaged in any anal intercourse with either regular or casual sex partners—including anal intercourse without ejaculation ('withdrawal') during the six months prior to the survey.

Generally, around 70 to 80 per cent of gay men engaged in any anal intercourse during the six months prior to interview, with slightly more among Health in Men participants. For each survey, the proportions have been quite stable over time; there have been no significant trends.

Table 1.1.2: Men engaging in any anal intercourse

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			1181	85.3						
Male Out: NGCA			651	76.2						
Sydney										
Health in Men					450	92.9	845	90.4	1175	90.6
Positive Health					232	81.9	214	82.2		
Periodic	3343	82.4	2916	84.0	2862	85.5	2884	84.4	2541	82.3
Male Out: GCA			223	87.0						
Male Out: NGCA			78	83.3						
Gay Asian Men	319	76.8					457	74.6		
Melbourne										
Periodic			1578	80.1	1830	78.9	1877	78.8	2064	79.8
Male Out: GCA			258	84.1						
Male Out: NGCA			103	73.8						
Brisbane										
Periodic	1225	80.7	1285	79.8	1570	81.1	1787	78.8	1510	80.3
Male Out: GCA			99	85.9						
Male Out: NGCA			62	66.1						
Perth										
Periodic			1035	77.4			790	75.2		
Male Out: GCA			93	86.0						
Male Out: NGCA			49	77.6						
Adelaide										
Periodic	463	75.2			565	77.3			834	78.7
Male Out: GCA			78	87.2						
Male Out: NGCA			42	78.6						
Canberra										
Periodic			350	77.7					255	83.5

GCA = gay-community-attached NGCA = non-gay-community-attached

1.1.3 PERCENTAGE ENGAGING IN ANY UNPROTECTED ANAL INTERCOURSE

Table 1.1.3 shows the number and percentage of men who reported that they had engaged in unprotected anal intercourse at least once in the six months prior to interview—including anal intercourse without ejaculation ('withdrawal')—with any male partner(s), regular or casual, for the years 1999 to 2003. This indicator varied considerably from sample to sample, reflecting differences between samples with respect to sex with regular and/or casual partners as shown in Table 1.1.1. In the Periodic Surveys in Sydney and Brisbane there was a significant upward trend in any engagement in unprotected anal intercourse, a trend not evident in the data from Melbourne, Perth or Adelaide, nor among Gay Asian Men in Sydney. Data from the past two or three years are strongly suggestive of overall rates of unprotected anal intercourse having reached a plateau.

Table 1.1.3: Men engaging in unprotected anal intercourse

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			1181	56.5						
Male Out: NGCA			651	50.5						
Sydney										
Health in Men					450	63.1	845	64.6	1175	65.4
Positive Health					232	50.0	214	55.6		
Periodic	3343	43.1	2916	48.3	2862	51.2	2884	51.3	2541	47.4
Male Out: GCA			223	54.3						
Male Out: NGCA			78	48.7						
Gay Asian Men	319	36.4					457	31.9		
Melbourne										
Periodic			1578	42.6	1830	46.8	1877	46.2	2064	43.7
Male Out: GCA			258	51.6						
Male Out: NGCA			103	46.6						
Brisbane										
Periodic	1225	38.8	1285	44.0	1570	44.0	1787	45.1	1510	46.0
Male Out: GCA			99	60.6						
Male Out: NGCA			62	50.0						
Perth										
Periodic			1035	45.7			790	45.4		
Male Out: GCA			93	57.0						
Male Out: NGCA			49	44.9						
Adelaide										
Periodic	463	39.7			565	41.9			834	42.1
Male Out: GCA			78	50.0						
Male Out: NGCA			42	50.0						
Canberra										
Periodic			350	42.9					255	42.4

GCA = gay-community-attached NGCA = non-gay-community-attached

1.1.4 PERCENTAGE ENGAGING IN UNPROTECTED ANAL INTERCOURSE WITH CASUAL PARTNERS

Tables 1.1.4a (total samples) and 1.1.4b (reduced base of those who had casual partners) show the number and percentage of men who reported that they had engaged in any unprotected anal intercourse—including anal intercourse without ejaculation ('withdrawal')—with casual partners during the six months prior to the survey for the years 1999 to 2003.

For this period, data from the Gay Community Periodic Surveys conducted in Sydney, Melbourne, Brisbane and Adelaide provide evidence of significant increases in rates of unprotected anal intercourse with casual partners. (This is not the case in Perth or among gay Asian men in Sydney.) Evidence from the latter years of data collection in Sydney and Brisbane suggests that rates of unprotected anal intercourse with casual partners have reached a plateau.

Key data from Table 1.1.4a—based on total samples—are also presented graphically in Figure 1. Where available, relevant data from surveys conducted during the three years prior to 1999 are also included. For the purposes of comparison with the Periodic surveys, only data for gay-community-attached men are presented from the Male Call and Male Out surveys. (Note that for legibility the *y*-axis has been drawn from 0 to 50 per cent rather than the complete 0 to 100 per cent.)

Figure 1: Percentage of men engaging in unprotected anal intercourse with casual partners

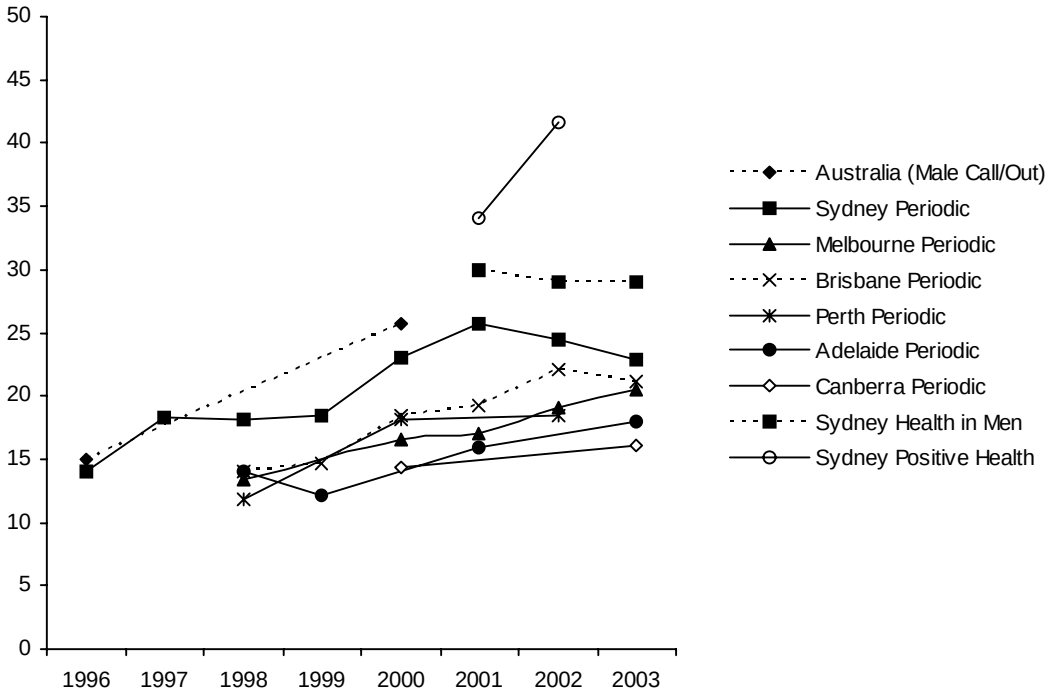


Table 1.1.4b, based on those men who had casual partners, shows the number and percentage of men who reported that they had engaged in any unprotected anal intercourse—including anal intercourse without ejaculation ('withdrawal')—with casual partners during the six months prior to the survey for the years 1999 to 2003. For these years, the Periodic Survey data sets from Sydney, Melbourne and Brisbane (but not Perth or Adelaide, or Gay Asian Men in Sydney) indicate a significant increase in the proportion of men engaging in unprotected anal intercourse with their casual partners. Evidence from the latter years of Periodic Survey and Health in Men data collection in Sydney suggests that rates of unprotected anal intercourse with casual partners have reached a plateau, although Melbourne and Brisbane Periodic Survey data are inconclusive as to whether rates have peaked when the reduced base of those with casual partners is examined.

Table 1.1.4a: Men engaging in unprotected anal intercourse with casual partners (based on all the men who participated)

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			1181	25.7						
Male Out: NGCA			651	25.3						
Sydney										
Health in Men					450	30.0	845	29.1	1175	29.1
Positive Health					232	34.1	214	41.6		
Periodic	3343	18.5	2916	23.0	2862	25.7	2884	24.5	2541	22.9
Male Out: GCA			223	26.9						
Male Out: NGCA			78	20.5						
Gay Asian Men	319	16.3					457	14.4		
Melbourne										
Periodic			1578	16.6	1830	17.0	1877	19.1	2064	20.5
Male Out: GCA			258	19.8						
Male Out: NGCA			103	21.4						
Brisbane										
Periodic	1225	14.7	1285	18.4	1570	19.2	1787	22.1	1510	21.1
Male Out: GCA			99	26.3						
Male Out: NGCA			62	21.0						
Perth										
Periodic			1035	18.1			790	18.5		
Male Out: GCA			93	18.3						
Male Out: NGCA			49	24.5						
Adelaide										
Periodic	463	12.1			565	15.9			834	18.0
Male Out: GCA			78	19.2						
Male Out: NGCA			42	28.6						
Canberra										
Periodic			350	14.3					255	16.1

GCA = gay-community-attached NGCA = non-gay-community-attached

Table 1.1.4b: Men engaging in unprotected anal intercourse with casual partners (based on the men who had casual partners)

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			847	35.8						
Male Out: NGCA			430	38.4						
Sydney										
Health in Men					360	37.5	656	37.5	927	36.9
Positive Health					151	52.3	159	56.0		
Periodic	2350	26.4	2122	31.6	2098	35.0	2062	34.2	1779	32.8
Male Out: GCA			168	35.7						
Male Out: NGCA			58	27.6						
Gay Asian Men	240	21.7					351	18.8		
Melbourne										
Periodic			1123	23.3	1209	25.7	1268	28.3	1429	29.7
Male Out: GCA			180	28.3						
Male Out: NGCA			68	32.4						
Brisbane										
Periodic	901	20.0	910	25.9	1124	26.9	1248	31.7	1056	30.2
Male Out: GCA			70	37.1						
Male Out: NGCA			42	31.0						
Perth										
Periodic			683	27.4			494	29.6		
Male Out: GCA			66	25.8						
Male Out: NGCA			32	37.5						
Adelaide										
Periodic	286	19.6			375	24.0			604	24.8
Male Out: GCA			58	25.9						
Male Out: NGCA			30	40.0						
Canberra										
Periodic			225	22.2					180	22.8

GCA = gay-community-attached NGCA = non-gay-community-attached

1.1.5 PERCENTAGE ENGAGING IN UNPROTECTED ANAL INTERCOURSE WITH REGULAR PARTNERS

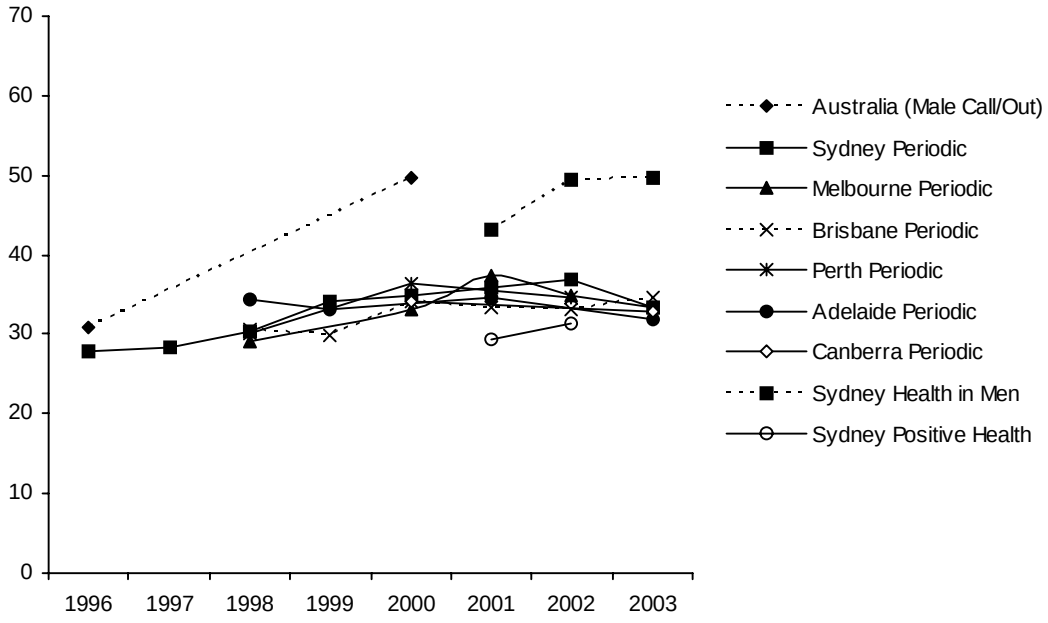
Tables 1.1.5a (total samples) and 1.1.5b (reduced base of those who had regular partners) show the number and percentage of men who reported that they had engaged in any unprotected anal intercourse—including anal intercourse without ejaculation ('withdrawal')—with regular partners during the six months prior to the survey for the years 1999 to 2003. Values for this indicator were steady across all data sets except the Sydney-based Health in

Men study and the Brisbane Periodic Survey, both of which showed a significant increase overall.

Key data from Table 1.1.5a—based on total samples—are presented graphically in Figure 2. Again, where available, relevant data from surveys conducted during the three years prior to 1999 are also included. For the purposes of comparison with the Periodic Surveys, only data for gay-community-attached men are presented from the Male Call and Male Out surveys. (Note that for legibility the *y*-axis has been drawn from 0 to 70 per cent rather than the complete 0 to 100 per cent.)

Table 1.1.5b, based on those men who had regular partners, shows the number and percentage of men who reported that they had engaged in unprotected anal intercourse—including anal intercourse without ejaculation ('withdrawal')—with regular partners during the six months prior to the respective survey for the years 1999 to 2003. During this interval, there was a significant increase in the proportion of men engaging in unprotected anal intercourse with regular partners in Periodic Survey and Health in Men data from Sydney, and Periodic Survey data from Brisbane.

Figure 2: Percentage of men engaging in unprotected anal intercourse with regular partners



1.1.6 RANGE OF ESOTERIC PRACTICES

Research at the NCHSR (Kippax et al., 1998) has indicated that there is a significant relationship between seroconversion and engaging in a range of esoteric practices, although these specific practices are not in themselves likely to lead to transmission of HIV. These practices include fisting (inserting the hand or forearm in the rectum), urolagnia (water sports), use of sex toys, use of cock rings, engaging in sadomasochistic and bondage or dominance practices, and dressing up as part of fantasy. Although information in Table 1.1.6 confirms that there is a significant relationship between engaging in esoteric practices and engaging in unprotected anal intercourse, there is no evidence for change over time in the level of engagement in these practices.

Table 1.1.6 gives the mean score on a scale of esoteric practices for men who reported any unprotected anal intercourse (UAI) and those who did not report any unprotected anal intercourse (no UAI). The *n* is the number of men from which the mean was calculated.

Table 1.1.5a: Men engaging in unprotected anal intercourse with regular partners (based on all the men who participated)

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			1181	49.7						
Male Out: NGCA			651	40.4						
Sydney										
Health in Men					450	43.1	845	49.5	1175	49.7
Positive Health					232	29.3	214	31.3		
Periodic	3343	34.0	2916	35.0	2862	35.8	2884	36.9	2541	33.4
Male Out: GCA			223	45.3						
Male Out: NGCA			78	38.5						
Gay Asian Men	319	27.9					457	24.3		
Melbourne										
Periodic			1578	33.2	1830	37.5	1877	34.9	2064	33.4
Male Out: GCA			258	43.8						
Male Out: NGCA			103	36.9						
Brisbane										
Periodic	1225	29.9	1285	34.2	1570	33.4	1787	33.1	1510	34.6
Male Out: GCA			99	54.5						
Male Out: NGCA			62	38.7						
Perth										
Periodic			1035	36.3			790	34.7		
Male Out: GCA			93	52.7						
Male Out: NGCA			49	30.6						
Adelaide										
Periodic	463	33.0			565	34.7			834	31.8
Male Out: GCA			78	42.3						
Male Out: NGCA			42	40.5						
Canberra										
Periodic			350	34.0					255	32.9

GCA = gay-community-attached NGCA = non-gay-community-attached

Table 1.1.5b: Men engaging in unprotected anal intercourse with regular partners (based on the men who had regular partners)

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			898	65.4						
Male Out: NGCA			414	63.5						
Sydney										
Health in Men					307	63.2	634	65.9	844	69.2
Positive Health					132	51.5	139	48.2		
Periodic	2227	51.0	1867	54.6	1836	55.8	1816	58.6	1514	56.0
Male Out: GCA			166	60.8						
Male Out: NGCA			51	58.8						
Gay Asian Men	210	42.4					258	43.0		
Melbourne										
Periodic			1007	52.0	1199	57.2	1193	54.9	1298	53.2
Male Out: GCA			192	58.9						
Male Out: NGCA			69	55.1						
Brisbane										
Periodic	762	48.0	803	54.8	968	54.2	1059	55.8	897	58.3
Male Out: GCA			80	67.5						
Male Out: NGCA			38	63.2						
Perth										
Periodic			679	55.4			500	54.8		
Male Out: GCA			72	68.1						
Male Out: NGCA			26	57.7						
Adelaide										
Periodic	294	52.0			371	52.8			511	51.9
Male Out: GCA			58	56.9						
Male Out: NGCA			28	60.7						
Canberra										
Periodic			215	55.3					160	52.5

GCA = gay-community-attached NGCA = non-gay-community-attached

Table 1.1.6: Mean of esoteric practices by unprotected anal intercourse (UAI)[1]

Source	1999		2000		2001		2002		2003	
	n	Mean	*n*	Mean	*n*	Mean	*n*	Mean	*n*	Mean
Sydney										
Health in Men										
Any UAI					284	2.08	546	1.87	768	2.02
No UAI					166	1.14	299	1.24	407	1.22
Positive Health										
Any UAI					116	3.38	119	3.29		
No UAI					116	1.39	95	1.40		

[1]The difference between the means for those who did and those who did not report unprotected anal intercourse was statistically significant for both studies.

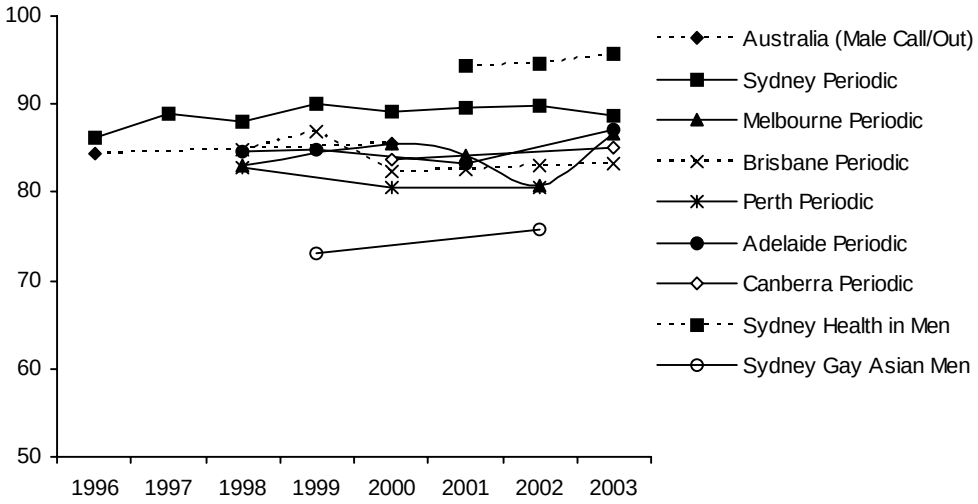
1.1.7 TESTING FOR HIV AMONG HOMOSEXUALLY ACTIVE MEN

Table 1.1.7 shows that, among homosexually active men who are socially attached to gay community, over 80 per cent of those in each sample have ever been tested for HIV. For the period 1999 to 2003, values for this indicator were steady for all of the data sets.

Among homosexually active men not socially attached to gay community, Male Out data from 2000 indicated less HIV testing than among their gay-community-attached counterparts. The most recent data (2002) from the Asian Gay Community Periodic Survey in Sydney (Gay Asian Men) indicated less HIV testing overall in this group, although no change from 1999.

Key data from Table 1.1.7 are presented graphically in Figure 3. Again, where available, relevant data from surveys conducted during the three years prior to 1999 are also included. For the purposes of comparison with the Periodic Surveys, only data for gay-community-attached men are presented from the Male Call and Male Out surveys. (Note that for legibility the *y*-axis has been drawn from 50 to 100 per cent rather than the complete 0 to 100 per cent.)

Figure 3: Percentage of men who had ever been tested for HIV



1.1.8 RECENT HIV TESTING AMONG HIV-NEGATIVE MEN

One of the ways in which some homosexually active men have responded to the HIV/AIDS epidemic is to monitor their own HIV antibody status by a series of HIV antibody tests. Table 1.1.8 gives information from a number of studies regarding recent testing for HIV. The question asked was, 'How long is it since you had a test for HIV?', and the percentages were derived by counting those whose responses indicated that they had been tested within the six months prior to the respective surveys. Data from the Health in Men cohort (2001 to 2003) and from Gay Asian Men in Sydney (1999 to 2002) indicate a decrease in recent HIV testing, whereas data from the Periodic Surveys in Sydney and Adelaide (1999 to 2003) indicate an increase in recent HIV testing. No trends were evident in other cities and studies.

Table 1.1.7: Percentage of men who had ever been tested for HIV

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			1181	85.5						
Male Out: NGCA			651	67.0						
Sydney										
Health in Men[1]					450	94.4	453	94.5	430	95.8
Periodic	3343	90.1	2916	89.2	2862	89.7	2884	89.8	2541	88.7
Male Out: GCA			223	85.7						
Male Out: NGCA			78	76.9						
Gay Asian Men	319	73.0					457	75.7		
Melbourne										
Periodic			1578	85.6	1830	84.2	1877	80.7	2064	86.7
Male Out: GCA			258	88.8						
Male Out: NGCA			103	64.1						
Brisbane										
Periodic	1225	86.9	1285	82.4	1570	82.5	1787	83.0	1510	83.2
Male Out: GCA			99	90.9						
Male Out: NGCA			62	69.4						
Perth										
Periodic			1035	80.5			790	80.6		
Male Out: GCA			93	86.0						
Male Out: NGCA			49	73.5						
Adelaide										
Periodic	463	84.9			565	83.2			834	87.2
Male Out: GCA			78	88.5						
Male Out: NGCA			42	64.3						
Canberra										
Periodic			350	83.7					255	85.1

[1]Based on new participants in Health in Men as annual HIV testing is a criterion for participation in the cohort
GCA = gay-community-attached NGCA = non-gay-community-attached

Table 1.1.8: Homosexually active men who are HIV-negative and were tested for HIV within the six months prior to the survey

Source	1999		2000		2001		2002		2003	
	n	%	n	%	n	%	n	%	n	%
Australia										
Male Out: GCA			924	40.5						
Male Out: NGCA			419	33.4						
Sydney										
Health in Men[1]					425	59.3	428	51.6	412	51.5
Periodic	2381	47.8	2099	47.0	2095	44.4	2144	50.3	1911	50.1
Male Out: GCA			169	43.8						
Male Out: NGCA			59	27.1						
Gay Asian Men	223	48.0					330	39.4		
Melbourne										
Periodic			1201	41.5	1373	40.3	1412	39.4	1565	42.1
Male Out: GCA			215	36.3						
Male Out: NGCA			57	29.8						
Brisbane										
Periodic	942	50.0	981	50.2	1217	51.0	1381	50.5	1171	48.9
Male Out: GCA			82	39.0						
Male Out: NGCA			41	26.8						
Perth										
Periodic			792	40.9			596	42.8		
Male Out: GCA			77	41.6						
Male Out: NGCA			35	48.6						
Adelaide										
Periodic	353	43.3			431	45.5			683	49.6
Male Out: GCA			66	37.9						
Male Out: NGCA			27	29.6						
Canberra										
Periodic			270	33.7					202	39.6

[1]Based on new participants in Health in Men as annual HIV testing is a criterion for participation in the cohort
GCA = gay-community-attached NGCA = non-gay-community-attached

1.1.9 HIV TESTING AMONG MEN UNDER THE AGE OF 25

Findings from Male Call 96 (Crawford et al., 1998) and the 2000 Male Out survey (Van de Ven et al., 2001) indicated a significant downward trend in the percentage of young men under the age of 25 who had been tested for HIV. The data in Table 1.1.9 show that the earlier downtrend is no longer evident. Only the Brisbane and Sydney Asian Gay Community Periodic Survey figures confirm a downward trend in HIV testing among younger gay men. (Note: These data are based in part on small numbers and should be treated with caution.)

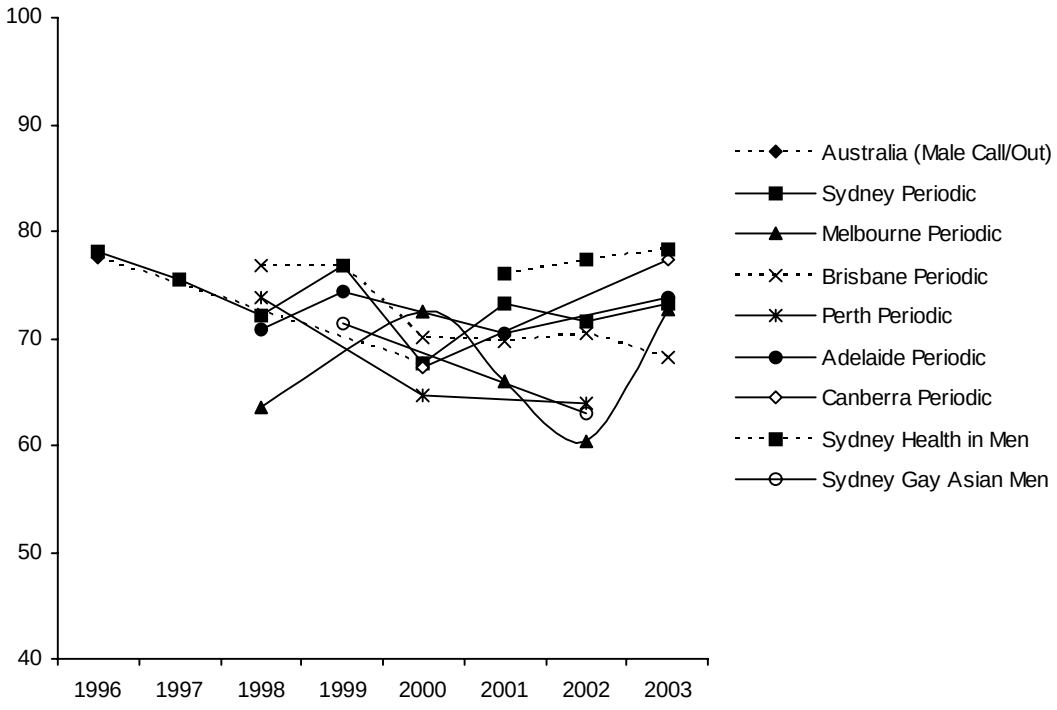
Key data from Table 1.1.9 are presented graphically in Figure 4. Where available, relevant data from surveys conducted during the three years prior to 1999 are also included. For the purposes of comparison with the Gay Community Periodic Surveys, only data for gay-community-attached men are presented from the Male Call and Male Out surveys. (Note that for legibility the *y*-axis has been drawn from 40 to 100 per cent rather than the complete 0 to 100 per cent.)

Table 1.1.9: Men under the age of 25 ever tested for HIV

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			71	67.6						
Male Out: NGCA			65	52.3						
Sydney										
Health in Men[1]					46	76.1	53	77.4	37	78.4
Periodic	346	76.9	260	67.7	281	73.3	291	71.5	254	73.2
Male Out: GCA			11	–						
Gay Asian men	56	71.4					62	62.9		
Melbourne										
Periodic			223	72.6	267	65.9	307	60.3	297	72.7
Male Out: GCA			10	–						
Brisbane										
Periodic	212	76.9	291	70.1	439	69.7	409	70.4	396	68.2
Male Out: GCA			12	–						
Perth										
Periodic			198	64.6			175	64.0		
Male Out: GCA			8	–						
Adelaide										
Periodic	74	74.3			115	70.4			157	73.9
Male Out: GCA			5	–						
Canberra										
Periodic			52	67.3					22	77.3

[1]Based on new participants in Health in Men as annual HIV testing is a criterion for participation in the cohort
GCA = gay-community-attached NGCA = non-gay-community-attached

Figure 4: Percentage of men under the age of 25 ever tested for HIV



1.1.10 PERCENTAGE ENGAGING IN UNPROTECTED ANAL INTERCOURSE WITH CASUAL PARTNERS BY SEROSTATUS

Table 1.1.10 shows the number and percentage of men who engaged in any unprotected anal intercourse with casual partners by serostatus during the six months prior to the survey for the years 1999 to 2003. It confirms that men who are HIV-positive are more likely to engage in unprotected anal intercourse with casual partners than men who are HIV-negative. Some unprotected anal intercourse reported by people living with HIV may be with partners who are also HIV-antibody-positive. Note, however, that information from SMASH (Grulich et al., 1998) showed that even if positive men who engaged in unprotected anal intercourse only with other positive men are removed, the remainder of positive men report more unprotected anal intercourse with casual partners than do negative men.

For the years 1999 to 2003, data from the Periodic Surveys conducted in Sydney, Melbourne and Brisbane provide evidence of increasing engagement in unprotected anal intercourse with casual partners among HIV-positive and HIV-negative men alike.

1.1.11 AGREEMENTS AMONG HOMOSEXUALLY ACTIVE MEN WITH REGULAR PARTNERS REGARDING UNPROTECTED ANAL INTERCOURSE

Agreements with regular partners to have only protected anal intercourse (or no anal intercourse) both within the relationship and with casual partners (that is, outside the relationship) are regarded as 'safe sex' agreements, regardless of the serostatus of the partners. Agreements with regular partners to have some unprotected anal intercourse can be assessed for safety only if both partners have been tested and each knows the serostatus of the other. That is, unless the seroconcordance (or otherwise) of men in regular relationships can be assessed reliably by such men, any agreement to have unprotected anal intercourse within the relationship is not a safe sex agreement. Table 1.1.11 shows the percentage of men with regular partners, both in seroconcordant relationships and in relationships which were not known to be seroconcordant, who had agreements to engage only in 'safe' sex. An agreement to have unprotected anal intercourse was classified as a safe sex agreement when partners (1) were seroconcordant (either positive or negative), (2) had a clear spoken agreement regarding anal intercourse within the relationship and (3) had a clear spoken agreement regarding anal intercourse with casual partners that involved no unprotected anal intercourse outside the relationship. Research at NCHSR has highlighted the importance of agreements in a series of published papers relating to 'negotiated safety' (Crawford et al., 2001; Kippax et al., 1993; Kippax, Noble, Prestage et al., 1997; Van de Ven et al., 1999d). Findings from this research show that a high proportion of men have agreements and stick to them.

Table 1.1.10: Men engaging in unprotected anal intercourse with casual partners by serostatus[1] (based on the men who had casual partners)

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
HIV Futures										
Positive[2]	795	26.3			725	29.1				
Male Out										
Positive			69	62.3						
Negative			936	34.3						
Sydney										
Health in Men										
Negative					360	37.5	656	37.5	927	36.9
Positive Health										
Positive					151	52.3	159	56.0		
Periodic										
Positive	481	43.2	404	51.5	375	61.3	337	59.9	275	58.9
Negative	1647	21.9	1519	27.3	1521	28.8	1521	29.3	1312	27.8
Gay Asian Men										
Positive	7	–[3]					16	–[3]		
Negative	173	19.7					255	15.7		
Melbourne										
Periodic										
Positive			110	36.4	115	49.6	122	57.4	158	57.0
Negative			864	22.2	909	23.0	972	24.6	1083	26.5
Brisbane										
Periodic										
Positive	74	27.0	68	42.6	74	48.6	96	47.9	84	56.0
Negative	696	19.5	696	24.9	869	25.1	963	30.1	810	28.1
Perth										
Periodic										
Positive			42	26.2			18	33.3		
Negative			530	27.9			381	28.9		
Adelaide										
Periodic										
Positive	25	32.0			24	41.7			35	42.9
Negative	216	18.5			293	23.9			497	24.5
Canberra										
Periodic										
Positive			10	–[3]					11	–[3]
Negative			175	21.7					138	21.0

[1]This table excludes men whose serostatus was unknown, either because they reported that they had not been tested or because they did not provide information regarding serostatus. The difference between positive and negative men in the percentage who reported unprotected anal intercourse with casual partners is statistically significant throughout, except for the Perth 2000 Periodic Survey data.

[2]HIV Futures figures are an underestimation as they are based on all homosexual/bisexual participants, not just on those who had casual male partners; such reduced base could not be determined because of the way questions were asked.

[3]Number of men too small to give a reliable percentage

Table 1.1.11: Men with regular partners who had 'safe sex agreements' by seroconcordance

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out										
Seroconcordant			605	70.6						
Nonconcordant			246	27.2						
Sydney										
Health in Men										
Seroconcordant					209	72.7	437	69.6	530	70.8
Nonconcordant					67	22.4	176	20.5	170	17.1
Positive Health										
Seroconcordant							67	38.8		
Nonconcordant							122	23.8		
Periodic										
Seroconcordant	1032	73.0	865	70.9	857	71.8	885	72.9	717	73.6
Nonconcordant	563	37.7	460	38.7	483	36.0	424	29.7	360	33.9
Male Out										
Seroconcordant			98	77.6						
Nonconcordant			38	34.2						
Gay Asian Men										
Seroconcordant	90	45.6					102	52.0		
Nonconcordant	74	27.0					94	21.3		
Melbourne										
Periodic										
Seroconcordant			423	68.8	571	73.2	515	71.7	578	69.4
Nonconcordant			232	28.0	320	26.6	318	25.8	320	35.0
Male Out										
Seroconcordant			123	78.9						
Nonconcordant			52	21.2						
Brisbane										
Periodic										
Seroconcordant	368	75.0	365	71.0	431	72.4	514	63.6	425	72.9
Nonconcordant	214	39.3	231	28.1	256	26.2	247	30.4	225	31.6
Male Out										
Seroconcordant			54	74.1						
Nonconcordant			25	40.0						
Perth										
Periodic										
Seroconcordant			278	74.8			204	67.6		
Nonconcordant			200	25.0			136	25.0		
Male Out										
Seroconcordant			54	72.2						
Nonconcordant			21	33.3						
Adelaide										
Periodic										
Seroconcordant	146	76.0			183	61.2			237	68.8
Nonconcordant	74	40.5			83	26.5			121	25.6
Male Out										
Seroconcordant			38	76.3						
Nonconcordant			13	30.8						
Canberra										
Periodic										
Seroconcordant			102	72.5					78	75.6
Nonconcordant			49	32.7					31	38.7

Only men with regular partners were included in Table 1.1.11. In this table, nonconcordant refers to men in relationships with regular partners where HIV serostatus of both partners was known and was discordant, or the serostatus of one or both partners was stated as 'unknown'. In every study, very few respondents reported that they were in a serodiscordant relationship (i.e. where one partner was known to be positive and the other negative), and this is why data from such respondents have been included in the nonconcordant category rather than being reported separately. Men with regular partners who did not respond to questions regarding their own or their partner's serostatus were excluded from the table.

The data are consistent across a number of studies in suggesting that around 70 per cent of men in seroconcordant relationships have an agreement to have 'safe' sex only (that is, to have no unprotected anal intercourse outside the seroconcordant relationship). The exception is among Gay Asian Men in Sydney, where safe sex agreements pertain to approximately 50 per cent of those in seroconcordant relationships. There is no evidence in the various Periodic Surveys that this percentage is changing (except in Brisbane which indicated a downward trend overall over the years 1999 to 2003).

Among nonconcordant couples, the percentage with an agreement to have only 'safe' sex—that is, an agreement to have no unprotected anal intercourse at all (either within the relationship or with casual partners)—is around 30 per cent in most samples, but sometimes lower, especially in the later years of data collection. This indicator showed a downward trend overall for the period 1999 to 2003 in Periodic Survey data from Sydney and Adelaide.

Of those without safe sex agreements, both concordant and nonconcordant, some had agreements that allowed the possibility of unsafe sex, some had no agreements, and some did not answer the relevant questions. Lack of a safe sex agreement does not necessarily imply unsafe practice.

1.1.12 NEGOTIATED SAFETY AND UNPROTECTED ANAL INTERCOURSE WITH CASUAL PARTNERS

Here we include for the first time data (for 1996 to 2003, where available) from HIV-negative men practising negotiated safety who broke their agreement and engaged in unprotected anal intercourse with casual partners. Data are reported from the Sydney, Melbourne and Brisbane Periodic Surveys which provided sufficient sample sizes for reliable calculations. Table 1.1.12 shows the number of men practising negotiated safety (*n*) and the percentage of these men who engaged in any unprotected anal intercourse with casual partners in the six months prior to survey. (The *n* is based on men in a seroconcordant HIV-negative regular relationship for at least six months who engaged in unprotected anal intercourse within the relationship and who had an agreement not to have unprotected anal intercourse with casual partners.)

In each city, small proportions of men engaged in unprotected anal intercourse with casual partners. Trends for Sydney and Melbourne were not significant, but there was a significant upward trend for Brisbane.

Table 1.1.12: HIV-negative men practising negotiated safety (*n*): percentage (%) who engaged in unprotected anal intercourse with casual partners

Source	1996		1997		1998		1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Sydney																
Periodic	175	8.0	219	7.3	287	6.3	363	6.1	312	8.3	312	10.6	330	8.2	276	9.4
Melbourne																
Periodic					163	5.5			157	7.6	222	5.0	174	6.3	192	11.5
Brisbane																
Periodic					125	3.2	110	4.5	103	5.8	132	3.8	153	9.2	140	7.9

Table 1.1.13: HIV seroconversion in the Health in Men cohort

	Intake 2001	Intake 2002
Number recruited	450	453
Number who completed first annual follow-up interview	394	389
Number of confirmed HIV seroconverters at the first annual follow-up	3	5
Incidence rate (per 100PY) at the first annual follow-up	0.73	1.29
Number who completed the second follow-up interview	348	N/A
Number of confirmed HIV seroconverters at the second annual follow-up	2	N/A
Incidence rate (per 100 PY) at the second annual follow-up	0.62	N/A

Table 1.1.14: Hepatitis A and B testing and incidence in the Health in Men cohort

	Intake 2001	Intake 2002	Intake 2003
Hepatitis A			
Number recruited	450	453	430
Number tested	434	434	422
Number tested seropositive	295 (68.0%)	295 (68.0%)	302 (71.6%)
Number tested seronegative who completed the first annual follow-up interview	101	101	N/A
Number seroconverted	26 (25.7%)	30 (29.7%)	N/A
Hepatitis B			
Number recruited	450	453	430
Number tested	433	433	427
Number with prior infection	89 (20.6%)	79 (18.2%)	69 (16.2%)
Number vaccinated	228 (52.7%)	232 (53.6%)	228 (53.4%)
Number tested seronegative who completed the first annual follow-up interview	79	88	N/A
Number infected during the 12-month interval	0	0	N/A
Number vaccinated during the 12-month interval	24 (30.4%)	24 (27.3%)	N/A

Table 1.1.15: Syphilis testing in the Health in Men cohort

	2001	2002	2003
Number tested	434	814	1190
Negative	412 (94.9%)	781 (96.0%)	1136 (95.5%)
Positive	20 (4.6%)	33 (4.1%)	51 (4.3%)
Equivocal	2 (0.5)	0	3 (0.3%)

1.1.13 HIV INCIDENCE IN THE HEALTH IN MEN COHORT

Of 450 Health in Men participants recruited in 2001, 394 completed a first follow-up interview in 2002, and three were confirmed HIV seroconverters. The HIV incidence rate in 2002 (for the 2001 intake) was 0.73 per 100 person-years. Of 453 participants recruited in 2002, 389 completed a first follow-up interview in 2003, and five were confirmed HIV seroconverters. The HIV incidence rate in 2003 (for the 2002 intake) was 1.29 per 100 person-years.

Of 348 participants who were recruited in 2001 and who completed their first follow-up interview in 2002 and their second follow-up interview in 2003, two were confirmed HIV seroconverters. The HIV incidence rate in 2003 (for the 2001 intake) was 0.62 per 100 person-years (Table 1.1.13).

1.1.14 HEPATITIS A AND B PREVALENCE AND INCIDENCE IN THE HEALTH IN MEN COHORT

In the Health in Men cohort, hepatitis A seropositivity tested at baseline interviews remained stable at around 70 per cent for participants recruited in 2001, 2002 and 2003. Of 101 participants who were recruited in 2001 and tested negative to hepatitis A virus, and who underwent hepatitis A testing again in 2002, 26 (25.7 per cent) acquired hepatitis A infection during their first round follow-up. Of 101 participants who were recruited in 2002 and tested negative to hepatitis A, and underwent testing again in 2003, 30 (29.7 per cent) acquired hepatitis A infection (Table 1.1.14).

The percentage of participants who had serological evidence of prior or current hepatitis B virus infection decreased from 20.6 per cent for the 2001 intake to 16.2 per cent for the 2003 intake, while the percentage of participants with serological evidence of hepatitis B vaccination remained stable over time at slightly over 50 per cent. For participants who tested negative to hepatitis B at baseline interview, 30.4 per cent (2001 intake) and 27.3 per cent (2003 intake) were found to have serological evidence of HBV vaccination at the time of annual follow-up (Table 1.1.14).

1.1.15 SYPHILIS IN THE HEALTH IN MEN COHORT

In the Health in Men cohort, the percentage of participants who tested positive to syphilis remained stable at round 4 per cent over time, for testing performed from 2001 to 2003 (Table 1.1.15).

1.1.16 GONORRHOEA AND CHLAMYDIA IN THE HEALTH IN MEN COHORT

Nucleic acid amplification testing (NAAT) for gonorrhoea and chlamydia was incorporated into the sexually transmissible infection testing options for Health in Men cohort participants from March 2003. Urine samples, throat swabs and rectal swabs were collected from each consenting participant. In all, 880 participants underwent these tests in 2003. Slightly more

Table 1.1.16: Gonorrhoea and chlamydia testing in the Health in Men cohort

	2003
Number tested	880
Gonorrhoea (number tested positive)	
Urine	3 (0.3%)
Throat	73 (8.3%)
Rectum	11 (1.3%)
Chlamydia (number tested positive)	
Urine	9 (1.0%)
Throat	9 (1.0%)
Rectum	44 (5.0%)

Table 1.1.17: Testing for sexually transmissible infections in the previous 12 months

Source	2003							
	Anal swab		Throat swab		Penile swab		Urine sample	
	n	%	*n*	%	*n*	%	*n*	%
Sydney								
Periodic	2386	26.7	2386	35.9	2386	27.5	2386	43.8
Positive Health	319	25.7	319	35.1	319	23.8	319	37.3
Melbourne								
Periodic	1999	24.2	1999	28.6	1999	23.7	1999	36.2
Positive Health	62	25.8	62	30.6	62	19.4	62	41.9
Brisbane								
Periodic	1415	17.1	1415	24.8	1415	21.4	1415	38.7
Adelaide								
Periodic	794	35.1	794	40.3	794	30.6	794	50.1
Canberra								
Periodic	238	23.5	238	29.0	238	20.2	238	41.6

Table 1.1.18: Beliefs about how syphilis was contracted

	n (%)
Through oral sex (insertive or receptive)	29 (50.9%)
Through anal sex without a condom	27 (47.4%)
Through oral–anal sex (rimming)	17 (29.8%)
Through kissing	11 (19.3%)
Through anal sex with a condom	7 (12.2%)
Don't know	13 (22.8%)

Note: These categories are not mutually exclusive.

than 8 per cent of participants tested positive to pharyngeal gonorrhoea, and penile and anal gonorrhoea were seen in 0.3 per cent and 1.3 per cent of participants respectively.

Five per cent of participants tested positive to anal chlamydia, and the prevalence of both penile and throat chlamydia was 1% (Table 1.1.16).

1.1.17 TESTING FOR SEXUALLY TRANSMISSIBLE INFECTIONS AMONG HOMOSEXUALLY ACTIVE MEN

Table 1.1.17 presents data from a number of studies involving gay respondents on the proportion of men who reported having various specimens taken for testing for sexually transmissible infections. The data are for 2003 only, when such questions were introduced broadly. For 2003, there was considerable variability across cities and according to the specimens provided. When additional data are collected in future years, we will be able to report trends.

1.1.18 SYPHILIS AND MEN WHO HAVE SEX WITH MEN IN SYDNEY

In Sydney, surveillance data from mid-2002 show a rapid increase in syphilis incidence among men who have sex with men in the inner and eastern suburbs (NSW Health, 2003). There is consistent evidence that syphilis, as an ulcerative condition, increases HIV infectiousness and HIV susceptibility (Wasserheit, 1992). Reducing the incidence of syphilis is therefore likely to aid in HIV prevention efforts. However, in order to design education programs that effectively target men who have sex with men, it is essential that we understand the risk factors for syphilis transmission as well as perceptions of the disease.

One study that addressed these issues, the Syphilis Study, recruited 57 men diagnosed with syphilis from sexual health centres and clinics in inner Sydney during 2003, with the majority recruited from clinics attended by gay men in the city centre and 'gay Sydney' (defined by postcodes 2010 to 2012 and including Darlinghurst, Surry Hills, Taylor Square, Elizabeth Bay, Kings Cross, Potts Point, Rushcutters Bay, Woolloomooloo and Strawberry Hills). This represented just under half of all the men diagnosed with syphilis in 2003 in the region covered by South East Health (formerly the South Eastern Sydney Area Health Service).

Men who were diagnosed with early syphilis in 2003 were more likely to report high numbers of sexual partners, to be HIV-positive, to have used drugs (particularly poppers, crystal meth, ecstasy and cocaine), to have used sex-on-premises venues, to have had sex with men from overseas, and to have participated in group sex and 'sex and drugs' scenes. Participants' beliefs about how they contracted syphilis (see Table 1.1.8) suggest that some men are unclear about potential risk activities and transmission routes. Awareness campaigns should continue to publicise the symptoms of syphilis, transmission routes, and the availability of testing and treatment.

1.2 OTHER STUDIES

In recent years the information available on populations other than homosexually active men has been transformed by the publication of the main report of the Australian Study of Health and Relationships, a grant-funded study carried out jointly by the Australian Research Centre in Sex, Health and Society (La Trobe University), NCHSR, NCHECR and the Health Promotion Unit of Central Sydney Area Health Service. The study surveyed 19 307 Australians aged 16 to 59 and is thus the largest representative sample survey on sexual health behaviour, attitudes and knowledge ever carried out in Australia, and one of the larger national sex surveys around the world (Smith et al., 2003a). In Section 1.2.1, summary results—first presented in this format in 2003 (Van de Ven, Rawstorne, Treloar & Richters [Eds], 2003)—are updated.

Sections 1.2.2 and 1.2.3 present summary results from convenience-sample surveys of university students and of women in contact with the gay and lesbian community in Sydney.

1.2.1 THE AUSTRALIAN STUDY OF HEALTH AND RELATIONSHIPS

Telephone interviews were carried out from mid-2001 to mid-2002 with 10 173 men and 9134 women in households (i.e. not in institutions such as hospitals, boarding houses or prisons), with an overall response rate of 73.1 per cent. The response rate was higher in women than men, but men in central Sydney were oversampled to give a large enough sample size to enable accurate comparisons with targeted samples of homosexually active men. The sample was weighted to reflect the location, age and sex distribution of the 2001 Census, and is therefore regarded as being broadly representative of the Australian population. The full report (volume 27 number 2 of the *Australian and New Zealand Journal of Public Health*) can be purchased for $30 from the Australian Research Centre in Sex, Health and Society at www.latrobe.edu.au/arcshs.

Percentages are presented below without standard errors or confidence intervals (CI). The 95 per cent CIs for estimates involving the entire sample will be within one percentage point either side of the estimates. When smaller subsamples are used, the standard error increases. Thus for a subsample of 331 (1.7 per cent of the total sample), if the observed percentage is 50 per cent, the 95 per cent CI is from 42 per cent to 58 per cent and, if the observed percentage is 5 per cent, the 95 per cent CI is 0.7 per cent to 9.3 per cent.

SEXUAL BEHAVIOUR

Three-quarters of the total sample (73.5 per cent of men and 77.0 per cent of women) were in a regular heterosexual relationship. Of those, 82.7 per cent (62.3 per cent of the total) lived together. People had sex an average of 1.84 times per week in the four weeks before interview; younger people and people with regular partners had sex more often than older people and people who only had casual partners. Among people who had had a regular

partner for the past 12 months or longer, 4.9 per cent of men and 2.9 per cent of women had had sex with someone else in the past year (Rissel et al., 2003a).

For men, the median age at first vaginal intercourse declined from 18 among men aged 50 to 59 to 16 for men aged 16 to 19. For women, the decline in median age was from 19 to 16. Contraceptive use at first intercourse has increased from less than 30 per cent of men and women in the 1950s to over 90 per cent in the 2000s (Rissel et al., 2003b).

Men had had more opposite-sex partners in their lifetime (mean 16.5, median 6) than women (mean 6.8, median 3) and also in the past year (men: mean 1.5, median 1; women: mean 1.0, median 1). Of the total sample, 92 per cent had had experience of vaginal intercourse; 6 per cent of men and women had never had intercourse (and 2 per cent did not disclose whether they had). More than half of those without experience of intercourse were under 20. About 3 per cent of people never have vaginal intercourse in their lifetimes. A minority of these people are gay men or lesbians who have had no intercourse with an opposite-sex partner.

In the most recent sexual encounter in the past year with an opposite-sex partner, 95.6 per cent of men and 93.9 per cent of women had engaged in vaginal intercourse. Although 20.9 per cent of men and 15.1 per cent of women had tried anal intercourse, less than 1 per cent had done it at their last heterosexual encounter (de Visser et al., 2003a).

Less than 3 per cent of men and women thought of themselves as anything other than heterosexual (i.e. gay, lesbian, bisexual or other). However, more people (8.6 per cent of men and 15.1 per cent of women) reported some same-sex attraction or experience. Of the men with any lifetime sexual experience with other men, 40 per cent identified as either gay or bisexual. Of women with any lifetime sexual experience with other women, only 24 per cent identified as either lesbian or bisexual (Smith et al., 2003b).

In the most recent sexual encounter between men, 90 per cent engaged in manual stimulation of the partner and 89 per cent were stimulated by the partner; 75 per cent received fellatio and 76 per cent gave it; and 38 per cent had insertive anal intercourse and 30 per cent had receptive ($n = 185$ for these questions). In the most recent sexual encounter between women, 91 per cent manually stimulated their partner and 95 per cent were stimulated by the partner; 66 per cent received cunnilingus and 62 per cent gave it ($n = 123$; Grulich et al., 2003a).

Although the majority of respondents had used a condom at some time in their lives, fewer than half of the respondents who were sexually active in the past year had used a condom. For vaginal intercourse, only 8 per cent of people always used condoms in the past six months for vaginal intercourse with a regular live-in partner, but 29 per cent did so with a regular non-live-in partner, and 45 per cent with a casual partner. Among men having sex together in the past six months, 23 per cent always used a condom for anal intercourse with a regular live-in partner, 38 per cent with a regular non-live-in partner and 87 per cent with a casual partner. In other words, of men with a regular live-in male partner, 77 per cent did not always use condoms for anal intercourse (in fact 74 per cent never did). This was true of 62 per cent of the even smaller group of men with regular non-live-in partners, but of only 13 per cent of the men having sex with casual partners (de Visser et al., 2003b).

TESTING FOR HIV

About two in five Australians aged 16 to 59 have been tested for HIV: 40.7 per cent of men and 38.9 per cent of women. Men who identified as gay or bisexual were more likely to have been tested and to have had a test recently. Of those tested, 0.3 per cent of men and 0.4 per cent of women were HIV-antibody-positive (Grulich et al., 2003b).

1.2.2 SEXUAL BEHAVIOUR AND CONDOM USE AMONG FIRST-YEAR UNIVERSITY STUDENTS

Table 1.2.2 shows the results of a convenience-sample survey carried out from a stall at Orientation Week at the University of New South Wales in 2002 and 2003. Although these students were all in first year, and had all finished high school a year or two earlier, they were on average somewhat older than other first-year university student samples (Richters and Song, 1999; Rodden et al., 1996), partly because UNSW has a high proportion of international students and local overseas-born students. Many overseas-born students repeat the final years of high school in Australia or do other pre-university courses here after completing high school overseas. (Students aged 22 and over were excluded from this analysis.) However, the UNSW students were less likely to be sexually experienced: 59 per cent had no experience of vaginal intercourse. Of those with a regular partner, 47 per cent had used a condom every time in the past month, as had 63 per cent of the small number who had had sex with a casual partner in the past six months. Slightly less than half of the young men and about a third of the young women kept condoms handy.

1.2.3 WOMEN IN CONTACT WITH SYDNEY'S GAY AND LESBIAN COMMUNITIES

Table 1.2.3 contains data from the biennial Sydney Women and Sexual Health (SWASH) surveys conducted by NCHSR, NCHECR and ACON in 1998, 2000 and 2002. (See also Richters et al., 2001, 2002.) Each year, most of the women (71 to 85 per cent) were recruited at the Sydney Gay and Lesbian Mardi Gras Fair Day. Some respondents were also recruited through other groups, venues and clinics in contact with gay, bisexual and lesbian communities, but to allow for reliable comparisons over time, the data in the table are based only on the women recruited at Fair Day.

In 2002, ages ranged from 16 to 59 (median age 30) and 71 per cent had post-school education. Asked how they thought of themselves, 71 per cent identified as lesbian/dyke/homosexual/gay, 8 per cent as bisexual and 15 per cent as heterosexual; 6 per cent chose the 'other' category or did not answer. Sexual identity was correlated with age: younger women more likely to identify as bisexual and less likely to identify as lesbian. Five respondents were transgender/trannies. Most respondents (424, 84 per cent) had had sex with a woman; 341 women (68 per cent) had done so in the past six months. A quarter of the women (124; 25 per cent) had had sex with a man they knew to be gay or bisexual; 16 women (3 per cent) had done so in the past six months. Four of the lesbians said they had had sex with a gay or bisexual man in the past six months, as had six of the bisexual women and six of the heterosexual women. Ten women (2 per cent) had had unprotected vaginal or anal intercourse with a male gay or bisexual partner (regular or casual) in the past six months. Ten women had done sex work in the past six months.

Table 1.2.2: Sexual practice among first-year students aged 21 or under at the University of New South Wales[1]

	2002 *n* = 303	2003 *n* = 280
Male	121	125
Female	182	155
Number of partners ever	**%**	**%**
0	40.0	49.3
1	20.8	18.2
2–4	22.8	20.7
>4	16.5	11.7
Ready access to condoms[2]		
Male	48.8	45.5
Female	36.3	28.3
Condom use with regular partner in the past month (total samples)		
Never	6.6	6.4
Sometimes	3.6	2.5
Most times	5.6	4.6
Every time	12.2	13.9
No partner or no intercourse	72.0	72.5
Condom use with regular partner in the past month (based on those with a regular partner)		
Never	17.8	16.1
Sometimes	12.3	8.9
Most times	16.4	14.3
Every time	39.7	53.6
No intercourse	13.7	7.1
Condom use with casual partners in the past 6 months (total samples)		
Never	5.6	4.6
Sometimes	3.0	1.8
Most times	4.0	1.4
Every time	12.5	13.6
No partner or no intercourse	74.9	78.6
Condom use with casual partners in the past 6 months (based on those with casual partners)[3]		
Never	13.6	13.3
Sometimes	11.9	8.9
Most times	18.6	6.7
Every time	55.9	71.1
Sexual practice, ever		
Vaginal sex	45.2	37.1
Regular partner	42.9	35.0
Casual partner	21.5	15.0
Anal sex	8.9	10.7
Regular partner	8.3	10.4
Casual partner	3.6	3.9
Any form of sex (oral, vaginal, anal)	53.5	47.5

[1]Students aged under 22 who finished high school in 2000 or 2001 for the 2002 survey, or 2001 or 2002 for the 2003 survey

[2]Answering 'yes' to the question: 'Do you currently keep condoms readily accessible; for example, in a purse, wallet, glove box or a bedside table?'

[3]Based solely on those who had sexual intercourse with casual partners

Of the 309 women who had had oral sex with a woman in the past six months, only 9 per cent had ever used a dental dam, and most of those (including the one HIV-positive woman) had done so only once. Use of gloves (13 per cent of women who had had sex with a woman) and condoms (17 per cent) was more common and they were used more frequently. Only a minority of women had received oral sex during menstruation, or given oral sex to a woman who was menstruating, but it was far more common to do so with a tampon in place than to use a dental dam.

Table 1.2.3: Women surveyed at Sydney Gay and Lesbian Mardi Gras Fair Day[1]

	1998 (*n* = 554)		2000 (*n* = 883)		2002 (*n* = 505)	
	n	%	*n*	%	*n*	%
Sexual identity						
Lesbian	396	71.5	611	69.2	360	71.3
Bisexual	54	9.7	80	9.1	78	7.5
Heterosexual	84	15.2	177	20.0	36	15.0
Other/missing	20	3.6	15	1.7	31	6.1
HIV status						
Negative	326	62.4	477	55.6	279	59.9
Positive	6	1.1	2	0.2	3	0.6
Unknown	199	36.5	379	44.2	184	39.5
Had an HIV test in past 12 months (% of those ever tested)	149	44.0	146	29.8	106	21.0[2]
Had sex with a gay or bisexual man in past 6 months	12	2.2	21	2.4	16	1.8
Lesbian	3		2		4	
Bisexual	3		12		6	
Heterosexual	5		5		6	
Had unprotected vaginal or anal intercourse (UVAI) with a gay or bisexual man						
Total sample: no UVAI	540	97.5	866	98.1	495	98.0
Total sample: some UVAI	14	2.5	17	1.9	10	2.0
Injecting drug use (IDU) in past 6 months						
Total sample: no IDU	525	94.8	864	97.8	492	97.4
Total sample: some IDU	29	5.2	19	2.2	13	2.6

[1]Sample size varies slightly for different questions due to non-response

[2]In 2002 the questionnaire response categories were changed; this figure is for testing up to 11 (not 12) months ago.

2

Living with HIV

On a national basis, only one study, HIV Futures—conducted initially in 1997 (Ezzy et al., 1998) and repeated in 1999 (Grierson et al., 2000) and 2001 (Grierson et al., 2002)—provides reliable information on both sexual practice and treatment uptake for people living with HIV and AIDS, including representation of people from all categories of HIV transmission. HIV Futures was repeated in 2003–2004 and the results from the latest round of data collection will be reported in this annual series of reports next year.

Regional information is available from other surveys, notably the Positive Health cohort study conducted in Sydney by NCHSR with input from the Australian Research Centre in Sex, Health and Society (ARCSHS) for a smaller Melbourne arm. The first round of face-to-face interviews for the Positive Health study was conducted in 1999, the second round in late 2000 and early 2001. Sexual practice questions were not included in the baseline interview schedule but were included in the Sydney follow-up in 2000–2001. The 2003 round of data collection for Positive Health extended into 2004 and the results from the latest round of data collection will be reported in this annual series of reports next year.

2.1 SEXUAL PRACTICE

With respect to sexual practice and the period covered by this report, only two data points (1999 and 2001) are available on a national basis for people living with HIV, so trends over time cannot be fully assessed. The number of responses from women in the HIV Futures study to questions regarding unprotected intercourse is too small to give reliable data, as are the number of responses from men who had female partners.

The HIV Futures study indicates little change in the percentages of HIV-positive men engaging in unprotected intercourse with casual male partners (see Table 2.1). With regular male partners, however, there was an increase in this practice from 1999 to 2001, with HIV-positive regular male partners and with HIV-negative regular male partners.

The Positive Health data indicate no change in (though relatively high proportions of) unprotected anal intercourse with casual male partners or seroconcordant regular partners. The data, however, do indicate a decrease in unprotected anal intercourse with discordant or nonconcordant regular partners. Data from other studies on sexual practice among homosexually active men who are HIV-positive (Table 1.1.10, page 27) also show a relatively high level of unprotected anal intercourse with casual partners among these men.

2.2 SELF-RATINGS OF HEALTH

In various studies, HIV-positive people were asked to rate their health as ‘excellent’, ‘good’, ‘fair’ or ‘poor’. Table 2.2 shows the percentage of people reporting ‘excellent’ or ‘good’ overall health. Over time, HIV-positive people’s self-ratings of health varied little in the HIV Futures studies. Sydney participants in the Positive Health cohort study tended to report better overall health in 2001 and 2002 than in 1999, whereas the reverse was the case among Melbourne participants.

Table 2.1: Unprotected intercourse among people living with HIV/AIDS[1]

Partner type	1999				2001				2002			
	Men		Women		Men		Women		Men		Women	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
HIV Futures	***N* = 828**		***N* = 89**		***N* = 818**		***N* = 74**					
Casual male	414	52.1	10	10.0	371	59.0	8	25.0				
Casual female	22	47.4			17	41.2						
Regular male (HIV-positive)	123	83.4	12	61.6	122	91.8	9	100				
Regular male (HIV-negative)	125	34.7	25	41.7	121	41.3	21	42.9				
Regular female (HIV-positive)	11	70.0			8	87.5						
Regular female (HIV-negative)	13	28.6			19	27.3						
Positive Health					***N* = 242**				***N* = 280**			
Casual male (HIV-positive only)[2]					79	74.7			102	73.5		
Casual male (HIV-negative/unknown)[2]					146	51.4			179	53.1		
Regular male (HIV-positive)					52	71.2			65	73.8		
Regular male (HIV-negative/unknown)					67	40.3			80	20.0		

[1]Shows the number and the percentage of people living with HIV/AIDS who reported unprotected intercourse (vaginal or anal) with casual and regular partners in the six months prior to the survey. '*N*' is the size of the complete sample and '*n*' is the number of people who answered the question (that is, who had a partner of the type shown).

[2]Based only on those who engaged in unprotected anal intercourse with casual partners (and therefore not comparable with HIV Futures figures above).

Table 2.2: Self-ratings of health as 'excellent' or 'good'[1]

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
HIV Futures	949	72.8			891	69.2				
Sydney										
Positive Health[2]	362	76.2			292	79.8	252	80.6		
Melbourne										
Positive Health[2]	56	76.7			105	68.6	83	70.7		

[1]Rather than 'fair' or 'poor'

[2]Includes 'excellent', 'very good' and 'good'

2.3 TREATMENT UPTAKE AND VIRAL LOAD

Evidence regarding the effectiveness of these treatments became widespread in the second half of 1996. HIV-positive homosexually active men in Sydney, Melbourne and other parts of Australia took up combination antiretroviral therapy very quickly after it became available Table 2.3.1). In the national sample from the HIV Futures study, 73.5 per cent of HIV-positive people reported being on combination antiretroviral therapy in 1999, a figure corroborated by data from other studies throughout Australia in the same year. (The different percentages in Table 2.3.1 to some extent reflect different definitions of 'combination antiretroviral therapy' as indicated by the footnotes to the table.)

Recent data indicate a significant decline in the proportion of people living with HIV using combination therapy among Positive Health participants in both Sydney and Melbourne, and among Sydney, Melbourne and Brisbane participants in the Gay Community Periodic Surveys. In 2000, data from the Australian HIV Observational Database (AHOD) became available and, whereas this open cohort shows variability over time, the overall trend in use of combination therapy is flat.

Table 2.3.1: People living with HIV/AIDS on combination therapy

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
HIV Futures[1]	952	73.5			884	71.0				
AHOD[1,2]			2282	69.7	2190	69.8	2057	75.2	1992	70.6
Sydney										
Periodic[3]	597	71.9	504	75.2	443	65.5	420	68.1	330	66.7
Positive Health[1]	362	78.2			292	72.6	322	68.3		
Melbourne										
Periodic[3]			138	78.3	151	66.9	150	70.0	177	55.9
Positive Health[1]	56	82.1			105	71.4	83	59.0		
Brisbane										
Periodic[3]	99	67.7	77	66.2	88	59.1	121	48.8	94	55.3
Perth										
Periodic[3]			50	74.0			27	74.1		
Adelaide										
Periodic[3]	34	73.5			33	57.6			42	59.5
Canberra										
Periodic[3]			17	70.6					13	(92.3)[4]

[1] 'Combination therapy' means two or more antiretrovirals.

[2] AHOD = Australian HIV Observational Database

[3] 'Combination therapy' means 'combination antiretroviral therapy'.

[4] Percentage to be treated with caution; based on small '*n*'

Key data from Table 2.3.1 are presented graphically in Figure 5. Where available, relevant data from surveys conducted during 1997 are also included. (Note that for legibility the *y*-axis has been drawn from 40 to 100 per cent rather than the complete 0 to 100 per cent.)

Table 2.3.2 presents data from various sources on the proportion of people living with HIV/AIDS who have undetectable viral load. Data are presented separately for those using antiretroviral therapy and those not using it at the time of data collection. Clearly, a larger proportion of those using antiretroviral therapy have undetectable viral load than those not using therapy. There are no significant trends in these data apart from in the AHOD open cohort which indicated increasing proportions of people with undetectable viral load among those using ART. Approximately three-quarters of those using therapy in 2003 reported undetectable viral load.

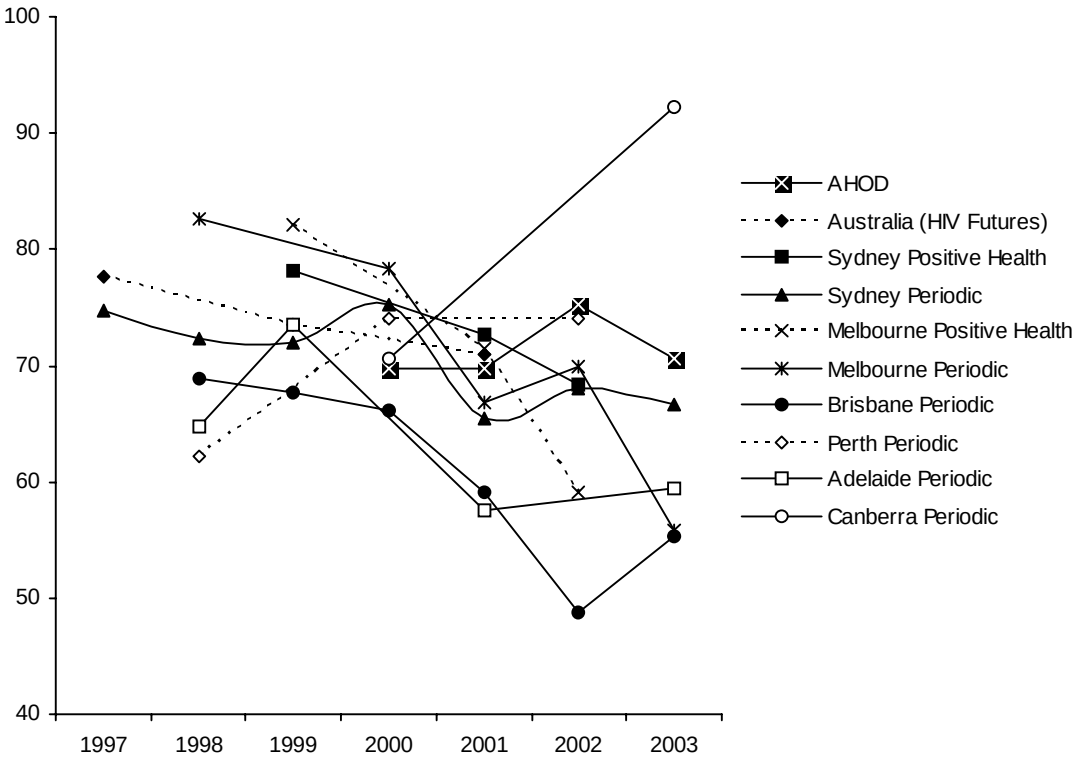
Table 2.3.2: People living with HIV/AIDS who have undetectable viral load

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
HIV Futures										
Using ART[1]	628	68.5			568	70.8				
Not using ART	199	13.4			200	17.7				
AHOD										
Using ART			1581	71.0	1520	74.3	1452	74.0	1403	80.0
Not using ART[2]			389	12.6	391	13.6	401	12.7	433	14.8
Sydney										
Periodic										
Using ART							100	80.0	217	75.1
Not using ART							53	13.2	108	24.1
Positive Health										
Using ART	283	63.3			206	67.0	220	70.0		
Not using ART	64	18.8			72	13.9	98	20.4		
Melbourne										
Periodic										
Using ART									98	74.5
Not using ART									77	16.9
Positive Health										
Using ART	49	46.9			74	56.8	59	66.1		
Not using ART	6	16.7			30	10.0	22	9.1		
Brisbane										
Periodic										
Using ART							58	75.9	51	74.5
Not using ART							61	21.3	41	19.5
Perth										
Periodic										
Using ART							18	84.2		
Not using ART							8	15.8		

[1]ART = Antiretroviral therapy

[2]Not using ART during the year

Figure 5: Percentage of people living with HIV/AIDS on combination therapy



2.4 TREATMENT EXPERIENCES

A significant consideration for people on combination therapy is the prospect or experience of adverse side effects. As indicators of side effects (see Table 2.4), the experiences of (a) diarrhoea or nausea, (b) anxiety or depression or fear, (c) lipodystrophy and (d) 'any side effects' were computed. There are few time points and therefore trends are difficult to discern. However, based on the available data, a smaller proportion of HIV Futures participants reported side effects. (The lower percentages from HIV Futures were attributable to the way the questions were asked, as an open-ended ['please specify'] question, so the figure would be an underestimation of participants' experiences of side effects.) Over time, there was a tendency for a greater proportion of Positive Health participants to report side effects, so much so that by 2002 nearly all participants in both Sydney and Melbourne experienced some side effects. Of note, experience of lipodystrophy among Positive Health participants increased from approximately 60 per cent in 1999 to approximately 70 per cent in 2002. Increase in the proportion of Positive Health participants experiencing diarrhoea or nausea was even more pronounced, from approximately 50 per cent in 1999 to approximately 75 per cent in 2002.

Table 2.4: Experience of side effects by people on combination therapy[1]

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) Diarrhoea/Nausea										
Australia										
HIV Futures	700	33.5			588	24.5				
Sydney										
Positive Health	292	50.1			194	64.5	155	73.6		
Melbourne										
Positive Health	49	46.9			70	81.4	49	75.5		
(b) Anxiety/Depression/Fear										
Australia										
HIV Futures					886	21.3				
Sydney										
Positive Health	292	66.4			194	60.8	155	69.0		
Melbourne										
Positive Health	49	79.6			70	72.9	49	77.6		
(c) Lipodystrophy										
Australia										
HIV Futures	909	28.5			836	38.4				
Sydney										
Positive Health	261	60.2			194	71.6	155	72.9		
Melbourne										
Positive Health	45	57.8			70	74.3	49	69.4		
(d) Any side effects										
Australia										
HIV Futures	708	54.8			588	43.9				
Sydney										
Positive Health	292	96.9			194	81.4	155	94.2		
Melbourne										
Positive Health	49	100			70	90.0	49	95.9		

[1]The side effects may not all be attributable to taking antivirals. From 2001, slightly different questions were asked in Positive Health than in 1999.

2.5 NORTHERN RIVERS STUDY

In November 2002, in-depth interviews were conducted in the Northern Rivers area of New South Wales as part of a qualitative study exploring how particular cultural and social environments mediate experiences of living with HIV, antiretroviral treatment and side effects such as lipodystrophy. Ethnographic fieldwork was also conducted during two weeks in the region, including formal and informal discussions with service providers in the local HIV sector and participation in local events. This research constitutes the regional arm of the Side Effects and Lipodystrophy Project. The following is a brief summary of preliminary findings from the Northern Rivers data.

PARTICIPANTS

Of 17 participants, all male, 15 identified as gay and two as heterosexual. Their ages ranged from 26 to 58 and most were in their 40s and 50s. Most of the men were on the pension, though a significant number wanted to work but were unable to find employment in the area. About half were single and half had partners, most of whom were also HIV-positive. Except for one man born in the region, all participants had moved to the Northern Rivers from an urban centre, predominantly Sydney and Melbourne.

REASONS FOR MOVING TO NORTHERN RIVERS

Searching for a better quality of life was by far the most common reason for moving to the Northern Rivers area. Many said that they had fallen in love with the region when visiting on holiday and had subsequently decided to relocate. There was a common perception among the participants that the stresses of city life had a detrimental effect on them and that the relaxed lifestyle and natural surroundings of the region would be more conducive to their health and their management of HIV. The decision to move was also influenced by a common impression that the Northern Rivers area had a substantial population of HIV-positive people and that relevant health services would therefore be reasonably good. Most participants said they were very happy with their decision and that they intended to stay, even though many found that the region was not quite what they had expected in terms of services.

PERCEIVED ADVANTAGES AND DISADVANTAGES

The most frequently cited advantages of living in the Northern Rivers were the gentler, slower pace, the beautiful environment, the climate, the healthy outdoor lifestyle, the friendly people in the area, and the lack of traffic, cars, pollution, crowds and noise. A few men said that one advantage of living in the Northern Rivers was less daily awareness of being HIV-positive because there were fewer gay people, venues and media to remind them.

Overwhelmingly, a lack of appropriate health services and HIV expertise was seen as the greatest disadvantage of living in the Northern Rivers area. Many said that there was an acute shortage of general practitioners with HIV experience and that existing doctors were stretched to the absolute limit. A close second was the lack of transport, the dependence on cars, and the long and costly travelling distances. This, according to some, made it more difficult to build social networks in a geographically dispersed area. Hence isolation was often raised as an issue. In relation to this, some participants mentioned missing friends and family as one of the disadvantages of having moved to the Northern Rivers. Lack of work was also mentioned by many as a significant drawback.

COMMUNITY

There was a general feeling among the participants that there was no 'gay community' as such in the Northern Rivers area. However, a few described what they saw as a 'fragmented' and 'disjointed' gay community with separate 'gay groups' in different local areas. Most said that their social networks were made up of gay and straight friends, neighbours and

peer support groups. (That 'peer support group' was mentioned as an important part of social networks was undoubtedly influenced by the fact that most of the participants in the study were recruited through peer support networks.) There was a definite tendency for relationships to be with other urban expatriates rather than with local people. Whereas many agreed that building friendships took a long time, some also commented that these friendships tended to be strong and genuine because people had more time and were more reliant on each other than in the cities.

HEALTH

The majority of participants had been HIV-positive for a long time, but only a few had experienced HIV-related illness. Most described their health as 'good' or 'fine', and some felt that their health had improved since they moved to the Northern Rivers area. Low energy and side effects from antiretroviral treatment were the most commonly cited health issues. Seven of the men also reported a history of depression and other mental health problems. Four of the participants were co-infected with hepatitis C, including both of the heterosexual men.

HIV HEALTH SERVICES

Issues to do with services in the area were a recurring topic in many interviews. Most participants agreed that there was a lack of HIV-related services, both health services and community support services similar to the Community Support Network in Sydney. The lack of choice of doctor was a major concern, as was the lack of professional expertise and home care in the event of declining health. Existing services were seen to be overstretched, with some claiming that this impacted negatively on the quality of care available. Having to wait several weeks for an appointment to see the specialists at the local AIDS and sexual health clinic was mentioned by many.

The participants seemed divided over the issue of insufficient services. Some argued that this was to be expected in a regional area, while others felt that more money and resources should be allocated to serve the growing population of people with HIV. One issue that was frequently and passionately raised in many of the interviews was that of the so-called 'whingers', purportedly a group of people who were seen to habitually make unreasonable demands and complaints, causing 'troubles' and tension. There was a great deal of anger among the participants directed towards this group. Two participants who thought they might be seen as part of this group said they felt silenced and ignored. At the time of the research, the issue seemed to be a considerable and complex one for the local AIDS Council and for the community.

HIV TREATMENT

Of the 17 participants, seven were not on any treatment for HIV at the time of their interview, though all of them had been so in the past. Most of the men had long and complex histories of HIV therapy. Problems with side effects were by far the most common reason for stopping treatment, though a few mentioned viral resistance as an issue, and one man said he had to stop while on treatment for hepatitis C. Three of the men who had discontinued their HIV therapy said that they had no intention of starting again and would only consider doing so if

their health deteriorated significantly. Two of these men stated that their viral load was still undetectable after two to three years without any treatment. The others described their decision to stop as more of a temporary measure to resolve side effects and to give their bodies a 'break' from the drugs.

COMPLEMENTARY THERAPY

Perhaps surprisingly, considering the region's renowned 'alternative' culture and lifestyle, the majority of participants did not use complementary therapies. One obvious reason for this is the prohibitive cost of such therapies when living on a pension, but many also said that they were not particularly interested or convinced about the benefits. However, those few who did use complementary therapies were heavy users and highly committed to (predominantly) vitamins, supplements and herbs as an integral part of their health management. Only one or two practised techniques such as yoga or meditation on a regular basis.

LIPODYSTROPHY

One aim of the study was to investigate how particular cultural and social environments influence body image and experiences of body shape change. At least 14 participants reported some degree of lipodystrophy or change in body shape. Their experiences were both similar to and different from those of the participants in the urban arm of the Side Effects and Lipodystrophy Project.

Concern about lipodystrophy being seen as a 'sign' of HIV and sickness was significant in both groups. Among the Sydney participants, this sense of forced disclosure was primarily a concern in relation to gay community because of a widespread perception that lipodystrophy was well known in that social domain. In the Northern Rivers area, forced disclosure was more of a concern in relation to the broader community for a number of reasons. There was a feeling that local people were 'really straight' and less accepting or less understanding than in cities, so many participants felt a need to carefully protect their HIV status. Many also spoke about the higher degree of visibility and 'talk' that comes with living in a smaller community. While most did not believe that the local population knew about lipodystrophy, many were concerned that people might think they looked 'sick' as a result of lipodystrophy, or that they might think 'that there is something wrong with you'. However, while many felt their body shape changes made them 'stand out' in the local landscape, some participants also observed that it was easier 'to hide' in the Northern Rivers area than in the city.

In contrast to what many of the Sydney participants referred to as the body-focused Sydney gay 'scene', body image was of lesser concern for people with lipodystrophy in Northern Rivers. They explained this with reference to the lack of emphasis on 'looks' and appearance in the local community in general and also with reference to the 'alternative' culture in the region which was seen as more inclusive and accepting of difference. Many participants said that people in the area were not into the so-called 'gym culture'. Some also mentioned the generally older age of HIV-positive people in the region as a reason for a more relaxed attitude to body image.

Only one of the participants had had New-Fill treatment for facial fat loss and there was markedly less awareness of New-Fill among the Northern Rivers participants than among the Sydney participants. Further analysis of the study data is currently in progress.

2.6 COMPLIANCE

Adherence to antiretroviral regimens is an important issue. An indicator of adherence—having missed any doses 'during the past two days'—was available from the HIV Futures and Positive Health studies. On this indicator, approximately 85 per cent of the 2002 Positive Health participants missed no doses. In the HIV Futures study, missing doses was related to the belief that medication gave an unwanted reminder of HIV status, and to the presence of depressive symptoms. Recent data from both studies show that approximately 50 per cent of those 'currently' taking antiretrovirals experienced any difficulty taking pills on time (see Table 2.6).

2.7 LIVING WITH HIV AND CULTURAL DIVERSITY

People from culturally and linguistically diverse backgrounds intersect with one or more priority groups in the National HIV/AIDS Strategy: gay and homosexually active men, injecting drug users, and people living with HIV/AIDS. However, it is also acknowledged that people from these backgrounds have specific needs concerning HIV/AIDS-related health promotion and support.

The aim of the Living with HIV and Cultural Diversity study was to investigate the lived experience of HIV-positive people belonging to ethnic and cultural groups outside the Anglo-Celtic mainstream. The focus was on common issues across cultures or ethnicities and risk-exposure categories. Data were collected through in-depth semi-structured interviews.

Table 2.6: Experience of taking pills

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) Missed any doses during past two days										
Australia										
HIV Futures	700	15.9			640	17.2				
Sydney										
Positive Health	292	22.3			194	13.9	178	14.0		
Melbourne										
Positive Health	49	18.4			70	28.6	60	15.0		
(b) Experienced any difficulty taking pills on time										
Australia										
HIV Futures	699	47.8			588	45.0				
Sydney										
Positive Health	292	32.5			194	49.0	178	48.9		
Melbourne										
Positive Health	49	40.8			70	60.0	60	48.3		

THE MEANING OF DIAGNOSIS

All participants experienced their diagnosis as a form of death sentence, irrespective of country of birth, time of diagnosis (before or after availability of highly active antiretroviral treatments), age and level of education. Even among those who were diagnosed in Australia in the late 1990s and as recently as 2002, knowledge about HIV and experience with HIV were strongly influenced by their knowledge and experience from their country of birth. An HIV diagnosis meant no treatment, no support, shame and no distinction between HIV and AIDS. The common perception was that people with AIDS died.

> *They did explain to me that I'm positive of HIV but in my language I don't have the word for HIV. We unfortunately presume that it's AIDS. Yeah, and he [doctor] tried to explain to me that 'Not yet, you just started.' When I was in Cambodia I saw the information, the brochure about this. They just call it AIDS ... AIDS disease, not HIV, and we believe it's terminal. It means when you've got it you won't live very long.*

The experience of diagnosis was particularly traumatic when it was part of the health check for migration. Married women, especially, were shocked when they were told that they were HIV-positive and had great problems making sense of it. In the accounts of the participants, there was no counselling before or after the test.

For women who had lived in Australia for a number of years and were diagnosed here, one difficulty was to be tested for HIV at all. There is still, among some members of the medical profession, the belief that HIV infection is associated with certain social groups and with a certain lifestyle, and that middle-aged, middle-class women who do not fit this stereotype cannot be infected with HIV.

> *When I start feeling sick like the flu I went to see my doctor ... He say to me, 'When you say the symptoms,' he say, 'could be that [HIV] ... But I don't think so because you are a lady.'*

All the women interviewed to date were infected by their husbands or believed they were. Being questioned by health care professionals about sexual behaviour and drug use only confounded the shock and confusion the women experienced when they were diagnosed.

> *They asked me how I got infected. 'Did you use needles? Did you use drugs? What sort of thing?' I could only say, 'I don't know.' Because the fact is, I don't know. I don't have any idea how I was infected.*

For participants diagnosed in their country of birth, social sanctions relating to homosexuality or sexuality generally meant that participants felt utterly alone and without support. For those diagnosed in Australia, where it is possible to speak more freely, language barriers and social isolation made communication impossible for new immigrants.

IMPLICATIONS OF DISCLOSURE

The cultural attitudes, values, beliefs and knowledges that coloured people's experience of an HIV diagnosis also affected their ability to disclose their status to their families, to members of their ethnic communities and to Anglo-Australians. For many it was a strictly guarded secret and this had implications for using support services, or rather not using these

services. Cultural barriers to disclosure were fear of gossip and loss of face, cultural restrictions on sexuality and sexual behaviour, social obligation to family, and geographical distance between participants in Australia and their families overseas.

A very strong factor for most participants was the fear that gossip would spread out of control and eventually reach family members in their country of birth. Participants from Asian countries spoke about 'losing face'. Participants from South America and Europe did not use that expression, but their concerns were the same: family, especially parents, had to be protected from the knowledge that their son or daughter had HIV. This was, in part, motivated by the belief that HIV was the same as AIDS and that anyone with that virus would die soon. Participants felt unable to explain the distinction between HIV and AIDS or to convince their families overseas that they were doing fine.

Losing face had consequences for the participants themselves: they feared they would be identified as gay, or associated with injecting drug use and prostitution. Losing face also had consequences for the family: a son's or daughter's HIV infection would have to be explained to the extended family. There were complex relationships between the nature of HIV, knowledge and assumptions about HIV, its mode of transmission, cultural beliefs about the sexuality of men and women, and social obligations to parents. All these made disclosure difficult. In this context, non-disclosure was an important mechanism to protect oneself and others.

> *If Thai people, if one person [in Australia] knows, and you know gossip. They will tell someone and tell, tell, tell. So it's better to stay by myself, not to let anyone know.*

So they can't gossip?

> *Yeah. Oh, big news! 'Academic in Sydney ... Oh, he got HIV.' You see, in Thailand that's big news. It's about a high academic who behave like gay. It becomes big news ... And my surname, my family surname, gone! And I cannot go to university. I lose my family. My mum will lose face ... That is most important. 'Oh, your son is gay.'... Her relatives, you know, you have to answer the relatives, 'Why, why, why your son is gay?'*

In conclusion, people from culturally and linguistically diverse backgrounds face an extremely steep learning curve from their initial experience of HIV as a terminal illness to living with HIV as a manageable condition. In addition, some participants need to negotiate two major life adjustments simultaneously: living with HIV and starting a new life in a new country, often without English and without family and friends.

2.8 SEROCONVERSION

The Risk Factors for HIV Infection study, which began in 1993, documents understandings of HIV transmission risk given in accounts by gay men of the purported event or events that they believe led to their seroconversion. The ongoing nature of this study allows for understanding of changes in perceptions of risk over time.

Men who have recently seroconverted are interviewed within six months of a documented infection. There was a break in interviewing men between 1998 and 1999. Sixty-five men

were interviewed prior to the introduction of highly active antiretroviral treatment late in 1996, and 34 men were interviewed between 1997 and the end of 2002. In 2003, 19 men were interviewed, bringing the total number of participants in the study to 118. Since the beginning of 2003, the majority of participants have been recruited via the PHAEDRA study based at the National Centre in HIV Epidemiology and Clinical Research. This is a prospective cohort study of individuals identified with primary HIV infection to examine the immunological, virological and therapeutic factors that may influence disease progression. The PHAEDRA study also collects data on behavioural risk factors associated with acquiring HIV infection.

The Risk Factors for HIV Infection study enables explorations of men's perceptions of risk and the meanings they attach to different sexual practices, relationships and contexts. The presumed mode of transmission offered by respondents early in their interviews was not always the same as the conclusion reached by the end of the interview and presented in Tables 2.8.1 to 2.8.3 (or indeed the same as the conclusion drawn by the researchers on review of the transcripts). The interviews became a joint process of reconstruction of 'what probably happened' as well as the offering of memories by the participant to the interviewer.

The findings indicate that up until the end of 1996 just over half of seroconversions were believed by the men in the study to have occurred within their regular relationships, some of which they knew to be serodiscordant for HIV. In the interviews since 1997 a significant number of seroconversions continued to be attributed to regular relationships, but it appeared that infection was now more frequently being attributed to casual sex. Although there is currently no epidemiological data available in Australia on the proportion of seroconversions that occur in the context of a regular or casual relationship, behavioural surveillance data from the Gay Community Periodic Surveys and other studies show generally increasing

Table 2.8.1: Type of sexual relationship at time of seroconversion

	Pre-treatment success (1993–1996)	Post-treatment success (1997–2002)	Post-treatment success (2003)
Regular relationship in which neither the participant nor his partner had casual sex	21[1]	2	2
Regular relationship in which participant and his partner had casual sex	13	14	5
Regular relationship in which participant had casual sex	4	2	2
Participant had two regular sexual partners	1	1	
Total regular relationships	39	19	9
Casual sexual partners only	26	15	10
Total	65	34	19

[1]Includes three participants, each of whom engaged in sex with his regular partner in a threesome

rates of unprotected anal intercourse with casual and regular partners in recent years (see Section 1 of this report).

The accounts of seroconversion offered by participants in this study provide significant insights into the contexts and meanings that surround HIV infections in both regular and casual relationships. Analysis of these interviews suggests that sexual encounters are framed by a number of factors including location, length of relationship, familiarity with the casual partner, incorrect assumptions about serostatus, intimacy, sexual attraction and romance (Kippax et al., 2003). In some cases, prior contact with a casual partner facilitated a degree of trust and intimacy that influenced decisions around unprotected anal sex in the incident(s) purported to have resulted in HIV infection (Ellard et al., 2004).

There is evidence in the interviews done in recent years of some men applying a crude form of negotiated safety with casual partners, where the decision to have unprotected intercourse was in part mediated by the disclosure of both sexual partners' HIV-negative status prior to anal intercourse. Willingness to rely on these disclosures was, in some cases, influenced by prior contact or familiarity with each other. This suggests that distinctions between casual and regular partner are at times blurred and that these categories may not always resonate with how some gay men experience or perceive these relationships (Ellard et al., 2004; Prestage et al., 2001). Some of the accounts of infection that are attributed to casual partners cite a recently finished regular relationship as part of the broader context of their infection. After the end of a relationship a man may seek new and diverse sexual partners and experiences after a long period of relative sexual stability with a regular partner. He may also desire sexual validation in response to feelings of rejection and unhappiness as a consequence of the relationship having ended. At the same time he may have become unaccustomed to using and negotiating condoms after an extended period with a regular HIV-negative partner where condoms were not used.

The accounts of men who believed they seroconverted within their regular relationships are commonly couched in terms of love and intimacy, or attributed to a breakdown in communication or trust. In many of these cases the seroconversion occurred in the early months of the relationship, when the feelings of love and trust were not always matched by open communication and negotiation.

Table 2.8.2: Assumed HIV status of partner at presumed event of HIV transmission

	Pre-treatment success (1993–1996)		Post-treatment success (1997–2002)		Post-treatment success (2003)	
Assumed HIV status	Regular	Casual[1]	Regular	Casual[1]	Regular	Casual[1]
Positive	13	4	4	1	3	0
Negative	14	3	4	6	0	3
Unknown	7	24	0	19	0	13
Total	34	31	8	26	3	16

[1] 'Casual' includes participants in open regular relationships who believe they contracted HIV from a casual partner

Analysis of the interviews since the introduction of combined antiretroviral therapy in 1996 suggests a complex relationship between treatments, viral load and risk-taking. It was common for participants who had been in a serodiscordant relationship to regard therapy as having greatly improved the health outcomes of people with HIV. It also reduced worry about mortality but did not appear in most cases to have influenced sexual risk-taking within relationships. While some of the men who attributed their seroconversion to a known HIV-positive regular partner acknowledged the potential of therapy to reduce viral load in some cases, very few explicitly used viral load as a risk-reduction strategy (Murphy et al., 2003). This study will continue to investigate the benefits and complexities of new clinical technologies and their impact on sexual risk behaviour.

The majority of men interviewed since 1993 have attributed their infection to unprotected anal intercourse, but over the years of the study a small number of men have attributed their seroconversion to lower risk activities such as oral sex, 'nudging' (brief anal insertion of the penis without a condom) or semen on an open wound. An earlier analysis of the first 75 seroconversion interviews explored the possibility of transmission through oral sex. Although the analysis could not establish how common oral transmission was in any epidemiological way, it appeared that in a few of the cases reported in this study oral transmission was the most likely mode of transmission (Richters et al., 2003b).

Table 2.8.3: *Purported* event of HIV transmission leading to seroconversion—type of sexual practice by partner

Sexual practice	Type of relationship			Total
	Regular	Casual within open relationship	Casual	
Pre-treatment success (1993–1996)				
Anal receptive	16	1[1]	17	34
Anal insertive	8	1	2	11
Anal receptive and insertive	6	2	4	12
Other[2]	4	1	3	8
Total	34	5	26	65
Post-treatment success (1997–2002)				
Anal receptive	2	6	10	18
Anal insertive	4	1	1	6
Anal receptive and insertive	1	2	2	5
Other[2]	1	2	2	5
Total	8	11	15	34
Post-treatment success (2003)				
Anal receptive	2	5	6	13
Anal insertive	0	0	1	1
Anal receptive and insertive	0	0	1	1
Other[2]	1	1[1]	2	4
Total	3	6	10	19

[1]Each of these men had an HIV-positive regular partner but attributed seroconversion elsewhere.

[2]These men believed they had become infected via oral–genital sex (11 men), sharing a needle (1), esoteric sexual practice involving sado-masochism (2) and blood contact with skin lesions (3).

This earlier analysis also focused on describing the usual patterns of sexual interaction reported by the men who had seroconverted. It found that: oral sex was almost always practised without condoms; 'nudging' was often not regarded as 'anal intercourse'; although ejaculation inside the partner was generally avoided, there was often semen on men's bodies or hands; and fisting was usually done with gloves, but anal fingering was not. Thus, even in a community where the practice of safe sex was explicitly accepted, there was room for HIV transmission without men necessarily being aware of risk-taking (Richters et al., 2003a). A number of the men who attributed their seroconversion to unprotected anal sex had sought to reduce the risk of HIV infection by only being insertive or by not allowing partners to ejaculate inside them when being receptive.

Recent analysis of the interviews has focused on the various ways that participants think and act in relation to risk. It found a range of discourses about risk including ones related to the fields of public health and HIV prevention education (Slavin et al., 2004; Kippax et al., 2003). Of the men interviewed in recent years, the majority had little or no detailed knowledge of treatments and testing technologies prior to seroconversion (Ellard et al., 2003; Murphy et al., 2003).

As in previous years, many of the men interviewed in 2003 had used drugs at the event(s) where they became infected. Yet it was rare for drugs and alcohol to be represented as having had a significant influence on their sexual risk behaviour.

2.9 CONTACT WITH THE EPIDEMIC

There is little quantitative information available regarding the impact of the changing nature of the HIV/AIDS epidemic on behaviour. Two indicators of the degree of contact with the HIV epidemic that may be important in monitoring change are 'knowing people with HIV' and 'ever knowing anyone who died following AIDS'. These indicators were included in various studies including the Health in Men and Positive Health cohort studies, 2000 Male Out and the Periodic Surveys in some state capital cities. In Table 2.9, data on these indicators are presented separately for HIV-negative and HIV-positive men.

The data show that HIV-positive men in Sydney had continuing high levels of contact with the epidemic. The exception was HIV-positive gay Asian men whose values on these indicators were substantially lower. HIV-positive men in other parts of Australia also had high levels of contact with the epidemic, although somewhat less in some places than their Sydney counterparts.

Information from the various studies shows that in terms of 'knowing anyone with HIV', HIV-negative men in various parts of Australia had fairly high levels of contact with the epidemic but over time there was a downward trend in some places, notably Adelaide.

Table 2.9: Indicators of contact with the HIV epidemic

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) Knows anyone with HIV										
Australia										
Male Out										
HIV-negative men			1305	66.8						
HIV-positive men			81	93.8						
Sydney										
Male Out										
HIV-negative men			389	67.6						
HIV-positive men			29	96.6						
Gay Asian Men										
HIV-negative men	223	46.6					330	52.1		
HIV-positive men	10	60.0					16	81.3		
Health in Men										
HIV-negative men					450	83.6	844	85.0	1175	84.9
Positive Health										
HIV-positive men	292	97.2			277	97.4	241	95.9		
Melbourne										
Male Out										
HIV-negative men			353	70.8						
HIV-positive men			20	95.0						
Positive Health										
HIV-positive men	49	100			92	94.6	69	97.1		
Brisbane										
Male Out										
HIV-negative men			246	63.4						
HIV-positive men			19	89.5						
Perth										
Periodic										
HIV-negative men							590	68.1		
HIV-positive men							26	96.2		
Male Out										
HIV-negative men			134	68.7						
HIV-positive men			5	–[1]						
Adelaide										
Periodic										
HIV-negative men	345	75.4			423	69.5			668	65.4
HIV-positive men	33	97.0			34	100			44	95.5
Male Out										
HIV-negative men			118	59.3						
HIV-positive men			2	–[1]						
Canberra										
Male Out										
HIV-negative men			23	65.2						
HIV-positive men			–	–						

… / continued

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(b) Ever knew anyone who died following AIDS										
Australia										
Male Out										
HIV-negative men			1343	57.8						
HIV-positive men			86	77.9						
Sydney										
Male Out										
HIV-negative men			394	66.0						
HIV-positive men			31	77.4						
Gay Asian Men										
HIV-negative men	223	27.8					330	18.5		
HIV-positive men	10	20.0					16	50.0		
Health in Men[2]										
HIV-negative men					450	67.6	453	58.1	430	57.2
Positive Health										
HIV-positive men	292	61.3[3]			277	50.9	241	38.6		
Melbourne										
Male Out										
HIV-negative men			364	58.2						
HIV-positive men			22	81.8						
Positive Health										
HIV-positive men	49	73.5[3]			92	58.7	69	40.6		
Brisbane										
Male Out										
HIV-negative men			256	52.3						
HIV-positive men			19	78.9						
Perth										
Periodic										
HIV-negative men										
HIV-positive men										
Male Out										
HIV-negative men			139	54.7						
HIV-positive men			5	–[1]						
Adelaide										
Periodic										
HIV-negative men	342	62.6			426	55.4			668	47.2
HIV-positive men	33	81.8			34	91.2			44	84.1
Male Out										
HIV-negative men			119	51.3						
HIV-positive men			2	–[1]						
Canberra										
Male Out										
HIV-negative men			23	43.5						
HIV-positive men			1	–[1]						

Note: To provide larger and more reliable samples, Male Out figures are state-based rather than capital-city-based.

[1]Number of men is too small to give a reliable percentage

[2]Based on new participants in Health in Men only

[3]Not comparable with other data as this figure is based on knowing anyone who died following AIDS 'in the past 12 months', rather than 'ever'

GCA = gay-community-attached NGCA = non-gay-community-attached

Drug use

3

3.1 HOMOSEXUALLY ACTIVE MEN

3.1.1 HOMOSEXUALLY ACTIVE MEN AND RECREATIONAL DRUG USE

Use of recreational drugs among homosexually active men is high for those attached to gay community (see Table 3.1.1). This information comes from the 2000 Male Out survey, the Health in Men and Positive Health cohort studies, and also from several Periodic Surveys (where relevant questions were also included). Approximately 50 to 80 per cent of these men (at the higher end of this range among men in the Health in Men, Positive Health and Living as Men studies) reported using at least one non-prescription drug in the six months prior to the survey. Use of more than one such drug was reported by around 55 to 65 per cent of those in the cohort studies and around 30 to 45 per cent of those in other studies.

Generally, the level of use as measured in the percentages reported here appears to be fairly stable over the time period observed. An exception is among gay Asian men in Sydney, where any drug use is showing an increasing trend albeit from a much lower base than most other samples. Based on Periodic Survey data, use of at least one drug increased significantly in Brisbane, and use of more than one drug increased significantly in Sydney, Melbourne and Brisbane.

Recreational drug use is one variable which shows strong regional variation. Differences between cities are highlighted where data were collected from more than one city for the same study. An example is the Living as Men study (Lambevski et al., 2000) which provided evidence that recreational drug use was much higher in Sydney than in Melbourne (see Table 3.1.1). Similarly, the Gay Community Periodic Surveys indicate more extensive use of drugs in Sydney than in other cities.

3.1.2 HOMOSEXUALLY ACTIVE MEN AND INJECTING DRUG USE

A minority of homosexually active men reported using a needle to inject drugs in the six months prior to various surveys from which data are available (Table 3.1.2). Gay-community-attached men were more likely to report such practice. In general, a higher percentage of men in the Positive Health and HIV Futures studies reported injecting, although the latter study asked about injecting 'in the previous 12 months' so this figure is not directly comparable with the others in Table 3.1.2.

The longitudinal data available suggest that the level of injecting drug use has remained relatively stable over the reporting period, albeit higher than rates in the general population based on National Drug Strategy Household Surveys; for example, any injecting drug use in the past 12 months (compared with six months for most of the data in Table 3.1.2) was reported by 1.1 per cent of metropolitan respondents and 0.7 per cent of regional respondents (Williams, 2001). Data from the Positive Health cohort and the Periodic Surveys in Sydney indicate a decline in injecting drug use.

Table 3.1.1: Recreational drug use among homosexually active men ('in past six months')

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) Any drug use										
Australia										
Male Out: GCA			1181	60.4						
Male Out: NGCA			651	48.1						
HIV Futures[1]	738	71.1			725	70.6				
Sydney										
Health in Men					450	81.1	845	78.6	1175	80.3
Positive Health	345	82.9			263	89.7	233	86.3		
Periodic	3343	70.5	2916	73.3	2862	73.2	2884	70.4	2541	72.8
Male Out: GCA			223	73.1						
Male Out: NGCA			78	53.8						
Gay Asian Men	319	30.1					457	38.1		
Living as Men[2]	528	82.4								
Melbourne										
Positive Health	52	84.6			90	67.8	65	86.2		
Periodic			1578	60.4	1830	60.7	1877	59.4	2064	62.7
Male Out: GCA			258	62.8						
Male Out: NGCA			103	47.6						
Living as Men[2]	310	74.8								
Brisbane										
Periodic	1225	43.6	1285	48.6	1570	52.1	1787	47.8	1510	56.5
Male Out: GCA			99	60.6						
Male Out: NGCA			62	61.3						
Perth										
Periodic			1035	58.0			790	55.3		
Male Out: GCA			93	57.0						
Male Out: NGCA			49	38.8						
Adelaide										
Periodic					565	54.9			834	56.4
Male Out: GCA			78	47.4						
Male Out: NGCA			42	40.5						
Canberra										
Periodic									255	49.4
Male Out: GCA			18	50.0						
Male Out: NGCA			10	–[3]						

… / continued

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(b) Used more than one drug										
Australia (Male Call/Out)										
Male Out: GCA			1181	38.9						
Male Out: NGCA			651	23.3						
HIV Futures[1]	724	49.4			702	49.4				
Sydney										
Health in Men					450	67.8	845	65.1	1175	65.5
Positive Health	345	62.6			263	69.6	233	56.7		
Periodic	3343	51.0	2916	58.6	2862	57.1	2884	53.6	2541	56.3
Male Out: GCA			223	55.2						
Male Out: NGCA			78	19.2						
Gay Asian Men	319	15.4					457	21.9		
Living as Men[2]	528	69.9								
Melbourne										
Positive Health	52	53.8			90	51.1	65	53.8		
Periodic			1578	39.7	1830	41.8	1877	40.1	2064	44.3
Male Out: GCA			258	37.2						
Male Out: NGCA			103	23.3						
Living as Men[2]	310	49.0								
Brisbane										
Periodic	1225	23.0	1285	27.5	1570	32.5	1787	29.3	1510	38.9
Male Out: GCA			99	39.4						
Male Out: NGCA			62	25.8						
Perth										
Periodic			1035	39.9			790	34.6		
Male Out: GCA			93	33.3						
Male Out: NGCA			49	26.5						
Adelaide										
Periodic					565	30.8			834	37.1
Male Out: GCA			78	24.4						
Male Out: NGCA			42	31.0						
Canberra										
Periodic									255	32.2
Male Out: GCA			18	27.8						
Male Out: NGCA			10	–[3]						

[1]Gay and homosexually active men only

[2]Gay and homosexually active men only. Of 254 heterosexual men in Sydney, 55.9% used at least one drug (other than alcohol) and 37.0% used more than one drug. Of 320 heterosexual men in Melbourne, the corresponding percentages were 39.1% for at least one drug and 14.1% for more than one drug.

[3]Number of men was too small to yield a reliable percentage

GCA = gay-community-attached NGCA = non-gay-community-attached

Table 3.1.2: Injecting drug use among homosexually active men in the six months prior to the survey

Source	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Australia										
Male Out: GCA			1181	11.3						
Male Out: NGCA			651	9.2						
HIV Futures[1]	716	13.5			720	14.6				
Sydney										
Health in Men					450	3.3	845	3.1	1175	3.6
Positive Health	345	17.7			263	13.3	233	6.4		
Periodic	3343	7.6	2916	7.2	2862	7.0	2884	5.4	2541	6.5
Male Out: GCA			223	14.3						
Male Out: NGCA			78	6.4						
Gay Asian Men	319	0.6					457	0.2		
Living as Men[2]	524	3.6								
Melbourne										
Positive Health	52	13.5			90	13.3	65	9.2		
Periodic			1578	5.0	1830	4.0	1877	4.8	2064	4.7
Male Out: GCA			258	6.2						
Male Out: NGCA			103	2.9						
Living as Men[2]	309	4.8								
Brisbane										
Periodic	1225	9.1	1285	8.6	1570	9.6	1787	10.1	1510	6.6
Male Out: GCA			99	11.1						
Male Out: NGCA			62	11.3						
Perth										
Periodic			1035	5.1			790	4.1		
Male Out: GCA			93	15.1						
Male Out: NGCA			49	6.1						
Adelaide										
Periodic[3]	463	7.5			565	4.1			834	4.6
Male Out: GCA			78	7.7						
Male Out: NGCA			42	11.9						
Canberra										
Periodic									255	1.6
Male Out: GCA			18	0						
Male Out: NGCA			10	0						

[1]Gay and homosexually active men only. Data are for IDU in past 12 months

[2]Gay and homosexually active men only. Of 254 heterosexual men in Sydney, 3.6% had injected; of 320 heterosexual men in Melbourne, 0.9% had injected.

[3]Questions changed over time and figures are not directly comparable

GCA = gay-community-attached NGCA = non-gay-community-attached

3.2 BARRIERS AND INCENTIVES TO DRUG TREATMENT

The Barriers and Incentives research project investigated barriers and incentives to drug users' accessing, utilising and remaining in treatment. A key feature of the study was the involvement of the peak Australian drug user organisation (Australian Injecting and Illicit Drug Users League [AIVL]) as a full partner in the study and their involvement in all aspects of design, planning, implementation and the formulation of recommendations.

The study involved:

- a review of international and national literature
- a drug user survey. Face-to-face interviews were conducted with 685 injecting and non-injecting users of heroin, cocaine and amphetamines, recruited from New South Wales (one inner Sydney site, one outer Sydney site and one rural site), Queensland (Brisbane and one rural site) and Western Australia (Perth).
- service provider interviews. Face-to-face interviews were conducted with 33 service providers and outreach referral services in areas in which participants in the injecting drug use survey were recruited to ascertain their views on real and perceived barriers (and incentives).
- key informant interviews. Face-to-face and telephone interviews were conducted with 28 key informants to obtain their views on barriers and incentives to treatment for drug users and about the ways in which barriers and incentives related to current and future national and state policies and programs.
- a one-day negotiation workshop with 45 participants representing both drug user and service provider interests. This was held to review and discuss the findings of the research arms of the study and to identify and discuss options for improved treatment service delivery for illicit drug users.

The team used a number of methods to examine the issues of access to drug treatment and retention in drug treatment issue from a variety of perspectives to reflect, to some extent, the complexity of the issues and to provide recommendations.

This summary report focuses on the findings of the surveys of drug users and of service providers. Among the drug users, three groups—those currently in treatment, those in treatment in the past and those never in treatment—were analysed in terms of demographic variables, their drug use and their experience of testing for blood-borne viruses.

SURVEY OF ILLICIT DRUG USERS

The sample, consisting of 685 participants, was divided into three groups depending on participants' experience of professional treatment: a group who were currently in professional treatment (329 participants), a group who were not currently in professional treatment but who had been in professional treatment in the previous six months (163 participants), and a group who had never undertaken professional treatment (193 participants).

The mean age of the sample was 31.6 years (range 18 to 64 years), with approximately 22 per cent of the overall sample aged 24 years or less. Participants in the current treatment

group and participants who had been in treatment in the past were older than participants who had never been in treatment. The sample was predominantly male (67 per cent), born in Australia (85 per cent), spoke English at home (97 per cent), had an education level to Year 10 or less (59 per cent) and reported an annual income of less than $20 000 (76 per cent).

There were few differences between the treatment groups on demographic variables. Participants in the never-treated and past-treatment groups were more likely than those in the current-treatment group to have an income above $20 000 per year. They were also more likely to obtain their main income from work or criminal activities such as dealing, rather than from social welfare benefits. And they were more likely to live in a rental property or in their own home and to live alone.

The total sample comprised 362 participants (53 per cent) who chose opioids as their primary drug and 323 participants (47 per cent) who chose stimulants (see Table 3.2.1). Fifteen participants had not used any drug in the past six months. However, seven nominated heroin and eight stimulants as the drug they had used most often. Almost 60 per cent of the sample indicated that they used drugs once or more a day and almost all (92 per cent) injected drugs. Opioid users were more likely to be in the current-treatment or past-treatment groups than in the never-treated group. Stimulant users were more likely to be in the never-treated group than in past- or current-treatment groups.

Table 3.2.1: Drug use by treatment status

	In treatment		Previously in treatment		Never in treatment		Total	
	n	%	*n*	%	*n*	%	*n*	%
Drug most frequently used (in past 6 months)*								
Opioids	194	59.0	98	60.1	70	36.3	362	52.8
Stimulants	135	41.0	65	39.9	123	63.7	323	47.2
Drug use frequency (in past 6 months)*								
Do not use drugs	0	0	6	3.7	9	4.7	15	2.2
Less than once per day	68	20.7	82	50.3	120	62.2	270	39.4
One or more times per day	261	79.3	75	46.0	64	33.2	400	58.4
How drug is used*								
Injected	306	93.0	159	97.5	136	84.5	628	91.7
Not injected	23	7.0	4	2.5	30	15.5	57	8.3

*$p < 0.001$

Table 3.2.2: Drug use history by treatment status

	In treatment		Previously in treatment		Never in treatment		Total	
	n	Mean	*n*	Mean	*n*	Mean	*n*	Mean
Age first started to inject	297	19.07	149	19.26	151	19.79	597	19.30
Years of injecting drug use*	294	13	146	13	147	10	587	12
Age first used ‘current’ drug	48	19.33	12	20.33	46	19.76	106	19.63
Age started injecting ‘current’ drug	297	20.45	149	20.31	149	20.40	595	20.40

*$p < 0.01$

Frequent users, i.e. users who normally injected drugs at least once a day, were more likely to be in the current-treatment group than in the past-treatment or never-treated groups.

Participants who used drugs by injection were more likely to be in the current- or past-treatment groups than in the never-treated group. Those who did not currently inject drugs were more likely to be in the never-treated group.

On average, participants had started injecting drugs at 19.3 years of age and had been injecting for 12 years (Table 3.2.2). Participants who had a longer history of injecting were more likely to be in the current- or past-treatment groups than in the never-treated group. There was only a short average time (less than one year) between age of first use of 'current' drug (19.63 years) and age started injecting 'current' drug (20.4 years).

Over 80 per cent of the total sample reported having been tested for hepatitis C, hepatitis B or HIV (Table 3.2.3). Hepatitis-C-positive status was reported by 44 per cent of the sample, whereas 8 per cent reported being positive for hepatitis B and 2 per cent for HIV. In addition, 18 per cent reported having been vaccinated against hepatitis B.

Participants who reported hepatitis-C-positive status were more likely to be in the current- or past-treatment groups than in the never-treated group. HIV-positive participants were more likely to be in the past-treatment or never-treated groups than in the current-treatment group (although the small numbers here warrant cautious interpretation of this finding).

Table 3.2.3: Blood-borne virus tests by treatment status

	In treatment		Previously in treatment		Never in treatment		Total	
	N	%	N	%	N	%	N	%
Ever been tested for hepatitis C**								
Never	17	5.2	6	3.7	48	24.9	71	10.4
Ever	310	94.2	156	95.7	142	73.6	608	88.8
Do not know	2	0.6	1	0.6	3	1.6	6	0.9
Hepatitis C test result*								
Negative	121	36.8	66	40.5	79	40.9	266	38.8
Positive	167	50.8	82	50.3	53	27.5	302	44.1
Unknown/No response	41	12.4	15	9.2	61	31.6	117	17.1
Ever been tested for hepatitis B**								
Never	30	9.1	12	7.4	57	29.5	99	14.5
Ever	285	86.6	144	88.3	123	63.7	552	80.6
Do not know	14	4.3	7	4.3	13	6.7	33	4.9
Hepatitis B test result								
Negative	177	53.8	90	55.2	81	42.0	348	50.8
Vaccinated	60	18.2	33	20.2	27	14.0	120	17.5
Positive	34	10.3	14	8.6	4	2.1	52	7.6
Unknown/No response	58	17.7	26	16	81	41.9	165	24.1
Ever been tested for HIV **								
Never	17	5.2	7	4.3	56	29.0	80	11.7
Ever	307	93.3	153	93.9	135	69.9	595	86.9
Do not know	5	1.5	3	1.8	2	1.0	8	1.5
HIV test result**								
Negative	291	88.4	145	89.0	119	61.7	555	81.0
Positive	0	0	6	3.7	8	4.1	14	2.0
Unknown/No response	38	11.6	12	7.4	66	34.2	116	17.0

*$p < 0.01$, **$p < 0.001$

SERVICE PROVIDER INTERVIEWS

Service providers focused on barriers at the personal and interpersonal levels, rather than at the organisational and societal or institutional levels. Main themes were drawn from the interviews.

- In general, service providers focused on the individual as the sole cause of drug problems in society and individual personal factors as the main barrier to treatment, leading to a treatment approach described as 'fix it'. Service providers described the community perception of drug use, drug users and drug treatment as highly intolerant and hostile, and indicated that the community expected abstinence (rather than anything else) as an outcome.
- Service providers identified differing treatment philosophies and their related treatment goals as at the core of many barriers to treatment. This impacted on service providers' referral and networking and was evident in the often competing interests of various agencies involved in the care and management of individuals. This worked to undermine the treatment progress of individual clients. Providers perceived that users' lack of fore-knowledge of the philosophical bases underpinning specific treatments led to users dropping out of treatments that did not match their philosophy of drug use.
- Alternative models, such as consumer involvement, based on rights of individuals within treatment, were not evident in the interviews. While national and state drug strategies recommend that drug treatment should be attractive to the user, service provider participants identified many aspects of the current system as particularly unattractive and demeaning.
- Service providers identified a number of specific practical barriers at the organisational level, such as costs, lack of places, waiting lists and confidentiality issues.
- Workforce issues were perceived as critical for the success of the sector. The workforce was portrayed as being in long-term 'crisis management'. Jobs were described as stressful, salary rates in non-government agencies were low, career structures not apparent and training piecemeal.
- Respondents acknowledged that a wide range of groups (e.g. immigrants, indigenous people, younger people, primary amphetamine users) were not currently being well served by existing services. Inadequate mental health care was described as a major failing within and between sectors.
- Respondents had an understanding of the complex, multiple needs of clients. With varying levels of success, efforts were made to connect clients with services that could help to address these needs. However, continuity of care was being undermined by a pattern of linkages based on ad hoc connections to other services.
- Court diversion, which respondents regarded as a major incentive for treatment, was an emerging issue at the time the interviews were conducted. Concerns were expressed about a possible development of a two-tiered treatment system, with those referred from courts getter quicker and cheaper access to treatment.

3.3 ACCESS TO NEEDLE AND SYRINGE PROGRAMS

In South East Health (formerly the South Eastern Sydney Area Health Service), client contact records in local needle and syringe programs (NSPs) do not reflect broader population statistics. It appears that particular groups of the population are underrepresented, particularly younger people and people from culturally and linguistically diverse backgrounds. It may be that some injectors favour other sources of equipment distribution such as vending machines or pharmacies, or that they access equipment through personal networks.

The aim of the Access to NSPs project was to understand the experiences of injectors who chose not to access primary NSP services, with a view to making recommendations to improve service provision to such people. The cross-sectional survey was of people aged 18 years and above who injected drugs, who lived, worked or visited the south-east Sydney area, and who did not routinely use primary NSP sites for access to injecting equipment. A number of strategies were used to recruit participants including: 'snowballing' and 'spotters'; peer recruiters; advertising through pharmacies, local services, and generalist and targeted subcultural magazines; mailouts to members of the NSW Users and AIDS Association (NUAA); and the distribution of flyers, cards and posters in public toilets. This summary report focuses on profiling the demographic, drug use, risk practice and blood-borne virus testing results of participants who had and had not used NSP services.

Overall, the sample had a mean age of 31 years (range 18 to 57 years), was mostly male (64 per cent), identified as Anglo-Australian (69 per cent), spoke English at home (91 per cent), identified as heterosexual (78 per cent) and relied on government benefits (59 per cent). Just under half had education only up to and including Year 10 (43 per cent), and 32 per cent indicated that they were employed. The mean duration of drug injecting was 11 years (range 0 to 35 years).

Participants who had never used NSPs reported a shorter mean duration of injecting than those who had ever used NSPs (Table 3.3.1). The mean age of first injecting was 20 years in both non-NSP users and NSP users (age range 7 to 45 years).

Thirty-eight per cent of participants had injected once a day or more in the previous six months. Participants who had never used NSPs were less likely to report injecting once a day or more in the previous six months than those who had used NSPs (Table 3.3.2). Fifty-one per cent of participants reported heroin or methadone as the most frequently injected drug in the past six months and 49 per cent reported stimulants (cocaine or speed). Participants who had never used NSPs were more likely to have used stimulants (rather than heroin) in the past six months.

Table 3.3.1: Length of injecting and age at first injecting by NSP utilisation

	Had never used NSP		Had used NSP		Total		*P* value
	Mean	SD	Mean	SD	Mean	SD	
Length of injecting (in years)	8.1	8.2	12.4	7.8	11	8.2	< 0.001
Age at first injecting (in years)	20.7	6.1	20.2	5.3	20.3	5.5	0.4

More than two-thirds of participants (69 per cent) reported having reused their own needles or syringes in the past six months. Participants who had never used NSPs were less likely to report having reused their own needles or syringes than those who had used NSPs.

Twenty-nine per cent of participants reported having used a needle and syringe after someone else in the past six months. Of the 83 participants who reported reusing a needle and syringe after someone else, approximately half (43) reused a regular partner's needle or syringe whereas 34 reported reuse of a friend's needle or syringe.

Reuse of injecting equipment other than needles and syringes was common among the participants. Of the 292 participants, 49 per cent reported having reused spoons, 34 per cent had reused tourniquets and 28 per cent had reused filters. Reuse of swabs was reported by only 3 per cent of participants. The rate of reuse of injecting equipment other than needles and syringes in the past six months was similar among participants who had and had not used NSPs.

A history of hepatitis and HIV testing was high among all participants: 87 per cent reported having had hepatitis C and HIV tests, and 81 per cent reported having had a hepatitis B test. Participants who had never used NSPs were less likely to have been tested for all three viruses than those who had used NSPs (Table 3.3.3).

Table 3.3.2: Injecting history and risk behaviour by NSP utilisation in the previous six months

	Had never used NSP		Had used NSP		Total		*P* value
	n	%	*n*	%	*n*	%	
Total sample	**102**	**34.9**	**190**	**65.1**	**292**	**100**	
Frequency of drug injection							
Less than once per day	72	71.3	109	57.7	181	62.4	0.02
Once a day or more	29	28.7	80	42.3	109	37.6	
Drug most injected							
Speed/Cocaine	58	58.0	80	44.0	138	48.9	0.02
Heroin/Methadone	42	42.0	102	56.0	144	51.1	
Reused own needles and syringes in the past six months							
Never	43	42.2	47	24.7	90	30.8	0.002
Ever	59	57.8	143	75.3	202	69.2	
Reused someone else's needles and syringes in the past six months							
Never	79	78.2	128	67.7	207	71.4	0.06
Ever	22	21.8	61	32.3	83	28.6	
Reused injecting equipment other than needles and syringes in the past six months							
Spoon	42	42.0	100	52.6	142	49.0	0.09
Swab	2	2.0	7	3.7	9	3.1	0.4
Filter	24	24.0	58	30.5	82	28.3	0.2
Tourniquet	34	34.0	65	34.4	99	34.3	0.9

Of the 248 participants who had been tested for hepatitis C, 240 participants provided information about the test results. Half (51 per cent) of those participants reported hepatitis-C-positive results. The self-reported hepatitis B infection rate was 10 per cent among participants (214) who had had a hepatitis B test and who provided the results. Fourteen participants (6 per cent) reported being HIV-positive among the sample of 239 who had been tested for HIV and provided the results. Participants who had never used NSPs were less likely to report positive results for hepatitis C and hepatitis B than those who had used NSPs. No association was found between NSP use and HIV results. Of 292 participants, 38 per cent reported having had the full course of hepatitis B vaccination. The hepatitis B vaccination rate was similar among participants who had and had not used NSPs.

Table 3.3.3: Testing for blood-borne viruses by NSP utilisation

	Had never used NSP		Had used NSP		Total		*P* value
	n	%	*n*	%	*n*	%	
Total sample	**102**	**34.9**	**190**	**65.1**	**292**	**100**	
Had hepatitis C test							
Never	29	29.9	9	4.8	38	13.3	< 0.001
Ever	68	70.1	180	95.2	248	86.7	
Unsure/No response	5		1		6		
Had hepatitis B test							
Never	33	34.7	19	10.3	52	18.6	< 0.001
Ever	62	65.3	165	89.7	227	81.4	
Unsure/No response	7		6		13		
Had HIV test							
Never	27	27.8	9	4.8	36	12.6	< 0.001
Ever	70	72.2	180	95.2	250	87.4	
Unsure/No response	5		1		6		
Hepatitis C result	**68**		**180**		**248**		
Negative	41	62.1	76	43.7	117	48.8	0.01
Positive	25	37.9	98	56.3	123	51.3	
Unsure/No response	2		6		8		
Hepatitis B result	**62**		**165**		**227**		
Negative/Vaccinated	59	96.7	134	87.6	193	90.2	0.04
Positive	2	3.3	19	12.4	21	9.8	
Unsure/No response	1		12		13		
HIV result	**70**		**180**		**250**		
Negative	67	97.1	158	92.9	225	94.1	0.2
Positive	2	2.9	12	7.1	14	5.9	
Unsure/No response	1		10		11		
Had hepatitis B vaccination							
No	60	66.7	98	59.4	158	62.0	0.3
Yes, full course	30	33.3	67	40.6	97	38.0	
Unsure/No response	12		25		35		

Hepatitis C

4

4.1 HEPATITIS C TESTING, DIAGNOSIS AND TREATMENTS

Data on hepatitis C testing, diagnosis and treatments were available from a number of studies including HIV Futures, the Australian HIV Observational Database, the Health in Men cohort of HIV-negative gay men in Sydney, and the Positive Health cohort of people living with HIV/AIDS in Sydney and Melbourne.

Substantial proportions of people living with HIV/AIDS (PLWHA) and gay-community-attached men have ever been tested for hepatitis C (see Table 4.1). PLWHA are generally

Table 4.1: Hepatitis C testing, diagnosis and treatments

	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) Tested for hepatitis C[1]										
Australia										
HIV Futures	924	63.8			894	65.4				
AHOD			2282	10.8	2190	10.4	2057	10.8	1992	8.9
Sydney										
Health in Men[2]					450	64.0	453	61.4	430	64.0
Positive Health	362	34.3			292	33.6	252	35.3		
Melbourne										
Positive Health	56	23.2			105	27.6	83	34.9		
(b) Tested positive for hepatitis C										
Australia										
HIV Futures	924	17.2			894	13.9				
AHOD[3]			247	10.1	228	10.5	223	8.1	178	10.1
Sydney										
Health in Men[2]					450	5.8	453	3.1	430	2.6
Positive Health	362	16.6			292	13.7	252	11.5		
Melbourne										
Positive Health	56	8.9			105	17.2	83	10.8		
(c) Ever taken treatments specifically for hepatitis C[4]										
Australia										
HIV Futures					125	10.7				
Sydney										
Positive Health							29	10.3		
Melbourne										
Positive Health							9	11.1		

[1]Questions about testing for hepatitis C were framed differently in the various studies reported here. In the HIV Futures and Health in Men studies, questions were framed in the context of 'ever tested' for hepatitis C whereas, in the AHOD and Positive Health studies, questions referred to testing for hepatitis C in the previous 12 months.

[2]Based on new recruits into Health in Men each year

[3]Percentages calculated on AHOD participants who had been tested for hepatitis C during each year

[4]These treatments included interferon monotherapy or combination therapy of interferon and ribavirin.

more likely than HIV-negative gay men to have been diagnosed with hepatitis C. In the full samples, HIV and hepatitis C co-infection is generally higher than 10 per cent in all of the studies with PLWHA participants. Among those PLWHA who are co-infected with hepatitis C, few have taken medical treatments specifically for hepatitis C.

4.2 CLINICAL MARKERS AND LIVING WITH HEPATITIS C

A large body of literature describes the impact of diagnosis of a chronic illness as a biographical disruption followed by a process of adaptation to living with the illness, or an illness trajectory (e.g. Bury, 1982; Paterson et al., 1999). Attitudes, expectations, behaviours and perspectives toward the illness and the individual's life can all change as a result of chronic illness diagnosis as individuals reassess the meanings they have attached to their lives. Adaptation to chronic illnesses can be influenced by many factors including individual coping styles, societal perceptions of the disease and physiological impacts such as severity of the disease. Few research projects have examined these factors related to living with hepatitis C.

Liver function tests provide a primary clinical marker used to monitor the condition and functioning of the liver in the management of hepatitis C. Little is known about how people with hepatitis C respond to liver function test results or about the relationship between these results and adaptation to life with hepatitis C as a chronic illness. There is limited research in other fields, such as HIV, about the effects of clinical markers on various aspects of living with a chronic illness, such as perceptions of health and risk.

This summary report focused on the effects of clinical markers on people with hepatitis C with regard to their health and physical being as well as their psychological state and lifestyle. In particular, we were interested in the impact of clinical markers test results on transitional processes in adaptation to living with hepatitis C as a chronic illness.

This summary used a sample of 36 participants selected from the original, larger study (see Van de Ven, Rawstorne, Treloar & Richters [Eds], 2003). The complete study recruited 78 participants with various relationships to blood: ex- and current injecting drug users, blood donors, blood recipients, those with blood disorders, those with high occupational exposure to blood (ambulance officers), those with hepatitis C from means other than injecting drug use, and those who practised body modification. This analysis focuses on data from interviews with hepatitis-C-positive individuals and their response to clinical markers such as alanine aminotransferase (ALT) levels which are measured in liver function tests for hepatitis C.

Clinical markers, in particular ALT levels, indicate the severity and progression of hepatitis C. Often, however, the results of these tests had no effect on participants' psychological state, attitude or behaviour, and they took little notice of the results. This might have been due to perceived unreliability of the tests in that they did not always correspond with how the person experienced hepatitis C. In other cases, participants disregarded ALTs because they held feelings of distrust towards the medical community.

they don't seem to make any difference to me … I've got a real cynicism for the medical view of things. My experience with a lot of that stuff is as a guinea-pig for a lot of these guys. (Bill)

Some participants simply gave little thought or care to test results or ALTs. If the results did not mean anything to them, they did not tend to pay them any attention. For some, they were just part of the routine of living with the virus, perceived as 'just a result' (Rodney). In other cases, participants occasionally took notice of their test results and ALT levels if they were feeling unwell, possibly in the hope that it would explain their physical experiences.

the only time I really pay much attention to them is if I'm particularly crook. (Christopher)

For some, however, the ALTs were more significant and acted as a motivator (alongside other factors such as fear, pain, limitations, concern for others, knowledge and past experience) in encouraging them to act in an attempt to manage the virus. Action taken by participants included beginning treatment for hepatitis C, trying alternative therapy, or often simply living a more healthy lifestyle.

I'm right into diet at the moment because my levels were quite high so I'm right into wanting to, eating the right foods … (Sue)

In a small number of cases, ALT levels appeared very significant. One participant, Wolfe, became immersed in the medical side of hepatitis C, and followed all his blood results, keeping track of his ALT levels. The motivation for this perspective was unclear, but he was thinking ahead, to his son and the future.

[talking about ALT results he has prepared on a spreadsheet] I am sorting, trying to keep my records straight for me ex and my son. Just in case when he gets a bit older if I'm not around and the doctor says I need to talk to your dad, and he says I can't, you'll have to read his reports. At least this way the doctor's got a bit of an insight into what my health was all about so he knows what to deal with my son. (Wolfe)

OVERVIEW

Clinical markers generally appeared to have very little or no effect on participants. As previous studies with HIV-positive participants have shown, viral load had very little impact on sexual activity and perceptions of risk (Davis et al., 2002). Crossley (1998) found that HIV-positive participants rejected the sick role and clinical markers, because they made no difference to them.

However, a small proportion of the participants were a little concerned with ALT results. It is possible that test results were more significant for people who were particularly ill, or in whose case the disease was more advanced, because health was a primary concern. These participants may have found it more important to follow the progress of the virus through the ALT results.

Typically, participants had little concern with the medical model of chronic illness as indicated in ALT results. The social consequences of living with hepatitis C, such as potential social limitations and isolation, were more significant and had greater impact on people with hepatitis C than clinical markers of disease progress.

5 The current climate

During more than two decades of responding to HIV, many changes have occurred. Time itself means that many people have become used to living with the epidemic; they no longer live with a constant sense of crisis. Those who were young when the epidemic began are now older and the young have become newly sexual and may be trying non-prescription drugs. The announcement at the 11th International AIDS Conference in Vancouver in July 1996 of the comparative success of new combination antiviral therapies added to a sense of being over the crisis. New therapies have lessened the burden for most people living with HIV and AIDS: there are fewer deaths and, despite often serious side effects, less debilitating illness among people living with HIV/AIDS.

Data collected during 2003 on a number of other subjects of current interest are included here. Data on post-exposure prophylaxis (PEP) awareness, uptake and experiences are presented. Findings from a study of sexually adventurous gay men in Sydney are summarised, as are findings from two studies involving young gay men. In addition, key findings from a study of internet gay chat site use are presented.

5.1 POST-EXPOSURE PROPHYLAXIS (PEP)

Data on non-occupational post-exposure prophylaxis (PEP) were available from the Periodic Surveys in Sydney, Melbourne, Brisbane and Canberra, as well as from HIV-negative gay men in the Health in Men study in Sydney. These data relate to awareness of the availability of PEP, use of PEP, and knowing others who have received PEP.

In the short period since PEP has been available in New South Wales, and become available in many other states, there has been a significant increase in awareness of its availability (see Table 5.1). Gay-community-attached men in Sydney are significantly more aware of the availability of PEP than their counterparts in either Melbourne, Brisbane or Canberra. Relatively few people have received PEP to date. Awareness of another person having received PEP is higher in Sydney than in Melbourne.

QUALITATIVE PEP STUDY

A qualitative arm of a study of PEP was conducted to explore the discursive understandings in narratives of men and women who thought they had been exposed to HIV and who took prophylactic treatment. Specifically, the study explored:

- details of the sexual practices which led to risk exposures
- participants' knowledge and understandings of risk and safe sex
- participants' familiarity with HIV, HIV-positive individuals and HIV-related issues
- participants' awareness and knowledge of PEP
- the effects of the availability of prophylactic treatment on attitudes towards actual and future sexual practices.

Table 5.1: Awareness and use of non-occupational post-exposure prophylaxis (PEP)

	1999		2000		2001		2002		2003	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
(a) PEP is readily available now										
Sydney										
Periodic					2760	39.0	2670	55.2	651	65.7
Melbourne										
Periodic					1651	19.2	1767	26.8	1916	44.8
Brisbane										
Periodic							1606	23.8	1439	37.0
Canberra										
Periodic									239	57.3
(b) Received PEP[1]										
Sydney										
Periodic					2721	2.9	2634	3.3		
Health in Men					450	6.4	453	5.3	430	8.4
Melbourne										
Periodic					1683	2.0	1727	2.1	1934	2.7
(c) Know anyone who has received PEP										
Sydney										
Periodic					2710	10.6	2594	14.6		
Melbourne										
Periodic					1652	6.7	1716	6.9	1906	11.0

[1]With the exception of Periodic Survey results from 2002 onwards, which report PEP use in the previous six months, all other percentages are based on whether participants had *ever* received PEP.

At the time of the initial visit to a doctor, patients were asked if they would like to participate in the interview arm of the study. From March 1999 to July 2001, of the 328 patients who were enrolled in the study, 88 (27 per cent) participated in the interview arm.

Incidents that led to potential HIV exposures were usually characterised as having involved a temporary absence of control rather than a general lack of control. PEP became a means of restoring order and reclaiming control. Control was exercised in various forms and permeated all aspects of PEP. Physical control determined what participants did sexually and what they allowed others to do to them. Verbal control took place after an exposure when they questioned their partners about practices and serostatus, and when they sought information about prophylaxis possibilities from friends, doctors and community organisations. Control over decision-making processes allowed participants to decide whether to take the treatment that was offered to them, and whether to disclose the incident and to whom. Control over sexual practices became an issue again in the determination of participants to practise safe sex in the future after the experience of PEP.

Rational decision-making and reasoning—about sexual practices, taking treatment and disclosing—were confounded by the somewhat messy reality of the physical, social and emotional contexts in which sex occurred. Participants acted in accordance with their own emotional needs and responded to a partner's emotional needs, at a specific time and in a specific social space. For example:

You sound like you were a little bit in awe of him.

Yeah, well, he's well off and leading a comfortable life ... I felt really comfortable in his flat, I should say, and I had this romantic notion, you know, this ideal husband whatever ... So he looked as if, and he actually told me that he'd done all the things he wanted to do sexually and he's ready to settle down, and I'm sort of in that mood. I was really pushing for a relationship to start and maybe that was one of the reasons why I didn't like to dampen the whole thing by persisting on having safe sex ... There must have been some signs thrown in there but I just focused on making things work.

Relationship issues were often cited as contexts in which incidents that led to potential HIV exposures occurred: ongoing conflict in regular relationships, vulnerability after relationship break-ups and the uncertainty surrounding new relationships. After the break-up of a long-term regular relationship, some gay men sought to distinguish sex with new casual partners from sexual practices with their ex-partners through different sexual positioning and taking different degrees of risk.

Yeah, being receptive [with a casual partner] was deliberate, too, because I found in this five-year relationship that I was giving so much and not receiving affection or support, and the upshot of this break-up, I suppose, was realising that. Well, I felt used and taken for granted in this relationship, which was with a very needy person, and it became a co-dependent relationship basically. So, it was important for me to become receptive. I mean, in a lot of ways. There were two reasons. One, that I totally got off in fucking my partner and seeing how much he enjoyed himself, and I guess I sort of felt like I was missing out on that attention that a top can give you. So, I wanted to become the receptive partner to try and achieve that goal. The other reason was, I think, mentally I just couldn't fuck anyone else because he had a special place in that respect.

In serodiscordant relationships, clinical markers are often factored into sexual practices and into risk assessment after a potential exposure. In these contexts, a partner's desire and the relationship are more important than the fear of HIV.

Well, occasionally, yeah, you think 'be careful and pull out before you come,' which is probably incredibly stupid but you do it particularly when you get to know someone. You start to take calculated risks. You say to yourself ,'Well S doesn't have any precome' ... and so you know as long as he pulls out before he comes then the risks aren't nil, but minimised ... He has trouble putting a condom on and keeping an erection and nearly loses it all the time if he puts a condom on. So, you know, if you love someone you take the risk. You calculate the risk ... Calculating the risk is trusting him, zero viral load. It doesn't mean you're going to take extra risks and start to say, 'It's safe to have unsafe sex because you're zero viral load' but I think it must reduce the risk and you take risks because you love someone. That's what it all boils down to. You take risks because you love them and you weigh up in your mind the pros and cons and, 'Well, I love this person.' He gets terribly frustrated by the fact that condoms basically destroy his erection and yet would love to be the active person occasionally. So you think, well, you're willing to take that risk.

HIV-positive and HIV-negative gay men have different knowledges and attitudes in relation to clinical markers and unprotected anal intercourse. For positive men, infectivity and risk assessment are based on their knowledge of clinical markers, where undetectable viral load means reduced infectivity. For negative men, risk assessment is based on the public health message of using a condom. (None of the participants in this study relied on the possibility of reduced infectivity of a positive partner with undetectable viral load. All decided to take prophylaxis.)

There can be multiple understandings of the concept of 'shared responsibility' around the negotiation of sexual practices and condom use. For an HIV-positive man it can mean taking the receptive position in unprotected anal intercourse with an HIV-negative partner. For an HIV-negative man it can mean disclosure of serostatus and using a condom. This can result in conflict and tension over control when an HIV-positive man discloses his serostatus after unprotected sex has occurred.

There is also some evidence in the interviews that HIV prevention messages such as 'assume every partner is positive' are read differently by HIV-positive and HIV-negative men and can result in different assumptions and practices. For an HIV-negative man it may translate into 'Assume a partner is negative if he does not request a condom'. For an HIV-positive man it may translate into 'Assume a partner is positive if he does not request a condom.' People appear to think that if a partner does not request a condom he can be assumed to have the same HIV serostatus.

Participants in the study generally perceived PEP in the same way as it was intended by health authorities—as a means of reducing the risk of HIV infection when other strategies have not worked; i.e. as a back-up rather than a replacement for other strategies such as condom use. The reactions to PEP were overwhelmingly positive. PEP was perceived as a source of hope and relief. It reduced anxiety and stress while participants waited for their test results and it enabled them to carry on with their lives. However, despite these positive reactions, PEP was not perceived as giving the green light for unprotected sex. Participants expressed their determination to maintain safe sex practices. The experience of a four-week course of combination therapies, the difficulties in adhering to the treatment regime, and side effects, strengthened participants' determination to avoid risk exposures in the future. Participants were also aware of the fact that PEP was still at the trial stage and that its effectiveness was not yet proven. For some participants, taking PEP was also an opportunity to reflect on their sexual practices and their knowledge about HIV.

> *I think it was actually the best thing that could ever happen. I don't know how you could think that because it was quite traumatic. But it made me start to look at myself and made me take responsibility for my life and made me realise, it's almost like being hit by a car. You get a second chance in life and you start looking at things differently and my focus is just fully on what I have instead of what I could have had.*

This qualitative study of PEP recommended, among other things, that:

- HIV education should take into account the different experiences and expectations of older and younger gay men
- future prevention messages should also address the social and emotional contexts in which exposure to HIV can occur
- HIV prevention for gay men in relationships needs to address the particular vulnerabilities to HIV that exist for gay men who have recently ended a long-term monogamous relationship, as well as for men who are experiencing conflict within their current relationship
- education programs should develop models that provide support for people on PEP that don't depend on disclosure of taking PEP (or disclosure of unprotected anal intercourse) within their existing social networks.

5.2 SEXUAL ADVENTURISM AND SYDNEY GAY MEN

A study conducted in 2003 investigated HIV, sexually transmissible infections (STIs) and drug risk in relation to gay men's sexual practice and involvement in sexual networks (e.g. sex venues, private sex parties and use of the internet). Thirty-one qualitative interviews were conducted with Sydney gay men who combined sexual activity with drug use and whose pattern of sexual activity was 'adventurous'. 'Sexual adventurism' was defined as having engaged in one or more of the following sexual activities: water sports, bondage and domination and/or sadomasochism (BDSM), fisting (inserting the hand or forearm in the rectum) and 'other esoteric' sexual practices. Men were also recruited on the basis that they used drugs for sex, though drug use was not a prerequisite for participation. The major themes explored included gay men's understanding of sexual health and risk, especially in relation to the transmission of HIV, hepatitis C virus or STIs, and how these understandings informed sexual practice.

Most of the interviewees were in their 30s or 40s, had migrated to Sydney from elsewhere and lived in the gay and lesbian precincts of the inner city. Most men were tertiary educated. The great majority of men were highly sexually active and attended sex venues. The more sexual partners men had, the more likely they were to report a recent STI. More than half of the men took 'party' drugs and many used them specifically for sex. Of the 31 men interviewed, the great majority were gay identified. One man identified as a leather boy and another as bisexual. The average age of the men was 37 and the range was 27 to 61. Over 70 per cent of the men were in their 30s or 40s.

Sexual adventurism among gay men relates to a range of esoteric sexual practices. Most of the interviewees regarded sexual adventurism as a range of non-normative sexual practices.

A SEXUALLY ADVENTUROUS SUBCULTURE

Many of the men interviewed in this study identified a sexually adventurous subculture in Sydney, centred on specific sex venues, dance clubs, organisations, the use of the internet and informal social networks. This subculture (or subcultures) is embedded within gay culture more generally, and sexually adventurous spaces are often shared between adventurous and non-adventurous men alike. While interviewees identified specific 'markers' of adventurism, not all men necessarily conformed to those markers.

There was a high degree of agreement between the interviewees about what adventurous sexual practices were. Most framed this in terms of 'vanilla' and 'non-vanilla' (and sometimes kink or fetish), contrasting their own practice with that of other gay men. Gay men's knowledge of the regularity and irregularity of different sexual practices is grounded in their embeddedness within gay culture. What men in this study viewed as borderline and disputed sexual activities are also recognised by researchers to be somewhat common among gay men, especially rimming and group sex and unprotected anal intercourse (Crawford, Kippax, Rodden, Donohoe & Van de Ven, 1998), while 'vanilla' sexual activities are nearly universal.

The men's narratives about sexual activity highlighted a number of related contextual factors of adventurous sex:

- To a limited extent, some men saw context itself as adventurous, especially sex that was outside the domestic and, in this sense, domesticated sphere.
- Although the interviewees recognised that others saw their sex as adventurous, many saw their activities as 'normal', a part of their usual sexual repertoire.
- For many men, being sexually adventurous was about extending their sexual boundaries, comfort zones and limits. This suggests sexual adventurism is partly about a 'quest for excitement' in what they perceive as a mundane (sexual) world, and is related to transgression.
- Almost all of the men were emphatic that their personal understandings and experience of adventurism became more extreme over time, and that gay sexual culture had become more adventurous over time.
- However, even given the extent of change over time, there was relative stability in what counted as adventurous between men.

SEXUAL PRACTICE

In the six months prior to being interviewed, the men in this study had on average just over 50 partners (range 1 to 140). Having more sexual partners was strongly associated with having had an STI in the past six months, especially syphilis, gonorrhoea or chlamydia. Half of the men had attended sex venues and a third had used the internet to find sexual partners. Eleven of the 31 men were in regular relationships, with more HIV-negative men than HIV-positive men in relationships. Seven men were in seroconcordant HIV-negative regular relationships, and none used condoms within their relationships. We have not characterised sex without condoms in regular relationships or positive–positive casual sexual encounters as unsafe, at least in terms of HIV transmission. Unprotected sex within these relationships was, on the whole, of a robust 'negotiated safety' type. One couple was seroconcordant HIV-positive, and they never used condoms within their relationship. While seroconcordant HIV-positive unprotected anal sex is not typically framed as 'negotiated safety', the interviewee considered it so. Two couples were in HIV serodiscordant relationships, and both couples always used condoms within their relationships.

In one nonconcordant couple, the interviewee (Trent) was HIV-negative and his partner was of unknown HIV status. For reasons unknown to Trent, his partner refused to be HIV tested. The couple routinely engaged in unprotected anal intercourse from their first occasion of anal intercourse, and HIV serostatus was not discussed. However, the couple almost always used condoms with casual partners. The interviewees engaged in a range of adventurous sexual activities, the most common of which—practised by about half of the sample—was fisting. Somewhat less common practices included water sports, BDSM and unprotected anal intercourse. The least common practices were scat (coprophilia), felching (sucking semen from the anus) and piercing the skin for sex. For those men who engaged in BDSM, there was a spectrum in terms of intensity or 'heaviness' of engagement. For example, some men were caned or whipped to the point of bleeding and bruising, and others were not.

Most interviewees who engaged in fisting did not use gloves and considered the HIV transmission risk to be minimal. Two interviewees described occasions of adventurous sex they deemed unsafe. The first involved an HIV-positive man, Simon, who bled from his anus

while being fisted by an HIV-negative man. The second example related to a group caning session between an HIV-negative man, Leroy, and a number of other partners of unknown serostatus. While being caned Leroy's blood began to spatter and the caning session was stopped. Most adventurous sexual practices are low risk for HIV transmission.

There were differential rates of condom use between HIV-negative and HIV-positive men. The majority of HIV-positive men did not use condoms with their sexual partners, or used them inconsistently, while the majority of HIV-negative men used condoms consistently for anal intercourse. All but one of the 13 HIV-positive men and about half of the HIV-negative men (10 of 18) had not used condoms in recent anal intercourse. While most HIV-positive men had had unprotected anal intercourse with casual partners, it was generally with other HIV-positive men. Most men disliked using condoms, for receptive and, especially, insertive anal intercourse, but some men were more able to accommodate their use than others. Only one interviewee referred to condoms in positive terms. In general, anal intercourse was considered more pleasurable without condoms.

There was a high level of unsafe casual sex amongst the men. Of the 31 interviewees, 13 had engaged in what we defined as high-risk 'unsafe sex' in the past 12 months: unprotected anal intercourse with an HIV nonconcordant partner. Almost all of the men's accounts of unsafe sex related to unprotected anal intercourse. The great majority of men regularly engaged in anal intercourse as a part of their sexual repertoire, both insertive and receptive. Only one man had not engaged in anal intercourse in recent years, primarily because his sexual activity rarely involved physical contact and was oriented toward exhibitionism. While some interviewees considered some forms of anal intercourse to be adventurous (e.g. when unprotected, rough or engaged over extended periods of time) all interviewees considered 'normal' anal intercourse to be 'vanilla'.

In this study, most of the HIV-negative men's unprotected anal intercourse was in the order of occasional 'slip-ups': one-off events seen as departures from their more usual safe sex practice. However, three HIV-negative men consistently engaged in unprotected anal intercourse with casual partners. Two of these men repeatedly engaged in unprotected anal intercourse with sexual partners known to be HIV-positive or of unknown HIV serostatus. For HIV-negative men, in most cases, verbally negotiating unprotected casual anal intercourse is fraught with difficulty: a high degree of trust is placed in the hands of a stranger. And, while some of the interviewees in our study sometimes engaged in what has come to be called 'strategic positioning', they also expressed considerable doubt about the safety of that strategy.

Although many cases of unsafe anal intercourse occurred in the context of adventurous sex, almost none of the events focused upon 'adventurous' sex. However, a number of interviewees had unsafe sexual encounters in the context of 'adventurous' sex. For example, Michael had recently engaged in a fisting session with five other men at a private sex party. Four of the men were HIV-positive and two, including Michael, were HIV-negative. In the session, Michael engaged in unprotected anal intercourse with a known HIV-positive partner. He described the incident as a 'slip-up' from his usual safe sex practice, and sought PEP treatment the following day.

HIV-negative men tended to mention specific factors that led to unprotected anal intercourse: that their partner was sexy, they were using drugs, they were highly aroused, their partner said he was HIV-negative, or that they felt that an HIV-positive man would be more careful. These suggest competing urgencies: on the one hand, the urgency of remaining

HIV-negative (i.e. condom use) and, on the other hand, the urgency of pleasure maximisation (i.e. not using condoms). Heightened states of arousal may override the (reasoned) importance of remaining HIV-negative. Added to this, a minority of HIV-negative men also displayed naive optimism that HIV-positive men would not have unprotected anal intercourse, or that the unprotected sex was negotiated on the basis that both men were HIV-negative.

While unprotected sex was typically considered more pleasurable for HIV-positive and HIV-negative men alike, most HIV-positive men sought out unprotected sex with other HIV-positive men. Many of the HIV-positive interviewees did not consider positive–positive unprotected anal intercourse to be unsafe. There was also a sense among HIV-positive interviewees (and some HIV-negative men as well) that there was nothing to lose when engaging in unprotected sex following seroconversion. As well, HIV-positive interviewees who regularly and intentionally did not use condoms for anal intercourse were unconcerned about HIV superinfection and other STIs.

Just over half (seven) of the reported recent episodes of unprotected anal intercourse amongst the HIV-positive men were with casual partners whose HIV status was negative or unknown. While condom use by HIV-negative men was primarily about protecting their own health, also at the expense of their own pleasure (i.e. self-interest), the fundamental reason for HIV-positive men's use of condoms was to protect the health of others at the expense of their own pleasure (i.e. altruism).

There was a continuum with respect to taking or devolving responsibility for transmitting HIV to others. Well over half the HIV-positive interviewees sat at the 'taking responsibility for others' end of the spectrum, which, in the extreme, elicited comments such as: 'The virus stops here' and '… this is my disease and I'm not sharing it, you know. I'm not going to kill somebody else' (Dwayne). For other HIV-positive men, however, responsibility was often or sometimes devolved to their sexual partners, especially in casual or anonymous sexual encounters. However, it must be stated that the individualising and responsibilising discourses of both HIV-positive and HIV-negative men were highly context sensitive. For some HIV-positive men, the more a sexual partner was 'known', the more feelings of responsibility toward that person came to the fore, regardless of whether the unprotected sex was insertive or receptive.

Often in this study HIV-positive interviewees disclosed their HIV status to other men as a way of negotiating unprotected anal intercourse. In the absence of condom use, establishing seroconcordance between sexual partners is paramount for preventing HIV transmission. However, in some contexts, cues other than explicit disclosure were used to establish the HIV serostatus of sexual partners: a 'sixth sense', lipodystrophy as a surrogate marker of HIV positivity, telling receptive anal intercourse partners that ejaculation was imminent, or assuming that one's sexual partner was HIV-positive (or didn't care about becoming HIV-positive) because the partner had consented to unprotected sex.

DRUGS FOR SEX

The relationship between drug use and sex is complex. The most sexually adventurous men were more likely to use drugs for sex. Crystal meth was the most commonly used drug for sex, but most men were polydrug users. However, many sexually adventurous men never

used drugs for sex. When using drugs for sex, the maximisation of pleasure and 'disinhibition' were primary, but there was a fundamental tension between disinhibition and remaining in control, both within the sexual domain and in life more generally.

Interviewees were asked the extent to which sex and drug use for sex impinged upon other aspects of their lives, such as friendships, family and work. The majority of men felt that their combination of sex and drug use did not negatively affect their lives in general. The men who regularly used drugs (approximately once a month or more) tended to describe complex strategies for regulating drug use. Many interviewees described a need to approach drugs with caution and to be moderate in use. Key among the strategies was remaining vigilant about mental and physical health, work performance, and limiting drug use to specified places and times.

Most men in the study recognised that drug use—in this context, drug use for sex—could negatively affect other areas of life and therefore that drug use needed to be continually monitored and moderated. Learning to avoid excessive drug use was sometimes described in terms of past excesses, and some men did express concern about times in their lives when drug use was less rather than more controlled. However, most men described having a balanced approach to the integration of drug use into their whole lives. Their narratives indicated that this balance was maintained through a dynamic process of self-reflection and strategic interventions.

An overarching concern for men who used drugs for sex was to retain self-control within sexual scenes. This concern about control was important on a number of levels: for example, maximising pleasure, remaining sexy, avoiding social embarrassment, and preventing HIV transmission and other harms to the body. For most interviewees, drug use was not a significant factor in unsafe sex. Many interviewees did not use drugs during sex because they were afraid of losing control. Other non-drug-users specifically mentioned the importance of not using drugs in sexually adventurous contexts. Andrew explained his desire to push sexual boundaries in a controlled way, and being drug-free was one way of ensuring that control.

Very few of the men who engaged in unsafe sex, whether HIV-positive or HIV-negative, attributed lack of safety to drugs. Rather they framed it within much more complex contexts. While HIV-negative men sometimes engaged in unsafe sex when using drugs, most men used condoms consistently. The consistent engagement of two HIV-negative interviewees in unsafe sex with men of unknown or HIV-positive status cannot be explained in terms of drug use. One of the men never used drugs, and the other avoided using drugs when engaging in adventurous sex. Further, combined with drug use or otherwise, HIV-positive men who engaged in unprotected anal intercourse did so with other HIV-positive men.

There are many ready-to-hand discourses circulating about reasons for unsafe sex, and drug use is frequently framed as inhibiting rational decision-making. As a consequence, it is the drug that is often reviled in order to make sense of unsafe sex while using drugs. Whereas some men blamed drug use for unsafe sex, or attributed adventurous sex to drug use, such use was rarely seen as the only reason (or even part of it). In a climate of zero tolerance toward drug use, policy-makers and educators are less able to encourage a functional drug-using culture, including drug use for sex. In contrast, the interviewees make clear that sexually adventurous gay men who use drugs for sex recognise the dangers of drug use and are highly motivated to minimise the harm that flows from drug use.

5.3 YOUNG MEN, SAFE SEX AND HIV

SAFE SEX

Although Australian data do not support the view (Van de Ven et al., 1997), there has long been a popular assumption that young gay men are likely to engage in unprotected anal intercourse. The young gay men in the Changing Community, Changing Practice? study conducted during 2003 reported low levels of unprotected anal intercourse and high levels of concern about HIV.

Ridge and colleagues (1997) found among their interview participants that 'HIV can be constructed as a means of bonding and having common destiny in a partnership, a way of gaining social status or support, a kind of delayed suicide, and even as not being a major issue.' These views on HIV were not apparent in the interviews conducted for the Changing Community, Changing Practice? study. Without exception, the participants considered contracting HIV entirely undesirable. Not all felt that HIV was an immediate risk for them, but this view was usually grounded in very careful safe sex practices. Almost half of the participants stated emphatically that they had never engaged in unprotected anal intercourse, even with a regular partner. For example, when asked how he decides whether to use a condom or not, Taylor (aged 24) replied, 'That's not a question: it always happens.'

Other participants described having unprotected anal intercourse once only, during their first sexual experience, or only in the context of a regular relationship. A few did describe other experiences of unprotected anal intercourse with casual partners. For example, Gilbert acknowledged a single instance, which occurred whilst overseas on holiday and disturbed him so much that 'All I wanted to do was come home and get tested.'

The interviews suggested that adherence to safe sex practices (condom use for anal intercourse) was generally very high amongst the participants. Harry, however, differed markedly from the others by describing relatively high rates of unprotected anal intercourse with casual partners (about five instances in the past year). In Harry's view, condom use was on the decline: 'Less and less people, as far as I'm aware, are using them.' When asked what influenced his choices about whether or not to use condoms, he replied, 'Partially what I'm on at the time, partly ... what I'm in the mood for.' Like the other participants, but with perhaps less justification, Harry rated contracting HIV as 'pretty unlikely' for him.

In analysing the interviews in relation to questions about HIV awareness, the study found no evidence to support a view that increases in rates of unprotected anal intercourse were likely to originate amongst young gay men. Similarly, the interviews did not suggest that the young men considered the prospect of acquiring HIV insignificant, or alternatively, in any way appealing.

TESTING

Although participants expressed a high level of awareness around the possibility of acquiring HIV, testing rates were variable. Some participants reported having been tested two or three times in the previous year, others had undertaken annual testing, and some had had only one test ever. To some extent these variations corresponded with factors such as age and

frequency of sexual activity. For example, Lachlan, who was 18, underwent his first HIV test in the week prior to interview, and Ronnie, who had had sex only once or twice in the past year, had not had a test for about nine months. (He reported quarterly testing during periods of more regular or frequent sexual activity.)

The participants also described considerable levels of fear and anxiety around HIV testing. For example, as Anton commented, 'It was very scary, but just, yeah, I think it's something you have to do.' Kyle cited a fear of doctors in general as an obstacle he faced in undergoing testing, and described poor rapport with his doctor as part of this fear. He explained that, for him, having to negotiate the constraints of the standard general practitioner consultation constituted a significant disincentive to attend. In addition to these anxieties and negative experiences, some participants described highly distressing circumstances around testing. Jarad, for example, had taken only one test and this was conducted as part of his application for permanent residency in Australia. Not only was Jarad expected to pick up and retain his sealed results for weeks before passing them on unopened to Immigration Department officials, but he was never directly informed of the results.

In a different context, Jess described a traumatic instance of misdiagnosis (false positive) which, on top of a relationship breakdown which prompted his test, caused him to commence antidepressant medication and even to consider suicide. As it was for Jarad, HIV testing for Jess was intensely stressful. These two stories were the most extreme in a group in which fear, anger and uncertainty featured disturbingly regularly. It is possible that both perceptions of testing and testing regularity are negatively affected by these common feelings, and that changes in policy and increased support could improve young men's experience of HIV testing.

DRUGS AND SAFE SEX

When asked about the impact of drugs on safe sex practice, respondents gave a range of responses. Harry was the only participant to describe relatively frequent unprotected anal intercourse related to drug taking. He expressed the view that drugs and alcohol could impair his ability to negotiate safe sex, and described several instances of drug-related unprotected anal intercourse, for example: 'I was paralytic one night and this guy fucked me without a condom. And another guy, I think.'

Among the other participants who did use drugs, sex while under their influence was not commonly reported. Jess, for example, said that if he took drugs prior to sex, he 'can't finish the job.' However, cannabis was cited by some participants as a good adjunct to sex. Consumption of alcohol prior to sex was also reported by some participants. Again, Harry notwithstanding, most participants argued that intoxication did not compromise safe sex practice.

Overall, while some extremes in attitudes towards illicit drug taking were evident in the interviews, the majority of participants described occasional drug use, including regular but largely moderate drinking and smoking of cannabis, and consumption of other drugs only when attending large events such as Mardi Gras. Only in one case was drug use said to affect safe sex practice. This was in keeping with comments the participants made elsewhere in the interviews, which indicated generally high levels of adherence to safe sex practices.

5.4 YOUNG QUEER MEN IN SYDNEY AND VANCOUVER

How does the sociocultural context inform how young queer (gay, bisexual, queer) men construct their selves? What aspects of context are most important? And how do young queer men navigate the process of 'coming out', including seeking friends and lovers, as well as other sexual companions? An ethnographic study commenced in 2003 followed two cohorts of young queer men in Sydney and Vancouver over a period of a year (Egan, 2004).

Data collection included observational fieldwork and informant interviews. On-the-street observations were conducted in late afternoon (after school hours), early evening, late evening and early morning hours, to uncover when and how young queer men occupied these visible spaces of queer community. Observations were also done in gay bars and nightclubs, at queer youth drop-in and support programs (with both staff and participant approval), at beaches, on university campuses (University of New South Wales, University of Sydney and the University of Technology, Sydney) and in parks and reserves. Informants were recruited through queer youth programs offered by non-governmental organisations, through university contacts, and by word of mouth.

Fifteen Sydneysiders and twelve Vancouverites participated in semi-structured interviews of one to two hours' duration. A quasi-life-narrative technique, constructed around experiences with family, primary and secondary schooling, work and tertiary education, seeking queer community and support (including seeking lovers and sex partners), was used to encourage participants to reflect deeply on their experiences. Interviews were transcribed verbatim and returned to each informant, with encouragement to amend the text so that it accurately reflected their experiences and beliefs. Transcripts were analysed using Atlas/ti software, using the constant comparative method.

Saturation was reached rather quickly with respect to three themes: HIV/AIDS as a force in shaping the queer self, K–12 school-based homophobia, and how 'the scene' in each city informed their sense of queer community.

HIV/AIDS

The archetype of young men—queer and not—as being foolhardy risk-takers was clearly refuted by these young men with respect to HIV knowledge and sexual risk-taking. Every participant was cognisant of HIV/AIDS and consistently practised harm minimisation by using condoms for anal intercourse with casual partners, eschewing anal sex, or only engaging in unprotected anal intercourse with a committed monogamous partner where both were known to be HIV-negative. Two men—one in Sydney and one in Vancouver—were HIV-positive. All were aware of HIV/AIDS, either through media or sexual health education in high school. Two-thirds were 'concerned' about HIV/AIDS, but felt confident in their ability to remain HIV-negative (or in their ability to avoid transmission of HIV if they were already HIV-positive) by adhering to safer sex guidelines. The balance of the informants were quite 'anxious' about HIV/AIDS, which most often led to their having limited (oral sex only) or no sexual activity. (One Vancouver participant was a virgin, having only kissed and cuddled.)

SCHOOL

Nearly all—25 of 27 men—had schooling experiences that ranged from 'fairly negative' (Bruce) to 'feeling alone' (Eric) to 'intimidation' (Tom), due to an oppressively homophobic environment. Antagonistic, bullying behaviour was common, ranging from name-calling to destruction of property to physical assault. Eighteen participants recounted experiences of harassment or violence directed towards them during their primary or secondary schooling. Nearly all participants believed it necessary to deny or hide their sexuality while in school, though some eventually came out to some extent while still at school. Those in the Vancouver cohort more often reported finding appropriate services, both in the queer community and in their schools.

THE SCENE

'The scene'—the clubs and bars that are the transparent and visible representation of queer life—was of greater importance in Sydney than in Vancouver. All but three participants had been to a gay bar or nightclub, with about one-third of informants attending a gay bar or club weekly. Experiences with substance use varied widely as well: dance party culture was much stronger in Sydney, which was reflected both in going-out patterns and substance use. Over half the sample initially sought the local scene to locate 'queer community' only to find that the scene itself was superficial rather than nurturing. Most informants found the sorts of support they sought—friends, men to date, sexual partners—by other means. Community groups and online chat rooms both featured prominently in these men's ways of finding community attachment.

These men understood and managed their vulnerability for HIV infection based on a local knowledge of that risk. Their school experiences reinforced their understanding that being openly queer could be dangerous. Their experiences on the scene, and in seeking other queer-specific support services or social groups to facilitate their learning about becoming queer, showed how these men sought out queer-specific knowledges to construct positive, affirming identities. Young queer men nonetheless must seek queer and queer-affirming spaces to acquire relevant, affirming knowledges, resulting in a unique and particular construction of the (queer) adult—particularly to counter virulent homophobia experienced in high school. In homophobic, heterocentric society, the onus remains on these men to find such spaces for themselves so long as mainstream society remains hostile.

5.5 CRUISING AND CONNECTING ONLINE

Gay men have taken to the internet and computer-mediated communication in increasing numbers since the 1990s. Popular gay chat sites on the internet such as 'gaydar' and 'gay.com' have provided an alternative medium through which gay men and other men who have sex with men can identify each other, socialise and arrange meetings and sexual contacts. Recent surveys of Australian gay men suggest that around 50 per cent make use of gay chat

sites to look for sex partners (Hull, Van de Ven, Prestage, Rawstorne, Grulich et al., 2003; Hull, Van de Ven, Prestage, Rawstorne, Kippax et al., 2003). These surveys also show that the proportion of gay men using gay chat sites to seek sex partners continues to increase. Various factors may account for this popularity but it is the apparent speed and ease with which gay men can find other men for sexual and social contact (whether virtual or face-to-face) that seems to be driving the growth in online interaction between gay men, together with the relative anonymity of the internet as a cruising environment (Rietmeijer, Bull & McFarlane, 2001).

The internet presents a challenge to educators to understand the features and dimensions of this new terrain, together with an opportunity to reach gay men (and other men who have sex with men) and to promote sexual health through a different avenue. However, as is well understood, educational and preventive strategies need to be carefully planned to address the needs, values and concerns of target groups. The context in which health messages would be encountered also needs to be considered. Preventive and educational strategies are likely to be seen as irrelevant, intrusive or patronising if they do not address the pertinent issues. To develop health promotion strategies targeting gay men on the internet, and gay chat sites in particular, a good understanding is required of the meaning and significance of gay chat sites as a cultural space in which gay men socialise and seek sexual contacts.

The Cruising and Connecting Online study set out to explore how gay chat sites were perceived and used by a sample of gay men, and to describe Australian gay men's attitudes to and experiences of seeking sex through gay chat sites. Online chat sites were investigated as environments in which gay men socialised and looked for sex partners. The study recruited 450 gay-community-attached men at the Midsumma Carnival in Melbourne and the Mardi Gras Fair Day in Sydney, both held in February 2003. Men were considered eligible to participate if they had ever used gay chat sites.

The main findings of the study were:

- Gay chat sites are social as well as sexual environments and support or mediate a range of relationships between gay men.
- Internet sex-seeking has become a popular supplement to and extension of the sex-seeking repertoire of gay-community-attached men.
- While seeking sex on the internet allows men to meet additional sex partners and is associated with higher rates of some HIV risk behaviour, the medium of gay chat sites may also facilitate HIV risk-reduction practices such as seeking out seroconcordant partners.
- Gay-community-attached men express distinctive patterns of gay chat site usage, reflecting different attitudes to and experiences of online activity and internet sex-seeking.
- Gay chat site users appear to be open to education and prevention activities online.

USE OF GAY CHAT SITES

The Cruising and Connecting Online study found that:

- 56 per cent of users had started using gay chat sites more than two years previously.
- 60 per cent of users had met casual partners through gay chat sites.
- 59 per cent had found friends.
- 24 per cent had found a boyfriend.
- Of those who currently used chat sites to find sex partners, 54 per cent used chat sites at least once a week.
- After identifying a potential partner online, chat site users often employed a wide range of preparatory and evaluative activities before meeting that person face to face.

OPPORTUNITIES FOR EDUCATION AND HEALTH PROMOTION

Given the relative ease with which some gay men can find sex partners online, gay chat sites are often represented within the research literature as potential risk environments. However, our study suggests that these sites support a range of activities and relationships in addition to sex-seeking, and may support mutual negotiation of sex practices and facilitate HIV risk-reduction strategies. In terms of education and health promotion, the evidence suggests a number of potential avenues for HIV prevention work among chat site users. Possibilities include:

- providing easily accessible sexual health information online
- investigating the use of chat sites by some gay men to seek out seroconcordant partners and the difficulties this may pose, especially for (known or self-assumed) HIV-negative men and their sexual partners. In particular, we do not know under what circumstances status is discussed explicitly online or when it is implied or assumed.
- understanding the culture of gay chat sites, particularly for new users and those who are not confident about using gay chat sites. Peer education may be an appropriate way to encourage online competence and confidence.
- addressing concerns about using gay chat sites, particularly the privacy and security of online information. Peer education may help to address some of the most common concerns.
- promoting STI and HIV testing among gay chat site users who have a high number of casual sex partners
- promoting agreements about the use of condoms both within and outside relationships (i.e. 'negotiated safety') for users who have both regular and casual partners. Chat site users were more likely to report both regular and casual partners, and higher rates of unprotected anal intercourse with casual partners.

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