

Syphilis, STIs and men who have sex with men in Sydney: Understanding and managing risk in context

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Acronyms

HIM	Health in Men study
HIV	human immunodeficiency virus
MSM	men who have sex with men
NSU	non-specific urethritis
PH	Positive Health study
PLWHA	people living with HIV/AIDS
SA	sexual adventurism
SGCPS	Sydney Gay Community Periodic Survey
STD	sexually transmitted disease
STI	sexually transmitted (or transmissible) infection
STIGMA	Sexually Transmitted Infections in Gay Men Action Group
UAI	unprotected anal intercourse
UAIC	unprotected anal intercourse with a casual partner or partners
UAIR	unprotected anal intercourse with a regular partner or partners

Introduction

Syphilis is a bacterial infection (*Treponema pallidum*) that can be contracted through direct contact with the sores, rashes or body fluids (such as semen or blood) of an infected person. Syphilis can also pass through broken skin on other parts of the body. It is usually contracted during sex when the skin or mucous membranes of the genital area, mouth, or anus of an uninfected person are most likely to come into contact with the sores or body fluids of an infected partner. As long as it is diagnosed early enough (usually with a blood test), syphilis is effectively treated with antibiotics. Treatment options include up to three weekly injections of benzathine penicillin, a course of procaine penicillin injections or a course of orally administered antibiotics such as doxycycline, depending on clinical factors such as stage and severity of infection (Donovan, 2004).

After years of low rates of syphilis among men who have sex with men (MSM) in industrialised countries, outbreaks of several hundred cases have recently been reported in the US, UK, Ireland, the Netherlands and France (Bellis, Cook, Clark, Syed & Hoskins, 2002; Higgins, Sukthankar, Mahto, Jarvis & Lacey, 2000; Nicoll & Hamers, 2002). In Sydney, surveillance data from mid-2002 show a rapid increase in syphilis incidence among MSM in the inner and eastern suburbs (NSW Health, 2003). There is consistent evidence that syphilis, as an ulcerative sexually transmitted infection (STI),

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 MSM, it is essential that we understand the risk factors for syphilis transmission among MSM as well as their perceptions of the disease.

This report includes findings from a cross-sectional study of social and behavioural risk factors for syphilis infection and transmission among MSM in Sydney (Part 1), as well as qualitative material on gay men's understandings and experiences of syphilis and other STIs (Part 2). The cross-sectional study recruited men diagnosed with syphilis from inner Sydney sexual health clinics, inviting them to complete a questionnaire about how they believed they contracted syphilis, their disease knowledge, sexual behaviour and risk practices for onward transmission. The qualitative material on syphilis, STIs and the perception and management of risk is taken from interviews with gay men in Sydney who engage in sexually adventurous sex practices. Detailed findings from the sexual adventurism study will be published separately (Smith & Worth, forthcoming). The results from both studies provide useful information in guiding educational and public health responses to the increase in syphilis among MSM in Sydney.

Please note:

- Part 1 reports on a survey of 57 men diagnosed with syphilis in Sydney in 2003. This represents just under half of all the men diagnosed with syphilis in the South East Health area in 2003.
 - The findings from the syphilis study are representative of men diagnosed with syphilis in inner Sydney in 2003.
 - Part 2 reports on a qualitative study of 31 sexually adventurous men in Sydney.
 - Neither study was intended to be representative of gay men in general. The findings should **not** be generalised to 'all gay men' or 'all gay men in Sydney'.
- The findings of both studies suggest the following:
- There is a continued need to educate gay men who have casual partners about syphilis and STIs.
 - The need for regular STI testing should be reinforced among gay men who have casual partners.
 - HIV-positive men and their doctors should be encouraged to discuss how STI testing is integrated into routine health monitoring.
 - There should be an opportunity to debate and publicise the alternative treatment options available for syphilis.

1

SYPHILIS AND MEN WHO HAVE SEX WITH MEN IN SYDNEY: A QUANTITATIVE SURVEY

Sample and recruitment

Fifty-seven men diagnosed with syphilis were recruited from sexual health centres and clinics in inner Sydney during 2003, with the majority recruited from clinics serving gay men in the city centre and 'gay Sydney'.¹ This represents 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 diagnosed with syphilis were asked if they would like to enrol in the study when they attended for treatment. The study was offered only to those with primary, secondary or early latent syphilis (all classified as 'early syphilis' for treatment purposes), as determined by the treating doctor. The typical treatment offered during the study was a course of daily injections of procaine penicillin (usually for 10 days). The study was explained to the patient by a doctor, and an information sheet was provided. If the patient consented to participate, the study nurse completed details of the syphilis test results (nature and titre of positive screening and confirmatory tests) and collected relevant clinical features, e.g. stage of syphilis and site of chancre, if present. The

participant then completed a short, anonymous questionnaire covering risk practices, sexual behaviour, treatment-seeking behaviour and knowledge of syphilis.

¹Gay Sydney is defined by postcodes 2010 to 2012. It includes Darlinghurst, Surry Hills, Taylor Square, Elizabeth Bay, Kings Cross, Potts Point, Rushcutters Bay, Woollahroomooloo and Strawberry Hills.

Demographic profile

Age

The age distribution of participants is shown in Table 1. The mean age of the men was 39.0 years (range 20 to 80 years). The men were therefore somewhat older than men in the Sydney Gay Community Periodic Survey (Hull et al., 2003).

Sexual identity

The majority of participants (96%) identified as gay or homosexual (see Table 2).

Gay community involvement

The men reported being highly socially involved with gay men (see Tables 3 and 4). This degree of gay community involvement was similar to that found in the Sydney Gay Community Periodic Survey (Hull et al., 2003).

Country of birth

The majority of participants (over 85%) were born in Australia or other English-speaking countries (see Table 5).

Table 1: Age

	<i>n (%)</i>
Under 25	2 (3.5%)
25–29	7 (12.3%)
30–39	20 (35.1%)
40–49	25 (43.9%)
50 and over	3 (5.3%)
Total	57 (100%)

Table 2: Sexual identity

	<i>n (%)</i>
Gay/Homosexual	54 (96.4%)
Bisexual	1 (1.8%)
Other	1 (1.8%)
Total	56 (100%)¹

¹Missing data, *n* = 1

Table 3: Proportion of gay friends

	<i>n (%)</i>
None	2 (3.5%)
A few	1 (1.8%)
Some	21 (36.8%)
Most	29 (50.9%)
All	4 (7.0%)
Total	57 (100%)

Table 4: Proportion of free time spent with gay men

	<i>n (%)</i>
None	0 (0%)
A little	5 (8.8%)
Some	25 (43.9%)
A lot	27 (47.4%)
Total	57 (100%)

Table 5: Country of birth

	<i>n (%)</i>
Australia	33 (60.0%)
New Zealand	6 (10.0%)
UK	4 (7.3%)
North America	4 (7.3%)
South America	3 (5.5%)
Other	5 (9.1%)
Total	55 (100%)¹

¹Missing data, *n* = 2

Geographic distribution

Reflecting the areas served by the clinics from which the men were recruited, the majority of participants (over 90%) came from 'gay Sydney', Sydney's eastern suburbs or the inner west (see Table 6).

Employment

Just over 70% of participants were employed in either full- or part-time paid work (see Table 7). This was a lower proportion than that found in the Sydney Gay Community Periodic Survey but higher than that found in the Positive Health study (Fogarty et al., 2003; Hull et al., 2003).

Education

Table 8 shows the highest educational level reported by participants, and comparison rates from the Health in Men (HIM) study and the Sydney Gay Community Periodic Survey (SGCPS). All comparison data are from 2003. Men in the syphilis study were more likely to have left school after Year 10, more likely to have attended TAFE and less likely to have attended university than men in the other studies.

HIV status

Over half the men diagnosed with syphilis and recruited into the study were HIV-positive (see Table 9). Of the 30 men who were HIV-positive, 19 (63%) reported an undetectable viral load and 6 (20%) reported a detectable viral load.

Table 6: Residential location

	<i>n</i> (%)
Gay Sydney	21 (37.5%)
Inner west	24 (42.9%)
Eastern suburbs	7 (12.5%)
Other area	4 (7.1%)
Total	56 (100%)¹

¹Missing data, *n* = 1

Table 7: Employment status

	<i>n</i> (%)
Full-time work	36 (63.2%)
Part-time work	4 (7.0%)
Unemployed	3 (5.3%)
Student	3 (5.3%)
Pensioner/On benefits	6 (10.5%)
Other	5 (8.8%)
Total	57 (100%)

Table 8: Education

	<i>n</i> (%)	HIM	SGCPS
Year 10	8 (14.3%)	9.1%	10.9%
Year 12	8 (14.3%)	15.7%	17.0%
TAFE	17 (30.4%)	22.0%	20.5%
University	23 (41.1%)	52.9%	51.6%
Total	56 (100%)¹	-	-

¹Missing data, *n* = 1

Table 9: HIV status

	<i>n</i> (%)
Not tested/No results	0 (0%)
HIV-negative	26 (46.4%)
HIV-positive	30 (53.6%)
Total	56 (100%)¹

¹Missing data, *n* = 1

Syphilis testing, knowledge and symptoms

Reasons for syphilis testing

The most common reasons given for seeking syphilis testing were that the participant had noticed symptoms that had worried them or the participant's doctor had suggested a test (see Table 10). Over a quarter of men said that they included syphilis testing within a regular testing pattern. Only one participant said that publicity about syphilis had contributed to his seeking testing.

Beliefs about contracting syphilis

The men were asked to indicate the sexual practice(s) that they believed had led to their contracting syphilis (see Table 11). As syphilis bacteria are highly infectious and relatively easily transferred during sexual contact, all of the activities listed in the table are potential transmission routes. Over half the men believed that they were infected through oral sex, while just under half thought that unprotected anal sex had played a role. Nearly 30% thought that oral–anal sex ('rimming') was a contributing factor, and nearly a fifth thought that kissing could have led to their syphilis infection. Over a fifth of the men did not know how they had contracted syphilis. Of course, it is difficult to know whether the men's assessments of how they were exposed were accurate. We should bear in mind that some men may have nominated activities such as protected anal sex because they did not realise that they could have contracted syphilis through other activities (e.g. oral sex).

Table 10: Reasons for syphilis testing

	<i>n (%)</i>
I had symptoms that made me worry	29 (50.9%)
My doctor suggested it	19 (33.3%)
It's part of my regular testing pattern	16 (28.1%)
I noticed a change	15 (26.3%)
A sex partner had syphilis	10 (17.5%)
I was being tested for HIV	8 (14.0%)
I did something risky	6 (10.5%)
I wanted to know if I had syphilis	4 (7.0%)
I saw ads/posters/articles about syphilis	1 (1.8%)

Note: These categories are not mutually exclusive.

Table 11: Beliefs about how syphilis was contracted

	<i>n (%)</i>
Through oral sex (sucking or being sucked)	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.

Symptoms

Participants indicated that they had experienced a range of symptoms associated with syphilis infection (see Table 12). The most commonly reported symptoms were rashes or sores/lesions/ulcers on various parts of the body. However, over a quarter of the men had experienced no symptoms.

Time taken to arrange testing after noticing symptoms

Of those men who had noticed symptoms ($n = 39$), just over 60% had sought testing for syphilis within two weeks of their symptoms appearing (see Table 13). However, just under 30% had waited between three and eight weeks and 11% had waited for more than two months before seeking testing.

Reaction after noticing symptoms

Men who noticed symptoms ($n = 39$) were asked about their reaction after noticing the symptoms (see Table 14). The majority of men (over 60%) thought they should seek testing as soon as possible. Nearly half did not think their symptoms were a sign of syphilis, but over a quarter told their sex partners that they had symptoms. A quarter of the men decided to wait and see what would happen, but only 10% thought the symptoms were unimportant.

Table 12: Symptoms of syphilis infection

	<i>n (%)</i>
A rash	24 (42.1%)
A sore/lesion/ulcer	23 (40.4%)
on penis	10 (17.5%)
in mouth	5 (8.8%)
in/near anus	9 (15.8%)
A lump	10 (17.5%)
in groin	2 (3.5%)
in/near anus	2 (3.5%)
on neck	3 (5.3%)
other	3 (5.3%)
Other symptoms	12 (21.1%)
No symptoms	15 (26.3%)

Note: These categories and subcategories are not mutually exclusive.

Table 13: Time taken to arrange testing after noticing symptoms

	<i>n (%)</i>
Less than a week	11 (28.9%)
1–2 weeks	12 (31.6%)
3–4 weeks	9 (23.7%)
5–8 weeks	2 (5.3%)
More than 8 weeks	4 (10.5%)
Total	38 (100%)¹

¹Missing data, $n = 1$

Table 14: Reaction after noticing symptoms

	<i>n (%)</i>
Arranged testing as soon as possible	25 (64.1%)
Thought it was something else	19 (48.7%)
Told sex partner(s)	11 (28.2%)
Waited to see what would happen	10 (25.6%)
Thought it was unimportant	4 (10.2%)

Note: These categories are not mutually exclusive.

Sexual behaviour

Participants were asked a variety of questions about their sexual behaviour. Where appropriate, data from the Sydney Gay Community Periodic Survey (SGCPS), the Positive Health (PH) study of HIV-positive men, or the Health in Men (HIM) study of HIV-negative men have been included for comparison. All comparison data are taken from complete 2003 samples.

Current relationships with men

At the time of the survey, all of the participants were sexually active with either or both casual and regular male sex partners (see Table 15). Over 90% of the sample had casual sex partners and over half the men reported regular relationships. The majority of men in regular relationships also had sex with casual partners.

Male sex partners in the previous six months

Men in the syphilis study reported more male sex partners in the previous six months than men in the Sydney Gay Community Periodic Survey and the PH and HIM studies (see Tables 16 and 17). Of syphilis study participants, 57% of HIV-positive men and 73% of HIV-negative men reported more than 10 male sex partners in the previous six months.

Unprotected anal intercourse (UAI)

In the six months prior to the survey, 36 men said that they had had sex with regular partners. Of these, 29 (80.6%) reported any unprotected anal intercourse with a regular partner (UAIR). Of the 55 men who reported sex with casual partners in the previous six months, 36 (65.5%) reported any unprotected anal intercourse with a casual partner (UAIC).

Table 15: Current relationships with men

	<i>n</i> (%)
None	0 (0%)
Casual only	24 (43.6%)
Regular plus casual	26 (47.3%)
Regular only (monogamous)	5 (9.1%)
Total	55 (100%)¹

¹Missing data, *n* = 2

Table 16: Number of male sex partners in previous six months, by HIV-positive participants

	Syphilis study	SGCPS	PH study
1	3.6%	11.1%	20.1%
2–10	39.3%	38.3%	44.9%
11–50	42.9%	32.9%	24.1%
> 50	14.3%	17.8%	10.9%

Note: Figures from SGCPS and PH exclude men with no partners in previous six months.

Table 17: Number of male sex partners in previous six months, by HIV-negative participants

	Syphilis study	SGCPS	HIM study
1	3.9%	20.4%	16.8%
2–10	23.1%	44.9%	40.9%
11–50	38.5%	26.9%	32.3%
> 50	34.6%	7.9%	10.0%

Note: Figures from SGCPS and PH exclude men with no partners in previous six months.

Table 18: UAIR and UAIC in previous six months, by HIV-positive participants

	Syphilis study <i>n</i> (%)	SGCPS	PH study
UAIR	17 (94.4%)	28.2%	51.5%
UAIC	24 (82.8%)	48.1%	56.8%

Tables 18 and 19 show rates of UAIR and UAIC for HIV-positive and HIV-negative men in the six months prior to the survey. Rates from the syphilis study are compared to the SGCPS and PH and HIM studies. The great majority of HIV-positive men in the syphilis study reported unprotected anal intercourse with both regular and casual partners in the previous six months. HIV-positive men in the syphilis study reported higher rates of UAIR and UAIC than HIV-positive men in other studies, and higher rates than HIV-negative men. HIV-negative men in the syphilis study reported similar rates of UAIR and UAIC in the previous six months to those in the HIM study. Participants in the syphilis study were more likely to report UAI with regular rather than casual partners, although this distinction was more pronounced for negative men.

Table 20 shows rates of insertive and receptive UAIC in the previous six months according to HIV status. HIV-positive men were more likely than HIV-negative men to report both insertive UAIC ($p = 0.061$) and receptive UAIC ($p = 0.001$). The difference was greater for receptive UAIC, suggesting some degree of 'strategic positioning' by participants to reduce the chance of HIV transmission (Van de Ven et al., 2002). Nevertheless, it should be noted that HIV-positive men were more likely to report both receptive and insertive UAIC.

Where men looked for male sex partners

Participants were asked to indicate where they looked for male sex partners (see Table 21). Men in the syphilis study were less likely to report using gay bars and more likely to report using beats and 'other sex venues' as places to find male sex partners, compared with men in the HIM study. Positive men were particularly likely to report using 'other sex venues', and this may reflect the use of 'dry' inner-Sydney sex-on-premises venues (sex clubs) by positive men.

Table 19: UAIR and UAIC in previous six months, by HIV-negative participants

	Syphilis study <i>n</i> (%)	SGCPS	HIM study
UAIR	12 (66.7%)	34.4%	69.6%
UAIC	11 (44.0%)	19.4%	36.6%

Table 20: Insertive and receptive UAIC in previous six months, by HIV status

	Insertive UAIC		Receptive UAIC	
	<i>n</i> (%)	<i>p</i>	<i>n</i> (%)	<i>p</i>
HIV-positive	20 (71.4%)	0.061	23 (82.1%)	0.001
HIV-negative	11 (45.8%)		9 (37.5%)	

Table 21: Where men looked for male sex partners

	Syphilis study		HIM study
	HIV-positive men	HIV-negative men	
Internet	56.7%	46.2%	53.1%
Gay bars	63.3%	53.8%	71.6%
Gay saunas	60.0%	57.7%	56.2%
Other sex venues	73.3%	57.7%	36.3%
Beats	40.0%	50.0%	35.0%
Among sex workers	3.3%	7.7%	3.9%

Note: These categories are not mutually exclusive.

Participation in sex scenes

The men in the syphilis study indicated that they participated in a variety of sexual subcultures and scenes that tended to involve increased numbers of male sex partners or 'adventurous' sex (see Table 22).

Overseas sex in the previous six months

Given the initially low rates of syphilis among men who have sex with men in Australia, it was thought possible that the increase in syphilis diagnoses in Sydney could have been triggered by MSM having sex with men who had become infected outside Australia. Participants were therefore asked whether they had had sex overseas in the six months prior to the survey or had had sex in Australia with somebody from overseas in the same period (see Table 23). Just under a fifth of the men had had sex overseas with somebody other than their partner/boyfriend. Over half the men said they had had sex in Australia with somebody from overseas in the previous six months. Over a quarter of the men had not had sex overseas or with an overseas partner.

Table 22: Participation in sex scenes

	Occasionally	Often
Group sex scene	57.9%	8.8%
Sex and drug scene	49.1%	10.5%
Sex party scene	26.3%	3.5%
Leather/BDSM scene	28.1%	7.0%

Table 23: Overseas sex in previous six months

	<i>n (%)</i>
Had sex when overseas*	12 (21.1%)
with boyfriend only	1 (1.8%)
with boyfriend and other partner(s)	4 (7.0%)
with other partner(s) only	7 (12.3%)
Had sex in Australia with somebody from overseas*	29 (50.9%)
Did not have sex overseas or with overseas partner	13 (26.5%)

*These categories are not mutually exclusive.

Drug use

Participants were asked about their use of drugs in the six months prior to the survey. Responses are shown in Tables 24 and 25, subdividing the sample according to HIV status. The tables are also divided into those who had ever used each drug (regardless of method of use) as well as the subsets of men who had ever injected each drug.

Overall, the syphilis study participants reported higher levels of drug use than men in the SGCPs

and PH and HIM studies. Of particular note were the high proportions of both HIV-positive and HIV-negative men in the syphilis study who reported using amyl nitrate (poppers), cocaine, crystal methamphetamine and ecstasy in the previous six months. HIV-positive participants also reported higher rates of usage of GHB and amphetamine (speed), and high rates of injecting speed or crystal methamphetamine. HIV-negative participants also reported elevated rates of steroid use.

Table 24: Drug use in previous six months, by HIV-positive participants

	Used (%)			Injected (%)		
	Syphilis	SGCPs	PH	Syphilis	SGCPs	PH
Amyl/Poppers	80.0	57.3	51.2			
Marijuana	66.7	54.6	57.7			
Viagra	36.7	34.7	22.4			
Ecstasy	63.3	47.5	39.4	3.3	2.1	1.8
Speed	40.0	31.8	25.6	16.7	7.4	6.0
Cocaine	30.0	17.2	9.4	3.3	2.1	0.8
GHB	16.7	N/A	4.5	0.0	N/A	N/A
Special K	26.7	N/A	15.9	0.0	N/A	0.8
Crystal meth	43.3	27.0	14.6	26.7	10.7	5.5
LSD	13.3	8.0	5.5	0.0	0.3	N/A
Heroin	3.3	2.1	1.0	3.3	1.8	1.0
Steroids	6.7	10.7	N/A	3.3	6.5	6.0

Note: These categories are not mutually exclusive. N/A = not applicable

Table 25: Drug use in previous six months, by HIV-negative participants

	Used (%)			Injected (%)		
	Syphilis	SGCPs	HIM	Syphilis	SGCPs	HIM
Amyl/Poppers	73.1	48.7	58.1			
Marijuana	46.2	45.3	53.2			
Viagra	30.8	17.4	24.4			
Ecstasy	61.5	48.1	53.6	0.0	0.9	1.1
Speed	30.8	31.5	28.3	7.7	2.6	3.9
Cocaine	30.8	17.8	19.2	0.0	0.7	0.6
GHB	7.7	N/A	N/A	0.0	N/A	N/A
Special K	26.9	N/A	33.7	0.0	N/A	0.4
Crystal meth	30.8	15.8	N/A	7.7	2.7	N/A
LSD	3.8	6.6	6.4	0.0	0.2	0.1
Heroin	0.0	0.8	1.8	0.0	0.6	0.8
Steroids	19.2	1.5	N/A	11.5	0.8	N/A

Note: These categories are not mutually exclusive. N/A = not applicable

Discussion

The findings of the syphilis survey suggest a number of opportunities for education and prevention activities in relation to syphilis and STIs. Looking at the characteristics of the men recruited into the study, MSM who were diagnosed with early syphilis in 2003 were also more likely to report higher numbers of sexual partners, to be HIV-positive, to report higher rates of recreational drug use (particularly poppers, crystal meth, ecstasy and cocaine) and injecting drug use, to use sex-on-premises venues, to have had sex with men from overseas, and to have participated in group sex and 'sex and drugs' scenes. Syphilis-related education and prevention activities should therefore continue to target men with increased numbers of sex partners who participate in 'adventurous' sex scenes and who use sex-on-premises venues. However, we may be looking at the beginning of an epidemic of syphilis and these characteristics are likely to change if the outbreak becomes more generalised among MSM in Sydney. As syphilis is a highly infectious condition, reduction of the period of infectiousness is central to the control of onward infection. To limit the further spread of infection, it is likely to be useful to encourage more widespread and routine STI testing among gay men/MSM in general.

Participants' beliefs about how they contracted syphilis suggest that some men are unclear about risky activities and potential transmission routes. Awareness campaigns should continue to publicise the symptoms of syphilis, information about transmission routes, and the availability of testing and treatment.

The majority of men in the study sought STI testing as soon as they noticed symptoms. Sixty per cent of men with symptoms (usually a sore or rash) sought testing within two weeks of the symptoms appearing. However, a substantial minority of men waited for three weeks or more after their symptoms appeared before seeking testing. This emphasises the need to publicise the availability of STI testing through doctors' surgeries, clinics and sexual health centres, and to encourage MSM to seek medical

advice if they experience unexpected symptoms. In addition, around a quarter of the men did not experience or notice *any* symptoms and only realised they had syphilis after testing. This suggests that MSM should continue to be encouraged to adopt regular STI screening as a health maintenance activity even if they have no obvious symptoms. The guidelines released by the Sexually Transmitted Infections in Gay Men Action Group in Sydney encourage MSM who are sexually active to seek comprehensive STI testing (for HIV, syphilis, gonorrhoea, chlamydia and hepatitis A and B) at least once a year (STIGMA, 2003). More frequent testing is recommended for men who have frequent changes of sexual partners and/or who attend sex-on-premises venues. Many of these issues are already addressed in current campaigns within New South Wales but may need reiteration and reinforcement.

2

SYPHILIS, STIs, RISK AND CARE: A QUALITATIVE ANALYSIS

Background

The material presented in this section is taken from a study of sexual adventurousism among gay men in Sydney. For more information on the study, please refer to the main project report (Smith & Worth, forthcoming).²

In 2003 thirty-one gay men who engaged in adventurous sex practices were recruited in Sydney, primarily through the cohorts of the Positive Health study (comprised of mostly HIV-positive men) and the Health in Men study of HIV-negative gay men. 'Sexual adventurousism' was defined as having engaged in one or more 'esoteric' sex practices such as watersports (sex practices involving urine), bondage/S&M, fisting, using drugs for sex, and other practices participants saw as sexually adventurous, i.e. body piercing during sex (see Kippax et al., 1998). How participants conceived of and experienced sexual adventurousism was explored in detailed interviews. The interviews also explored sexual subcultures and networks, drug use, sexual risk and safety, self-regulation, and participants' knowledge of STIs (including HIV and hepatitis C).

The participants in the sexual adventurousism (SA) study were similar to the men in the syphilis study in a number of ways. Nearly all of SA study participants (94%) identified as gay, and over 70% of the men were in their thirties or forties. Most of

the men lived in inner-city or 'gay' Sydney, and over half attended sex venues. Over half the men had taken drugs other than alcohol, amyl nitrate and marijuana in the previous six months, and a third had used drugs as sexual enhancers. The SA participants differed from men in the syphilis study in that they had completed higher levels of education (the majority were tertiary educated), had more male sexual partners (80% reported more than 10 partners in the previous six months), and were less likely to be HIV-positive (42% vs. 54%). All the men in the SA study had experienced STIs in the past, although only nine reported an STI in the previous six months. Six of the men in the SA study had had syphilis, with three cases having occurred recently. Five of the men who had had syphilis were HIV-positive.

Although the sexual adventurousism study participants were not demographically nor behaviourally identical to the men in the syphilis study, there was enough similarity between the two groups to suggest that their perceptions and experiences of STIs would be useful in illustrating and providing context for the quantitative data presented in Part I. In order to explore how STIs were understood and experienced, particularly in relation to sexual practice and the negotiation of risk, the sections that follow present an analysis of interview material in which STIs (including syphilis) were discussed. The names of all participants and venues have been changed to protect anonymity.

² The project coordinators (Gary Smith and Heather Worth) can be contacted at the NCHSR or by email (gary.smith@unsw.edu.au or h.worth@unsw.edu.au).

Experiences of syphilis and treatment

Three of the men in the sexual adventurous study had experienced syphilis infection recently (within the previous 12 months). All of these men were HIV-positive. Their accounts of diagnosis and treatment suggest that syphilis can have a notable impact:

STEPHEN: ... *I actually, curiously, ended up getting syphilis this year, for the only time in my life. And the experience of that was such that I won't be, um, doing that again in a hurry.*

BRUCE: *I know I had syphilis last September. Bloody awful, 'cause they didn't diagnose me for two months.*

INTERVIEWER: Oh really? So you got secondary syphilis?

BRUCE: *I did. And [the HIV specialist] had never seen a case of it. Well, he'd seen a case of it, but he said the people in the sexual health clinic wouldn't have, so he took photos of me and my rash. He said, 'This is really interesting. I'm really interested.'*

As Bruce's account suggests, syphilis is not a particularly common STI, even for those working within the sexual health field. With the development of eradication strategies based around diagnostic testing and antibiotic treatments, and the changes in gay men's sexual practice following AIDS, up until recently syphilis had largely slipped from view. This means that cases such as Bruce's are now worthy of special attention by clinicians.

In addition, less treatable and more serious conditions such as cancer and HIV/AIDS have displaced syphilis and other 'historical' diseases as sources of fear and moral opprobrium in the public imagination (Sontag, 1979, 1989). The accounts of having syphilis given by these men did not seem to reflect historical representations, in which syphilis is seen as a disease marking its 'victims' as morally

lacking or suspect (Quétel, 1990). Nevertheless, syphilis was recognised by participants as a particularly infectious STI that could go unnoticed by the bearer:

STEPHEN: *Syphilis is in fact in some ways more insidious than gonorrhoea. Because you can have no symptoms. And you know, [it] often goes like wildfire.*

Compared to STIs like gonorrhoea (which is generally symptomatic), syphilis is less likely to generate symptoms and may often go unnoticed (and therefore be inadvertently transmitted). Left untreated, syphilis may develop into a degenerative and potentially fatal condition affecting the nervous system, and the fear of these later stages of the disease was mentioned by a few of the men (which, in this respect, links in with older representations of the disease).

Paul, who had been diagnosed with and treated for secondary syphilis, remarked that the infection was worthy of special attention because 'if it's in an advanced stage it will just make you mental'. Adrian, who had had syphilis when he was younger, thought that it might play a role in the HIV-related conditions he was currently experiencing: 'I had syphilis when I was 21 or 22. Maybe that's a contributing factor to my blindness now.' But, in general, and for men who had been diagnosed with syphilis recently, it was the experience of antibiotic treatment that was most notable:

STEPHEN: ... *I think once people have had syphilis, I think they need to really understand that it's ten procaine [penicillin] shots over ten days and no one's going to believe you when you roll up on a Sunday at the doctor's that you're there for flu shots...*

The consecutive daily injection of antibiotics (particularly procaine penicillin) tends to be seen as the 'gold standard' for the treatment of syphilis in Australia (e.g. Mutimer, 1998). Alternative treatment options, such as a course of oral antibiotics (e.g. doxycycline) or a single injection of benzathine penicillin, tend only to be offered if a patient is allergic to penicillin or is unable to attend a course of injections at the clinic. Otherwise, a minimum 10-day course of intramuscular injections of procaine penicillin may be the preferred clinical option. As Stephen indicates, this course of treatment can be quite intrusive and disruptive to an individual's routine, as well as increasing the chances that an individual will be recognised as attending a doctor's surgery or clinic for a sexual health problem. This suggests that there is still a degree of stigma attached to others knowing that one has an STI, although in the case of syphilis the practical aspects of treatment may be the overriding concern.

For Bruce, not having been diagnosed until after secondary syphilis developed, together with the complicating factor of having received antiretroviral therapy for HIV, made the experience of syphilis infection and treatment very unpleasant:

BRUCE: *I got so sick I had to go into hospital.*

INTERVIEWER: Is that right?

BRUCE: *Over three days they pumped me so full of antibiotics until they finally figured out what it was. And they took so much blood ...*

INTERVIEWER: They didn't know you had syphilis?

BRUCE: *No. [The HIV specialist] didn't even pick it up because ...*

INTERVIEWER: So they assumed that it was HIV-related or something?

BRUCE: *Um, or a drug reaction because I'd just started a new combo. And so they'd take me off that combo which ruined that combo 'cause I'd built up resistance to it. Um, he had never seen a case of secondary syphilis present itself in that way. I was in his office every fortnight for about six weeks. I finally got so sick I couldn't go to work. Into hospital, a massive lot of tests. A*

massive lot of antibiotics. After about the third round of testing over about three or four days, 'We just got a positive result for something. Syphilis.' [giggling] 'Fuck! Well at least I know.' [laughing]

INTERVIEWER: But they hadn't tested you for that for all those weeks?

BRUCE: *No, because it hadn't presented in the classical form at all. At all.*

While Bruce was, in retrospect, amused by his clinicians' difficulty in diagnosing syphilis, his account emphasises syphilis's reputation as 'the great imitator', with symptoms that are often indistinguishable from many other diseases. The effects of antiretroviral drug regimes may also complicate clinical diagnosis and management. The difficulty of diagnosing the infection and the potentially dangerous consequences of the advanced stages of the disease meant that most of the men who had ever been diagnosed with syphilis had decided that routine STI testing was the best way to manage concerns about reinfection:

INTERVIEWER: So syphilis is another kettle of fish? That you've discovered?

STEPHEN: *Yeah, I think so, absolutely. And I think, 'How do you deal with stuff like that?' And it's about testing, it's about ensuring that everybody's testing all the time.*

As discussed in the following sections, regular STI testing was one of the strategies advocated by other men in the SA study. Unsurprisingly, those who had been diagnosed with syphilis had a raised awareness of the disease's effects. However, in general, syphilis and other STIs were not of major concern to men in the SA study. The following sections therefore explore how STIs are positioned in relation to sexual practice and risk, conventions around passing on STIs, and the various strategies adopted by men to manage the likelihood of exposure to STIs.

The (in)significance of STIs

In light of the fact that HIV infection is still incurable, potentially lethal and difficult to treat, it is perhaps unsurprising that sexually transmitted infections do not have the same importance as HIV for gay men. Most STIs can be treated quickly and effectively with antibiotics and other drugs or can be controlled by ongoing medication. Regular STI testing also allows asymptomatic infections to be detected and treated. The potentially severe and chronic consequences of HIV infection, and the availability of effective STI tests and treatments, mean that many gay men see STIs as having a relatively low priority in their health maintenance activities. However, even 'sexually adventurous' gay men describe negative aspects of STIs, including potentially unpleasant and uncomfortable symptoms, the shame and stigma of infection and, to a lesser extent, the effects of STIs on HIV susceptibility and viral load. Because the possible effects of STIs are somewhat different for HIV-negative and HIV-positive men, in the following sections we look at each group separately.

HIV-negative men

Although they knew that they could be exposed to STIs through their sex practices, most of the HIV-negative men in the SA study were relatively unconcerned about them. Knowing that there were effective STI treatments available, few of the men said that they would change their sex practices. Colin's perspective is typical:

COLIN: ... *if you want to participate in reasonably active gay sex then ... horses for courses. And there are treatments for them, the majority of them. Um, so I'm willing to take those risks, given that I want to enjoy the spectrum of sexual activity.*

For Colin, the pleasure and enjoyment derived from sex outweighs the risks of contracting STIs, which are seen as the inevitable consequences of

sexual activity ('horses for courses'). Adopting the position of rational decision-maker (as well as deliberate pleasure-seeker), Colin suggests a considered evaluation of risk in which STIs are an acceptable potential consequence of his sexually adventurous practices (including aspects of leather play, bondage and group sex). Other HIV-negative men in the study suggested that they did not explicitly evaluate the risk of STIs, but they did consider HIV to be an ongoing concern:

INTERVIEWER: ... Other than that you are conscious of HIV?

PETER: *Oh yeah.*

INTERVIEWER: But you don't think gonorrhoea, syphilis, herpes or any of that sort of stuff is a worry?

PETER: *No.*

INTERVIEWER: Do you ever think you might catch something like that?

PETER: *Um, the chance is there. But it doesn't pop into my head [when having sex].*

Peter suggests that while he is 'conscious' of HIV and has knowledge of STIs, he is not concerned about STIs. HIV and STIs are constructed as issues to be dealt with separately, with HIV as a 'conscious' issue and the risk of STIs as a background concern. In many ways this separation is a realistic one, given the very different consequences of HIV infection and other STIs. However, the separation of STIs and HIV is not as clear-cut as men like Peter would like. STIs are known to increase the likelihood of HIV acquisition or transmission (Wasserheit, 1992). However, not worrying about STIs may also be a response to the difficulty in preventing their transmission. Strategies that prevent HIV transmission may not be as effective in preventing STI exposure. For example, because many STIs are more infectious than HIV, condoms are less effective

in preventing their transmission (Donovan, 2004). In addition, many STIs are readily transmitted through sex practices in which condoms are not usually employed, such as oral–genital and oral–anal sex (sucking and rimming), or even kissing. Many of the HIV-negative men, who saw their practices as safe for HIV, therefore knew that there was a chance they could still get STIs:

INTERVIEWER: So with gonorrhoea and syphilis, chlamydia and whatever, do you worry about contracting them?

HANK: *I know there's the possibility and since I do have oral sex without a condom with people there's always a chance of it. I know what to look for visually but I also know that's no guarantee because lots of people are asymptomatic or don't have symptoms at the time you might have sex with them or what have you. I know it's a risk but it's something that's fixable so ...*

INTERVIEWER: So it's a risk you're prepared to take.

HANK: *Yeah.*

Like most gay men, Hank does not use condoms for oral sex and understands that this is a possible transmission route for STIs. Like Colin, Hank considers the risk of getting an STI acceptable (and possibly unavoidable). Hank talks about looking for visual signs of infection (presumably sores, rashes or discharge) as another strategy he uses to reduce the risk of STIs (see 'Managing STI exposure' below), but is aware that many people have STIs without symptoms or knowing that they are infected. Once again, the 'fixable' nature of most STIs allows Hank to see his sex practices and the risks they generate as acceptable.

Perhaps because many gay men consider STIs to be an inherent risk of sex (especially with casual partners), and because it is difficult to identify straightforward strategies that could reduce the risk of STI exposure without severely limiting one's sexual repertoire, some men in the SA study preferred to avoid thinking about STIs:

INTERVIEWER: And do you ever worry about getting these STDs? Do you ever see that as a concern?

GORDON: *No.*

INTERVIEWER: So it doesn't figure prominently in your consciousness when you're having sex ... sort of thinking, 'Oh, I could be getting this disease or that disease or whatever'?

GORDON: *No. If I did I couldn't be having the sex.*

INTERVIEWER: And so why do you see it as not that much of a problem? Or much of a concern?

GORDON: *I don't know. I don't know the answer to that. I suppose because ... I've only had anal gonorrhoea which is obviously treatable, and I've had plenty of screens so, apart from the four I've had here, I would have at least had that much or more in [my country of birth]. For the range of activities that I've indulged in, I'm probably on the safer side of things.*

For Gordon, worrying about STIs is a 'passion killer' and is something that he avoids doing when having sex. STIs are constructed as something to deal with *after* exposure may have occurred, through regular screening and treatment, if necessary. These strategies, along with Gordon's assessment that his practices are on 'the safer side of things', position Gordon as responsible and managing risk (even if he is still at *some* risk), and mean that Gordon can continue to engage in and enjoy sex without feeling concerned or inhibited.

Peter also suggests that STIs do not really figure in pre-emptive evaluations of risk before sex, and only become a problem after they are contracted:

INTERVIEWER: ... if you did get something, do you think that it's not that big a deal if you do get something?

PETER: *Oh sure, it's a pain in the arse if you get something and if you're caught you're going to have to get better. But it's just not something that pops in my head. Like if [my partner] came home tonight and said, 'We're going to [sauna]', I'd say, 'Cool let's go.' I wouldn't even worry about it.*

STIs are constructed as inconveniences that may result from sex but which are not paid much attention *before* sex. The chance of contracting an STI is not something that inhibits Peter's sexual

activities (such as going to the sauna), and is not seen as something that the individual can do much about. In fact, the idea that you can get 'caught' by an STI or by someone with an STI positions the individual as passive and therefore not responsible for infection. However, it is also interesting to note the apparent imperative to 'get better' after an infection is noticed, which indicates a responsibility on the part of the bearer to seek treatment. We discuss the apparent responsibilities of those who get 'caught' with STIs in more detail in the section on 'STI conventions' below.

HIV-positive men

In general, HIV-positive men in the SA study were less concerned about STIs than HIV-negative men. Reflecting the significance of HIV infection as a chronic and potentially life-threatening condition, the experience of being HIV-positive tended to be seen as a primary concern, outweighing considerations about treatable STIs:

PAUL: *That is why I'm not so worried about STDs. Because I've already got the virus, I mean so what? It's like, you've got STDs, this is curable, so phhhh*

Like HIV-negative men, HIV-positive men in the study prioritised their sexual practices over the risk of contracting STIs. Positive men like Simon and Adrian (below) positioned themselves as rational agents who had evaluated the risk of STIs and saw them as an acceptable trade-off for the pleasure derived from their sex practices:

INTERVIEWER: Do you worry about getting an STI through your sexual activities?

SIMON: *Not really. I mean I engage in sexual activities which to me are within a sort of an acceptable framework of risk I suppose in terms of disease acquisition.*

ADRIAN: *I think every negative man should just assume that everybody is positive. Not just for HIV but for every other disease that's around. I mean you've got more chance of catching hepatitis C or syphilis or gonorrhoea or NSU*

[non-specific urethritis] than HIV. So it's a risk you take. I mean sex is a risk. Should it be that we just cut sex out completely? Well, obviously that's impossible. So, I don't know what you do. I mean I think I'm being fairly responsible by the standard or by the bar I've set myself. And I can't do any more, I don't think, other than locking myself away in a monastery. Or judging by what goes on in monasteries I don't know whether that's a valid thing [laughs]. But rather than just being celibate. No. I refuse. I'm still a sexual being and while I've still got it I'm going to make full use of it. But, I hope, responsibly.

These extracts highlight that even men who see themselves as 'fairly responsible' or adopting 'an acceptable framework of risk' do not think they can avoid STIs (short of total abstinence) and therefore accept that the chance of getting an STI is 'a risk you take'. The apparent unavoidability of STIs may partly explain why some positive men discount the associated risks of STIs in relation to viral load. Clinical research suggests that STIs should be of particular concern to people living with HIV/AIDS because of their potentially adverse effects on viral load (Rotchford, Strum & Wilkinson, 2000). However, HIV and other STIs tended to be seen as separate issues by HIV-positive men in the SA study. Some argued that the issue of STIs and their interaction with HIV was largely irrelevant to positive men's everyday lives:

STEPHEN: *... you know I quietly chuckle whenever we hear lectures about 'You've got to be really careful about not getting other STIs because it might make your viral load go up'. So, if you ask around positive guys, 'Have you really been worried about what happened to your viral load when you got a dose of the clap or, whatever?', well, actually, no they didn't. Unless you were having clinical markers taken at the time. You never would have known anyway.*

Stephen suggests that among the positive men he knows, the effects of STIs on viral load are not generally considered. Stephen's account distinguishes between three types of knowledge and expertise, each of which has a different value and significance within the evaluation of STIs and their effect on viral load. Firstly, professional advice

encouraging positive men to consider the effect of STIs on viral load is seen as a 'lecture' and is dismissed. The idea of a 'lecture' suggests information that is being delivered in a dictatorial manner, a form that does not necessarily take account of the second type of knowledge that Stephen's account suggests: positive men's experiences of viral load and STIs. (Earlier in the interview Stephen suggests that clinical concerns about the interaction of STIs and HIV are not part of the 'experienced lived reality' of positive men.) In this 'lived reality', positive men (like negative men) tend to separate their experiences of HIV and other STIs, because (as we have seen) STIs tend to be seen as unavoidable, treatable and acceptable risks. Finally, Stephen identifies 'clinical markers' (presumably viral load, CD4 and other blood test results) as a third source of information that may be taken into consideration when evaluating STI effects. These markers have a more neutral role in Stephen's account.

Although test results are generated by doctors and specialists (usually as part of a routine monitoring regime), they are not dismissed in the same way as professional advice or 'lectures'. Test results are positioned as a neutral source of information which positive men (as well as doctors) use to make assessments about their viral load and health status. Stephen therefore suggests that positive men who have routine blood tests shortly after having an STI might recognise that their viral load has gone up as a result of 'a dose of the clap', but that most positive men would not see a change in their test results unless they were tested around the time of the STI. Stephen's account implies that unless HIV-positive men 'see' evidence that their viral load has been affected by an STI, the link between STIs and viral load will remain an abstract idea (what Stephen elsewhere calls an 'esoteric scientific concept') and not part of their 'lived reality'.

STI conventions

Although both HIV-negative and HIV-positive men in the SA study generally regarded STIs as inconveniences or acceptable risks when talking about their sex practices, a number of men said that there were informal conventions about how STIs should be managed, particularly when dealing with sex partners. Participants suggested that men who knew they had an STI should seek treatment and avoid passing the infection on to other people. Those who knowingly transmitted an STI were considered irresponsible. The assumptions raised about trust, disclosure and the responsibility for one's health and that of others are discussed in the following sections.

Being responsible while infected

A number of men in the study had very clear ideas about what they would or would not do if they knew they had contracted an STI:

INTERVIEWER: ... do you ever worry about [that] maybe you've already got an STI?

PAULO: *Well, if I know I'm sick I don't have sex with anyone.*

INTERVIEWER: We've talked about it already, but do you have concerns about transmitting STIs or whatever, or getting it?

HANK: *No, because if I suspect I have one I'm certainly not going to have sex with anybody and I'm going to get it fixed immediately.*

INTERVIEWER: So you would stop sex if you ...

HANK: *Oh, absolutely. I'm much more concerned about my health that I would never, I'd feel horrible if I gave something to somebody.*

Both Paulo and Hank say that if they know they have an STI they abstain from sex with other people. Having an STI is regarded as being 'sick' and something that needs to be 'fixed immediately'. For

these men, having an STI seems to implicate the subject in aspects of the socially sanctioned 'sick role', in which in order to avoid being seen as blameworthy for becoming ill, the subject must act responsibly, seek medical advice and comply with appropriate treatment until they are well (Parsons, 1970). Acting responsibly in this case means considering the health of yourself (by seeking treatment) and that of your potential sex partners (by avoiding passing on the STI). Knowingly transmitting an STI is at best seen as bad form, and at worst positions the infected individual as malicious or wilfully irresponsible.

It is interesting to note that in these accounts it is the person with an STI who is seen as *solely* responsible for managing the infection and for preventing onward transmission, as is not the case in HIV education and prevention. With HIV, considerable effort has been expended in promoting the idea of shared responsibility between sex partners (with varying degrees of success). However, it seems that it is acceptable to be judgmental about gay men who knowingly have sex while they have STIs in a way that would be considered strange or unacceptable if the subject of discussion was HIV. The understanding that it is more difficult to prevent the transmission of many STIs than of HIV may play a role here, but some men suggested that it was the short-term (and potentially unpleasant) consequences of STIs that made the 'etiquette' surrounding them so important:

INTERVIEWER: ... Do you think that when it comes to something like gonorrhoea or syphilis that people are more ... would be less concerned about passing it on? If they had it?

STEPHEN: *Well, there's a real convention about ... you don't deliberately pass on an STI if you know you've got it. I don't know people who do that. I mean I just don't. And it's even worse in a way than passing ...*

INTERVIEWER: So it's not necessarily about deliberately passing on, but it would be about 'I want sex and I've got this' and 'Well, I'm going to have sex anyway.'

STEPHEN: *Yeah, if you don't know you've got it then ...*

INTERVIEWER: Knowing you've got it, but having sex, not to pass it on, but to have sex.

STEPHEN: *Look, my sense of that is it's less rather than more. There's no issue. I mean I just don't think, I mean there's a real etiquette around that. You don't deliberately pass on gonorrhea to somebody if you know you've got it. And guys actually talk about that quite often. They talk about it more than HIV. Because it's more immediate. You know and you can sort of see it ... I mean, God, you know, ten shots of procaine [penicillin] in your arse over ten days. I mean you know ...*

Although exactly what STIs are supposed to be 'worse than' is unclear from Stephen's account, he argues that the effects of STIs are in some ways more immediate and are therefore discussed more than HIV. STIs often (but not always) have short-term physical effects and treatment can be uncomfortable and disruptive. There is therefore an expectation that infected individuals will 'do the right thing' and protect their partners.

It is also interesting to note that when the interviewer tries to ask whether there are conditions under which a person can have sex when they know they have an STI ('Knowing you've got it, but having sex'), this is not taken up by Stephen. In fact, none of the men in the SA study talked about whether there were circumstances under which you could *knowingly* have sex with an STI. Abstinence during infection and treatment was largely seen as the only option. This is clearly quite different than in the case of HIV, in which it is taken for granted that HIV-positive individuals have a right to enjoy sexual pleasure, and where significant efforts are made to understand, debate and promote the conditions under which HIV-positive individuals and their partners can be sexually active while protecting themselves from health risks. Once again, this may reflect the difficulty in identifying practices that are 'safe' for STI transmission, in contrast to HIV.

Trusting others

Conventions around acting responsibly when one has an STI rely on a shared understanding of what

counts as 'responsible' as well as detailing what one is supposed to do (and avoid doing) when infected. This implies that gay men have to trust one another to behave similarly when they have an STI. However, perhaps unsurprisingly, the men in the SA study distinguished between different sex partners, seeing some as more trustworthy and caring than others. Casual and relatively unknown partners were not generally expected to take as much care as regular or known partners, who were seen as more reliable and trustworthy:

INTERVIEWER: Do you think you feel more concerned if it's somebody that you know than somebody you don't know, around transmitting STIs?

HANK: *I don't think I'm more or less concerned about transmitting it. I'd be more or less concerned about catching it. If it's somebody I know ... I would trust that if they had something or suspected they had something that they would not have sex with me.*

Hank suggests that he sees himself as a responsible subject, and that he would not knowingly transmit an STI to *any* sexual partner, regardless of whether he knows them or not. However, other men are seen as less predictable. Hank reasons that men he knows would be like him, and would not knowingly take the risk of passing on an STI, but implies that men he doesn't know might not be so reliable.

Other men in the study also indicated that they trusted regular or known partners to protect them from STIs, usually by abstaining from sex, but *not* from necessarily disclosing an STI to them. Simon's account is unusual in that he recalls a sex partner explaining why he was abstaining from sex:

INTERVIEWER: ... What's that, if you have [an STI] you wouldn't have sex with somebody?

SIMON: *No, I seem to be really good with that. I wouldn't, no.*

INTERVIEWER: Yeah, and you would expect other people to do the same?

SIMON: *Yeah, actually somebody's done that to me already. Someone who said that he was out of operation because he had something. I can't remember what it was now but ... He said he was all clear, I mean you know, he was quite open about it, and it was no problem.*

Abstaining from sex (being 'out of operation') until you are 'all clear' is seen as 'good' behaviour, and is something that is expected of sex partners who know each other. This may be important in maintaining trust between regular scene participants in the relatively contained sex scenes in which these men participate. However, because of the stigma of infection and the potential for rejection, it is likely to be much easier to disclose an STI to a known or regular partner than to a casual acquaintance or stranger (whether in or outside of these sex scenes). We should also bear in mind that casual sex environments often rely on non-verbal communication, and an in-depth discussion about any subject (let alone STIs) might be difficult to initiate. Therefore, conventions around protecting sex partners from STIs seem to rely primarily upon individuals who know they are infected abstaining from sex and not necessarily disclosing STIs. As it has been argued in relation to HIV, it is not reliable to assume that a sex partner will disclose their status and risk rejection, particularly if they are cruising in a casual sex environment. Ted elaborates on the unreliability of expecting casual sex partners to disclose STIs:

INTERVIEWER: But have you ever thought about viral load and risk of transmission? What about if somebody has an STI, that they might be more infectious or you might be if you've got an STI?

TED: *I don't know but if a guy told me they currently had a sexually transmitted disease or they've just seroconverted and have a high viral load, I probably wouldn't have sex with them.*

INTERVIEWER: But you wouldn't necessarily know that because you don't discuss it?

TED: *Yeah. No. I mean if a guy ... it's a self-defeating question. If a guy's cruising for sex, and they've got an STD and they've got a high viral load, they're not going to disclose it anyway because why else are they cruising for sex? You*

know what I mean? I mean it's a ridiculous proposition to think you're going to have a medical conversation before sex. You know? Like a guy who's positive will sometimes tell me they're positive just so that I can make an informed decision about what I want to do.

INTERVIEWER: But you think most ...

TED: *But, like, I always think you may as well say to yourself, 'Most guys are positive.' Because that's the only way to think about it.*

Ted points out that being told about an STI or high viral load is likely to stop a sex encounter from happening, and therefore he recognises that men with STIs or high viral load are unlikely to disclose that information when they are cruising. Even though some men do discuss HIV status in the preliminaries before a sex encounter, discussing STIs or debating viral load is seen as a 'medical conversation' that is unlikely to happen. Ted concludes that trusting others to disclose is not a reliable strategy and a preferable approach is assuming every encounter has some risk for STIs and HIV.

Protecting partners

As well as trusting known partners more than casual partners, men talked about wanting to protect regular partners from STIs. While some of the men quoted earlier were adamant that they did not want to transmit an STI to *any* partner, other men suggested that passing on an STI to a casual partner was not a major concern:

INTERVIEWER: So, do you think people care less about what happens to their casual sexual partners? They care less if they give them a disease, basically?

JOHNNY: *Yeah, because they'll never meet them again. Um, there is a lot less care.*

INTERVIEWER: And would you say that's also true for yourself?

JOHNNY: *No. Well, my care is for contracting something myself. And my main point is I do not want to get something.*

As Johnny suggests, in a casual sex encounter, men may be more likely to prioritise their own health over that of their partner and to see other men as potential sources of infection (rather than seeing themselves as potential carriers of STIs). In contrast, at the beginning of a regular relationship, men may be particularly careful about not passing on STIs, in order that they are seen as responsible:

PAUL: *... if I know someone I like I would really prefer to start off having safe sex. Rather than barebacking. Which is weird because ... it's not weird, but my logic is, if I know this guy and if I'm truly emotionally attached to this guy, I don't want this guy to get STDs from me. I would like to have safe sex for the next three months until I go and do my blood test and come back and confirm everything is negative. Then I'll have barebacking sex with him, provided that he's positive. But otherwise I really just prefer this guy to have safe sex with me.*

For Paul, having safe sex until he gets clear test results for STIs demonstrates care for his partner and his commitment to the relationship. What is implied is that passing on an STI to a regular partner is likely to make one appear careless or irresponsible, and this could threaten the relationship. Although condom-protected sex is not a guaranteed way of preventing STI transmission, it does reduce the chances of infection and greatly reduces the likelihood of transmitting HIV. Testing can then be used to demonstrate that both partners are free of STIs and to confirm each other's HIV status, providing a basis for trust and a means through which to negotiate the terms of the relationship. For Paul, test results allow him and his partner to consider introducing different sex practices into the relationship (particularly 'barebacking' or unprotected anal intercourse).

Other men who are already in regular relationships, but who also have casual partners, may be particularly concerned to not 'bring STIs into the relationship':

JOHNNY: *Um, if I'm going to get fucked, they're wearing condoms. Simple, straight up. My partner's the only one that doesn't. Because we*

have that commitment. I also have him to worry about as well as myself.

INTERVIEWER: What do you mean by commitment?

JOHNNY: *Well, we're the only ones that bareback. Therefore if anybody ... I don't want to with him. I don't want to be the one responsible for giving him HIV or an STD. And vice versa. So there's nothing done without being safe. As far as the safe sex side of things go. And I'm very ...*

INTERVIEWER: There's nothing done without being safe?

JOHNNY: *Outside of my relationship.*

For Johnny and his regular partner, who are both HIV-negative, using condoms with casual partners reduces the chance of giving each other an STI as well as protecting each other from HIV. For Johnny, using condoms outside the relationship and not using them within it demonstrates commitment and trust between him and his regular partner. This is a form of 'negotiated safety' (Crawford, Rodden, Kippax & Van de Ven, 2001).

STI conventions: limitations

Conventions about how gay men protect themselves and others from STIs reflect common expectations about how STIs should be dealt with, about responsibilities for protecting partners, and the different ways in which sexual partners are valued and trusted. Men in the SA study suggested that gay men with STIs are expected to prevent STI transmission by abstaining from sex and by seeking appropriate treatment, although it was recognised that men are unlikely to disclose STIs. Although it was seen as irresponsible to knowingly put *any* partner at risk of infection, when men in the study were considering the importance of preventing STI transmission, regular partners were prioritised over casual partners.

While conventions such as these are in some ways quite useful in informing gay men's sexual practice in relation to STIs, they are in other ways problematic. Conventions about protecting partners, seeking treatment and preventing transmission rely on men *knowing* that they are infected, and many

men will be unaware that they have an STI if, for example, they have an asymptomatic infection or innocuous symptoms. Regular STI testing then becomes essential in providing knowledge about STIs, and many men will of course not seek testing if they do not have obvious symptoms or a regular testing regime.

The recognition that gay men may unknowingly pass on STIs troubles the assumptions about responsibility implied by STI-management conventions. While men who knowingly put others at risk of STIs are clearly seen as careless, irresponsible or morally suspect, it is far from clear how men who unintentionally expose others to STIs are regarded. Because the responsibility for preventing STI transmission is seen to lie squarely with the infected person (rather than something that can be shared between partners, as in the case of HIV), it is likely that men who unknowingly pass on STIs will still be regarded as blameworthy by others. In any case, assigning responsibility (and blame) for STI transmission to infected individuals does not seem particularly helpful in encouraging gay men to consider how their practices might expose them to STIs or aid in their transmission. For the purposes of education and prevention, it may therefore be useful to question the ways in which responsibility is assigned in gay men's understandings of STIs. It may also be useful to challenge the notion that casual partners are not as worthy of care as regular partners with respect to STIs. Supporting the positive aspects of STI conventions may also be productive here (i.e. encouraging the idea that all gay men benefit from protecting one another from infections).

Managing STI exposure

Although STIs were not seen as significant impediments to having sex, the men in the sexual adventurism study did talk about a number of ways that they could reduce their exposure to STIs before, during or after sexual activity. Many of the strategies used to prevent risk of exposure to STIs appeared to be adaptations or extensions of safe sex strategies primarily aimed at preventing HIV transmission, while other strategies appeared to be specifically targeted at STIs. All of these strategies are included in Donovan's (2000a, 2000b) comprehensive reviews of lay and clinical strategies used to prevent or control exposure to STIs. As discussed below, some of the strategies described by the sexual adventurism study participants appeared more plausible than others in reducing the risk of exposure to or transmission of STIs, and often rested on ambiguous assumptions about the relative risks of particular places, people and prevention tactics.

Choice of venue

Some men indicated that going to particular venues (usually sex-on-premises venues) was associated with an increased chance of getting an STI, and avoiding these venues, or limiting the time spent there, was seen as a way to reduce exposure to STIs. Venues were associated with STIs either because they were seen as supporting particular sex practices and scenes or because they were seen as poorly maintained and unhygienic:

SIMON: ... well, for example, like the [Attic], which I think is absolutely filthy, just seems to have, like, disease crawling all over the walls, so I can choose not to go there. To some extent say [Underground] as well. Saunas are a bit better because you can have a wash, people can have a wash and all of that so that does play a part. I think that does actually play a part of why I choose to go to some places and not others.

Simon highlights a practical strategy to reduce STI exposure (being able to wash) that is easier to do in 'wet' sex-on-premises venues like saunas rather than 'dry' sex venues such as sex clubs. However, his perception of certain venues as 'filthy' and having 'disease crawling all over the walls' suggests an emotive link between the poorly maintained and dirty appearance of some dry venues and potential exposure to STIs. This implies that the lack of care and hygiene expressed in the fabric of a venue is seen as implicating or 'contaminating' the practices of its patrons (i.e. that dirty venues equate to dirty patrons), and that assessments of 'cleanliness' carry a moral implication.

Other men saw some venues as supporting particular sex scenes and practices (such as unprotected anal sex, group sex or using drugs as sexual enhancers) that were regarded as risky for STIs, and therefore saw moderating their attendance at these venues as a useful strategy:

INTERVIEWER: So you're not really worried about getting STIs particularly?

PAUL: *Oh, [pause] I'm not worried. I don't worry to myself.*

INTERVIEWER: You don't worry about it enough to change ... ?

PAUL: *To want a change of my sexual behaviour. But [strong emphasis] it does warrant modifying my sexual behaviour a bit. That is why I'm probably not doing the sex clubs so often and that is probably why I'm avoiding [Underground] a little bit more nowadays ...*

Choice of partner

A number of men suggested that they assessed the risk of exposure to STIs when selecting potential sex partners, and that choosing certain partners and not others could help in risk reduction. For some this

meant inferring the likelihood of STI exposure from a man's appearance and attitude:

JOHNNY: *And I'm quite lucky [that I haven't had any STIs]. I suppose I'm one of the lucky ones. But I'm also very careful.*

INTERVIEWER: Careful? In what ways are you careful?

JOHNNY: *I, I don't know. I tend to look at people first. Someone that I don't think has good hygiene. I don't tend to ...*

INTERVIEWER: How can you tell if someone has good hygiene?

JOHNNY: *I don't know. It's just the way people look. If someone looks really dirty, um, or has that little bit over-the-top, who-gives-a-fuck attitude, then I tend to steer clear.*

For Johnny, avoiding STIs is partly good fortune ('I'm one of the lucky ones'), and partly a result of being 'careful'. Being careful means assessing whether men have 'good hygiene' from 'the way people look' and their 'attitude'. An apparently 'dirty' appearance or an 'over-the-top' or 'who-gives-a-fuck' attitude are reason enough for Johnny to avoid certain men, presumably because these characteristics connote a lack of care or personal hygiene, or a reckless attitude to sex practices. Appearing dirty or reckless can suggest a greater chance of having an STI for some men.

Other men also used appearance as an indicator of likelihood of exposure to STIs, particularly when they were intending to engage in potentially risky practices such as 'barebacking':

PAUL: *... when I actually have bareback sex, I tend to look at a guy's appearance more. And if this guy is like ... I don't know ... just part of my brain telling me to psych myself up, 'Oh, this guy is clean', because he looks more clean cut. Looks like, you know, looks ordinary. I've never seen him before, so he's probably not so much in the scene and ... yeah, I wouldn't mind doing barebacking with him, you know, if he chooses.*

Paul's reasoning behind trying to find 'clean cut' and 'ordinary'-looking partners for unprotected anal sex is that they are less likely to be regular participants of 'the scene' and are therefore less likely to have or pass on an STI. Appearance, of course, is not a reliable indicator of a person's likelihood of having or passing on an STI. Physical appearance does not necessarily bear any relation to health, STIs can be asymptomatic, and attitude and appearance do not necessarily indicate the type of practice that a partner might engage in (Paul, after all, implies that he has a reasonable chance of engaging in 'barebacking' with a 'clean cut' or 'ordinary' guy). Other men therefore focused on the practices they saw other men engaging in, or made assessments based on the sex practices that were suggested to them by potential partners:

ALISTAIR: *... how I make my decisions is based on what I know up to that point. And that might be, you know, in my experience, it's very rarely a couple of minutes. Or a couple of seconds. Because I don't run around sticking my dick in holes. I don't want to get a lot of things. And I said to someone the other day, I think of my dick as a Rolls Royce and I don't let anyone [near it] unless he's got a licence [to] drive it. Yeah [laughs].*

INTERVIEWER: So when you're saying that you're talking about STDs other than HIV?

ALISTAIR: *Well, exactly. There's a certain care that I have for myself. Not always about them. If I see someone's just been fucked by ten people I'm not going to line up. That's the way I work. And like I said, very rarely I'll meet someone ... if I meet someone and they ask me to fuck them within five minutes, they're up shit creek without a paddle. Because I ain't gonna give it to them [laughs]. As simple as that. I'll just say, 'No. Go and find someone else.' Because that's not the experience that I want.*

Alistair positions himself as a careful assessor of potential sex partners, who limits his participation in anonymous or spontaneous sex acts with men he doesn't know. Alistair implies that he expects other partners to demonstrate respect and care for

his well-being, even though he admits this care is not necessarily reciprocated by him. Men who he sees having sex with multiple or consecutive partners are discounted as risky for STIs, as are men who proposition him without first demonstrating care or trustworthiness. Alistair sees this care and thoughtfulness as part of the 'experience' that he wants from a sexual encounter, positioning himself as a valuable commodity to be accorded respect by other men.

Condoms

The proportion of gay-community-attached men in Sydney who always use condoms for anal sex has fallen since the late 1990s (Hull et al., 2003). However, condoms are still consistently used by a large majority of gay men. In addition to protecting against HIV, condoms reduce the chance of contracting an STI through genital and anal contact, although they do not eliminate the risk of STI transmission by these routes. Condoms were used by SA participants to reduce exposure to STIs, sometimes on their own or in combination with other strategies:

INTERVIEWER: So do you actually do anything to minimise your chances of getting STDs apart from condoms?

CHARLES: *No, not really. Condoms are the only thing.*

INTERVIEWER: What sort of things would you do?

TRENT: *Um, well, condom use, obviously looking for any signs of that someone might have genital herpes or something like that.*

For men who used condoms, their function of protecting against STIs could be seen as welcome but secondary to their role in preventing HIV transmission:

INTERVIEWER: So you're being self-protective [when you use condoms]?

ANTHONY: *Yeah, yeah ... like, what if my virus gets into somebody else and it goes in somebody else's system and goes 'oh, wow' and it can go berserk*

... we don't [know] how it's going to react. If there's no discussion of people's status that means that if I'm fucking somebody I assume everybody I'm fucking is negative. Like, if I'm fucking them, even if I can tell that somebody I think is probably on antiretrovirals, I think, 'You don't want my virus; I don't want yours. Put this on!' And for anybody that's ambiguous at all, which is like 90% of the rest of the population, I put a condom on because it's safe. I'm not gonna give you this. By the same token, I don't want to get syphilis. I don't want to get gonorrhoea. I don't want to get all that stuff.

INTERVIEWER: Have you had an STD in the last year?

ANTHONY: *Nup. I haven't had an STD in a long time. The HIV's enough.*

Anthony is highly aware of the potential consequences of passing on '[his] virus' and takes responsibility for not transmitting it to others, including other HIV-positive men. Anthony argues that making assumptions about sex partners' serostatus is often unreliable, so it is easier to assume that all his partners are at risk of infection ('I assume everybody I'm fucking is negative'). Even if he thinks that a partner is HIV-positive (like himself), Anthony is conscious that there may be detrimental effects from cross- or super-infection by different strains of HIV. Because of these concerns, using condoms is seen as protective in a number of ways, not least because it sidesteps the ambiguity of assessing HIV or health status in sexual encounters. Using condoms is also seen as reducing the chance that Anthony will contract an STI.

Perhaps unsurprisingly, other men were less sanguine about the use of condoms to prevent STI transmission. For some HIV-positive men in the SA study, the use of condoms was no longer taken for granted:

INTERVIEWER: Well, you could use condoms [to reduce the chance of getting an STI].

STEPHEN: *Yeah, but I don't think positive guys are going to do that. Um, you could. You're absolutely right. One hundred per cent correct. And we all know that if you want to be safe, you should use*

condoms. But the reality is that guys have moved beyond it and they're making all manner of risk assessments without them. And we've got to face that reality. You're not going to get them back onto condoms.

Although Stephen accepts the utility of using condoms, he suggests that HIV-positive men have 'moved beyond' the use of condoms and are now making 'all manner of risk assessments' when they have sex. Making 'risk assessments' positions HIV-positive men who do not use condoms as rational decision-makers who manage the risks of HIV and STI exposure, thereby maintaining their position as responsible agents. However, the idea that positive men are making 'all manner of risk assessments' also implies that sex without condoms allows more choices (and pleasure) during sex, and Stephen therefore suggests that positive men are not going to be persuaded 'back onto condoms'.

For other positive men like Paul, using condoms had apparently failed in preventing him from becoming infected with HIV. Paul knew that condom use could not prevent all forms of STI transmission, and this reinforced his belief that condom use or 'safe sex' did not appear to offer any obvious benefit:

PAUL: *I had safe sex and I still got the virus. I mean what worse could have happened to me? So phew. I could still have safe sex and I could still get STDs. You could get syphilis just from kissing.*

INTERVIEWER: So you just do what you want to do and enjoy it?

PAUL: *Definitely.*

Even for some HIV-negative men, the apparent inevitability or unavailability of STIs can make condom use appear futile or a 'wasted effort', despite condoms' effectiveness in preventing HIV transmission. Consider Brad's reasoning about why he does not use condoms:

BRAD: *... you're putting a condom on to remove—[lowers voice] I might be having a breakthrough here myself—to remove the possibility of contracting an STD, um [pause], yet, all the other*

things that you do during sex you could potentially still get an STD. And for the sake of however long it is that your dick is up their arse, you're going to stop ... you're going to lessen the chances of catching that STD because you wear a condom. And oh, I just think it's [pause] ... I'm just not completely sure that it's worth all that.

INTERVIEW: You're saying that you're not going to reduce your chances of getting an STD much by wearing a condom, is that what you're saying?

BRAD: *Yeah. One of the other things that I do during sex. If I'm like eating cum out of some guy's arse. Or if I'm going down on a guy and I've got a cut in my mouth. Or all these other things that are ways that I could contract this STD, whatever one it is, and I've had them all. But I don't have HIV. Then I don't understand why I'm going to go to all the trouble of putting on a condom. And not having it be how I want it to be.*

Brad is aware that wearing a condom could reduce his chance of contracting an STI when he's having anal sex, but he also knows that other practices he engages in (such as oral sex or 'felching') can result in STI exposure. Brad seems to suggest that because condoms are not more effective in stopping STIs, it is not worth using them for STI prevention, and because he has not got HIV so far, he might not need to use condoms for HIV prevention. Add to this 'the trouble of putting on a condom' and the apparent interference with his enjoyment of sex ('how I want it to be'), and we can see a complex set of rationalisations and optimistic thinking that accepts some benefits of condoms, identifies plenty of drawbacks and concludes that, overall, condoms are not worth the effort.

Washing

As discussed above, washing after sex is used by some men as an STI risk-reduction strategy when they are in sex-on-premises venues such as saunas:

TED: *No, I wash my hands all the time now which I didn't used to. You know, like, after sex I wash my hands now. I wash my dick. I sort of take my dick out of my pants and wash it in a handbasin after sex.*

Washing the hands (and genitals) with soap and water immediately after sex is thought to be useful in reducing the transmission of various STIs, such as chlamydia, gonorrhoea and gut infections like shigella, and has been promoted as a risk-reduction strategy in STI campaigns in New South Wales and elsewhere (e.g. ACON, 2003). It is possible that the absence of washing facilities at 'dry' sex-on-premises venues (sex clubs) might contribute to STI transmission at these venues. Conversely, the availability of showers at 'wet' venues such as saunas, and the etiquette of washing between consecutive sex partners in these contexts, may help in the reduction of STI transmission.

Testing

None of the strategies described above are a guaranteed way of preventing STI transmission. Knowing that many STIs can also present without symptoms, many of the men saw testing as a necessary strategy to detect and stop the spread of STIs:

INTERVIEWER: But how are you going to prevent yourself from getting syphilis?

STEPHEN: *Exactly, good question [laughs]. But it's interesting that everybody does the same as I do. And test regularly. That's the only way you're going to stop it ...*

The Sexually Transmitted Infections in Gay Men Action Group in Sydney recommends that sexually active gay men undergo comprehensive testing for common STIs at least once a year, and that men who have a large number of sexual partners should seek more regular testing (STIGMA, 2003). Some of the men in the SA study had already adopted similar testing regimes:

HANK: *If I haven't had any symptoms of any sort I'll get a full screen done about once a year. I probably should do it more often but I always think, 'Oh, it's probably a good idea to do it every three or four months' but I do it once a year for sure. When I do my yearly check-up.*

Some of the HIV-positive men in the SA study suggested that STI testing was incorporated into regular health monitoring by their HIV specialists. Participants described how their doctors included STI tests when regular blood tests were conducted:

ALISTAIR: *I have blood done every month.*

INTERVIEWER: And do you know what they check for?

ALISTAIR: *No. Well, no. She just tells me if something's going wrong. [laughs]*

INTERVIEWER: But do you ever have swabs? You know, checking for gonorrhoea or syphilis or ...?

ALISTAIR: *No, they do all that with the blood I think.*

INTERVIEWER: What does [your doctor] check for in those bloods? Any STD ... ?

ADRIAN: *I have no idea.*

INTERVIEWER: Yeah, so is that a part of your HIV management? Do you have a gay doctor that you do that with?

ANTHONY: *Yes I do. I've had him for seven years now.*

INTERVIEWER: When you go, does he do swabs? Anal, urethral, oral?

ANTHONY: *No, he does bloods and he'll not just do HIV, he'll do everything—syphilis, gonorrhoea, the whole bit. Um, the whole shebang.*

These HIV-positive men believed that their HIV specialists undertook STI testing as part of routine blood testing and HIV monitoring. Although the men trusted their doctors to undertake the necessary tests and inform them when something had 'gone wrong', they did not always appear to know for which STIs they were being tested. None of the men talked about having oral or anal swabs taken (or doing a urine test), which are normally included in sexual health tests for oral, anal and urethral STIs. In fact, blood tests alone would not be used to detect common STIs like chlamydia and gonorrhoea (which are usually tested for with swabs or urine samples). These men may therefore believe that they

are being routinely screened for a range of STIs when in fact they are only being tested infrequently, selectively or not at all. This does not mean that these men are uninvolved in their HIV care or blindly trust their doctors, but it does suggest that STI testing can be taken for granted when undergoing routine HIV-related tests. It may therefore be useful to encourage doctors to discuss the STI tests they do or do not include as part of routine HIV monitoring. HIV-positive men should also be encouraged to ask their specialists whether they are tested for a range of STIs on a regular basis.

Discussion

The qualitative material on syphilis and STIs presented here was taken from a small study of gay men who engaged in 'sexually adventurous' practices (Smith & Worth, forthcoming). In many respects these men are demographically and behaviourally similar to the men recruited into the syphilis study (see Part 1). This material may therefore be useful when trying to understand the perception and experience of STIs from the perspective of men who might be considered 'high risk' for syphilis and other infections, with the caveat that we are not presenting a 'definitive' picture of what gay men think about STIs.

STIs: inevitable, treatable, acceptable?

In general the men in the SA study did not regard STIs as particularly relevant to their sexual practices, and did not consider them important enough to decide to change or modify their behaviour. STIs tended to be regarded as 'inevitable', 'treatable' and often 'acceptable' consequences of sexual activity. For HIV-negative men, the risk of STIs was seen as relatively unimportant compared to the risk of HIV infection. For HIV-positive men, the challenge of living with 'the virus' while maintaining autonomy and sexual pleasure tended to outweigh concerns about treatable conditions like STIs. The role of STIs in increasing susceptibility to HIV infection among HIV-negative men, or in increasing viral load among HIV-positive men, was not seen as particularly relevant or important. Such concerns were positioned outside the 'lived reality' of most men, particularly those who were HIV-positive.

STI conventions and responsibility

Although STIs were not seen as particularly serious health risks, the conventions detailing how STIs should be managed indicated that STIs had personal and social implications for gay men. Men who

realised they had an STI were expected to seek prompt treatment and avoid exposing other men to infection, most commonly by abstaining from sex, or less commonly by disclosing to sex partners. Seeking treatment and protecting others from STIs was seen as responsible behaviour, while delaying treatment or knowingly exposing others was seen as wilful, reckless or malicious. The ambiguity around whether or not men 'knew' that they were infected means that some men were seen as blameworthy for passing on infections when they did not realise they were infected.

STI conventions firmly positioned infected individuals as responsible for managing infections and for protecting others, even though it was understood that men may not have realised they had an infection or that disclosure of an STI was unlikely in casual sex environments. This means that men who regarded themselves as 'free' of STIs were unlikely to consider STIs unless a sex partner raised the issue (which was unlikely given the disincentives to disclosure), and men may not have considered how their sex practices exposed them to STIs until they became infected themselves. It may therefore be useful to consider whether STIs could be repositioned as a 'shared' responsibility between gay men, as was the case with HIV, in order to better manage the risks of STI transmission in casual and regular sex encounters and to avoid blaming or stigmatising individuals for STI transmission. Positioning STIs as a shared responsibility might also avoid the perception by some HIV-positive men that they are being 'lectured' to and made to feel responsible for the undesirable synergies between STIs and HIV.

Strategies to avoid and manage STIs

A number of strategies to avoid and manage STI exposure were mentioned by men in the SA study. Some of these, particularly the use of condoms and washing after sex, are useful strategies and have been

encouraged and promoted in STI education campaigns. While most men in the SA study were committed to the use of condoms, especially HIV-negative men, almost all of the men reported that condoms detracted from sexual pleasure. A minority of men experienced sufficient problems with condoms that they felt unable to use them. In addition, for a few men the awareness that condoms could not totally prevent STI transmission fuelled the perception that they were unnecessary or pointless, despite a recognition that they were effective in preventing HIV transmission and could be the best current option for STI prevention.

Other tactics, such as avoiding particular sex venues or assessing the risk of infection from the appearance or behaviour of potential sex partners, were also mentioned by men in the SA study. While aspects of these strategies may help in reducing STI exposure, some of the assumptions on which the strategies rest make them unreliable. Assessing the risk of STIs from the appearance of sex partners in particular relies on folk assumptions that link exterior appearance, cleanliness, reliability and moral virtue. The assessment of a partner as 'clean' from their physical appearance or attitude may of course bear no relation to their sexual practices, awareness of STI risks, or likelihood of exposure to STIs.

Because of the ambiguities of assessing STI risks before or during sex, and the difficulty of totally preventing STI transmission, many of the men used regular STI testing to detect potential infections, in line with current guidelines (STIGMA, 2003). However, we have some concern that a number of HIV-positive men in the study believed that they were regularly tested for STIs by their HIV specialists (as a result of routine blood tests), but were unsure for which STIs they were being tested. Some men may have been under the impression that they were being tested for a full range of STIs on a regular basis when that was not the case. There is clearly a need here to encourage HIV-positive gay men and their doctors to discuss whether or not STI testing is included in routine HIV monitoring.

Syphilis-specific issues

Few of the men in the SA study had recently been diagnosed with syphilis. However, for those men the

experience of syphilis had left a lasting impression. This was not necessarily because syphilis was seen as a particularly awful or personally stigmatising STI, as in historical representations of the disease. Although syphilis was recognised as an especially infectious STI that could have serious long-term health consequences, it was the experience of diagnosis and treatment that was most notable. The few men who had recently experienced syphilis mentioned difficulties in getting the infection diagnosed and suggested that the common treatment for syphilis (daily injections of procaine penicillin) could be uncomfortable and disruptive.

With the continued increase in syphilis notifications in Sydney, education campaigns are encouraging gay men to seek testing for syphilis and other STIs, and are publicising the availability of effective treatments. The perception that syphilis treatments are unpleasant or disruptive could be regarded as a barrier to testing and treatment and is therefore worthy of further consideration. Although a course of daily procaine penicillin injections is regarded as the 'gold standard' for syphilis treatment in Australia (Mutimer, 1998), there is still a lack of clear evidence that this option is significantly more effective in treating syphilis than other alternatives (such as weekly benzathine penicillin injections, or courses of oral antibiotics) (Parkes, Renton, Meheus & Laukamm-Josten, 2004). In order to allay concerns about treatment it may therefore be worthwhile to publicise the range of treatment options available, even if the actual choice of treatment must ultimately be informed by clinical evaluation of the presenting individual's circumstances and discussion with the treating doctor.

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