

HIV/AIDS, Hepatitis C and Related Diseases in Australia Annual Report of Behaviour 2000

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**HIV/AIDS, Hepatitis C &
Related Diseases in Australia**

Annual Report of Behaviour

edited by National Centre in HIV Social Research

 **NCHSR**
National Centre in HIV Social Research

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HIV/AIDS, Hepatitis C and Related Diseases in Australia
ANNUAL REPORT OF BEHAVIOUR

Edited by
National Centre in HIV Social Research

in collaboration with
Australian Research Centre in Sex, Health and Society
National Centre in HIV Epidemiology and Clinical Research



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PREFACE

This report is the second in the annual series to review behavioural data relevant to HIV/AIDS and related diseases in Australia. Specifically these data relate to behavioural risk of transmission of HIV and behaviours related to the social aspects of treatment and care. Where available, data relevant to the related diseases—other sexually transmissible infections and hepatitis C—are also presented.

Unless stated otherwise, all data provided in this report are from the four-year period 1996-1999. In this way, each annual report builds on the previous report by comparing data from the last year with data from the previous three. Data pertaining to trends over time in behaviour relevant to risk of HIV transmission over a period extending from 1984 to 1995 can be found in *Valuing the past investing in the future: Evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-96* (Feachem, 1995) and its *Technical Appendices 3* (Crawford et al., 1995), 4 (Crofts et al., 1995) and 5 (Smith et al., 1995). Data from the four-year period (1995-1998) after the Feachem evaluation were presented in the first report in this series, *HIV/AIDS and Related Diseases in Australia: Annual Report of Behaviour* (National Centre in HIV Social Research, 1999).

It is timely for this extensive and detailed information—edited by the National Centre in HIV Social Research (NCHSR)—to be made available to interested organisations and individuals.

The report is published as a companion to the *Annual Surveillance Report* (National Centre in HIV Epidemiology and Clinical Research [NCHECR], 2000). Some of its tables provide data that overlap with or duplicate those in the NCHECR report. In particular, Tables 1.1.4, 1.1.5, 1.2.1, 2.3 and 3.1.2 are derived from the same data as those provided by the NCHSR for inclusion in the NCHECR's Annual Surveillance Report. We acknowledge the contribution of the National Centre in HIV Epidemiology and Clinical Research to this report.

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

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

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The behavioural data reported in this Annual Summary are the collective effort of researchers, funding organisations, collaborators and participants.

AIDS Action Council of the ACT

AIDS Council of Central Australia

AIDS Council of New South Wales

AIDS Council of South Australia

Australian Federation of AIDS Organisations

Australian National Council on AIDS, Hepatitis C and Related Diseases

Australian Research Centre in Sex, Health and Society

Commonwealth Department of Health and Aged Care

Department of Human Services, South Australia

Health Department of Western Australia

National Association of People Living with HIV/AIDS

National Centre in HIV Epidemiology and Clinical Research

New South Wales Health Department

New South Wales Users and AIDS Association

Northern Territory AIDS Council

People Living With HIV/AIDS (NSW)

People Living With HIV/AIDS (Victoria)

Queensland AIDS Council

Queensland Health Department

Queensland Intravenous AIDS Association

Queensland Positive People

Tasmanian Council on AIDS and Related Diseases

Victorian AIDS Council/Gay Men's Health Centre

Victorian Department of Human Services

Western Australian AIDS Council

Management and staff of venues and sexual health/medical centres across the country and many thousands of participants in the research projects.

SUMMARY

This report brings together information for the four-year period 1996 to the end of 1999 regarding the monitoring of practices which may risk transmission of HIV and practices related to the social and behavioural aspects of the treatment and care of people living with HIV/AIDS. It builds on data from the *Valuing the past: investing in the future: Evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-96* (Feachem, 1995) and the first report in this series, *HIV/AIDS and Related Diseases in Australia: Annual Report of Behaviour* (National Centre in HIV Social Research, 1999). Data are organised around a number of themes or topics, namely:

- 1. Sustaining safe sex behaviour**
- 2. Living with HIV**
- 3. Drug related behaviour**
- 4. The current climate**

With regard to **sustaining safe sex behaviour**, the most detailed information in this report comes from studies of homosexually active men, the population most affected by HIV in Australia. Limited data are available regarding other populations, namely people living with HIV; first-year tertiary students; men recruited for the Living as Men study; and people recruited at the Sex Industry Exposition in Melbourne.

Since the mid 1980s there has been a decrease in the practices which risk transmission of HIV and an increase in protective behaviour, particularly condom use, among homosexually active men and other populations. These changes happened quite early (that is, by the middle to late 1980s) and have mostly been sustained. There is little evidence of anything other than stability in these practices from the early 1990s to around 1995 (Feachem, 1995). During the period 1996 to 1999, safe sex appears largely to have been sustained.

However as indicated by data detailed in this report, there are signs of small but significant increases in unprotected anal intercourse among homosexually active men since 1996 in some areas. The increases in unprotected anal intercourse which have occurred among men in regular relationships are in general of the order of 6%, for example from around 28% to 34% in Sydney. Much of the unprotected anal intercourse within regular relationships is safe with regard to HIV transmission as it occurs within seroconcordant relationships. Changes in levels of unprotected anal intercourse in casual sexual encounters are uneven across the country. There is however, evidence of an increase among men in Sydney from around 14% in 1996 to 18% in 1999. HIV-positive men are more likely to engage in unprotected anal intercourse than HIV-negative men, although some of this unprotected anal intercourse is safe with regard to HIV transmission as it occurs between HIV-positive partners.

There has been a small decline among HIV negative homosexually active men in HIV testing, consistent across the areas studied. For example, the percentage of Sydney men tested 'in the last six months' decreased from 55% in 1996 to 48% in 1999.

As noted in the living with HIV section, retrospective accounts of homosexually active men who have recently seroconverted indicate that about half of the recent seroconversions among homosexually active men in Sydney occurred within regular relationships. In a similar fashion, the accounts of men who have requested post exposure prophylaxis (PEP) point to risks within regular relationships, particularly in the case of PEP within regular relationships known to be HIV serodiscordant.

Information in this section is also provided relating to the uptake of therapies and other treatment-related issues. Positive homosexually active men in Australia took up combination antiretroviral therapy very quickly. The data indicate that a plateau was reached by about the middle of 1998, with around 65-70% of HIV-positive men on combination therapy, and these levels have essentially been maintained.

The need for adherence to therapy regimens is generally well understood and current data indicate a high level of commitment to adherence despite the difficulties experienced by those on antiretroviral therapy.

Measures of 'contact' with the HIV epidemic indicate continuing high levels during the reporting period, notably among HIV positive men. HIV negative men in Sydney have high levels of contact with the epidemic but over time there was a downward trend. HIV negative men in other parts of Australia continue to have less contact with the epidemic than their Sydney counterparts.

Up until the end of 1999, the National Centre in HIV Social Research had obtained some data on **drug related behaviour**, especially 'recreational' drug use among homosexually active men. The data indicate high levels of drug use, particularly among men who are attached to gay community, with 70-80% reporting the use of at least one non-prescription drug in the six months prior to interview. While drug use is common, injecting drugs is a minority practice. It is difficult to comment on changes in drug use although the few available data indicate stability in use.

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

Although there is some optimism with regard to the efficacy of new combination therapies slowing progression to AIDS and reducing the burden of illness, there is also evidence that the majority of people are sceptical about lowered risk of HIV transmission as a result of lowered viral load. There is little in the collected data that speaks to 'complacency' or to 'safe sex fatigue'. However, for some homosexually active men there is a significant association between HIV optimism and risk practice.

The *Clinical Markers* study has provided evidence of a marked difference in attitudes and approaches to minimising risk amongst gay men, the most significant difference being between positive and negative men. Coupled with the preliminary evidence of increases in unsafe sexual practices in parts of Australia, it is important to maintain a close watch on risk practices in all affected communities throughout Australia and to keep up prevention, care and support efforts.

The background is a dark, textured surface. Overlaid on this are several thin, white, geometric lines. These lines form a series of rectangles and squares of varying sizes, some of which are nested or overlapping. The lines are primarily vertical and horizontal, creating a grid-like structure. The overall effect is minimalist and architectural.

SUSTAINING SAFE SEX BEHAVIOUR

1. SUSTAINING SAFE SEX BEHAVIOUR

During the period covered by this report (1996 to 1999) much of the work of the NCHSR was concerned with monitoring sexual practice among homosexually active men, the population most affected by HIV. The NCHSR has also concerned itself with other populations at comparatively lower HIV risk, including young people. The theme which provides most detailed information is that of sustaining safe sex behaviour. In this report a distinction is made between regular and casual sexual partners. This distinction is important because the meanings of sexual behaviour change depending on whether such behaviour occurs within a regular or committed relationship or in a casual encounter. Moreover strategies for safe sex take into account the context (regular partner or casual encounter) of sexual practice. Among homosexually active men, many of whom have both regular and casual partners, the distinction is specially relevant.

1.1 Safe sex behaviour among homosexually active men

With respect to homosexually active men, information in this report comes from both national data (*Male Call 96*), and State-based data. In the *Male Call 96* study (Crawford et al., 1998) as in 1992 (Kippax et al., 1994) two groups of men could be identified. One group included men who are attached to gay community, and are referred to as gay community attached (GCA). The other group consisted of men who are not attached to gay community, many of whom do not identify as gay but instead as bisexual or heterosexual and many of whom, unlike most of their gay counterparts, have sex with women as well as men. This group is designated non gay community attached (NGCA). Men in the *Male Call* studies were classified as GCA or NGCA on the basis of their responses to a set of questions relating to their social life. These two groups differed significantly with respect to many of the indicators included in this report, and hence *Male Call 96* data are given for each group separately. In general, data from State-based studies such as the Gay Community Periodic Surveys, the Sydney Men and Sexual Health cohort study (*SMASH*), the Melbourne Men and Sexual Health survey (*MMASH*) and the Brisbane Regional and Sexual Health survey (*BRASH*) are based on men recruited from gay communities.

The most complete State-based data are from Sydney where *SMASH* was available as a source of information, and where the periodic surveys funded by the New South Wales Health Department have been carried out on a six-monthly basis since February 1996. Results from the Sydney periodic surveys and from *SMASH* have appeared on a six-monthly basis in the Surveillance Reports published by the National Centre in HIV Social Research in association with the New South Wales Health Department and the AIDS Council of New South Wales since June, 1996 (Van de Ven, Campbell, Prestage et al., December 1995; Van de Ven, Richters, Campbell et al., June 1996; Richters, Van de Ven, Campbell et al., December 1996; Richters, Van de Ven, Campbell et al., June 1997; Richters, Van de Ven, Knox et al., December 1997; Richters, Knox, Van de Ven et al. June 1998; Knox, Van de Ven, Richters et al., December 1998; Knox, Van de Ven, Prestage et al., June 1999; Knox, Van de Ven, Prestage et al., December 1999). For the purpose of this report, these data have been aggregated in order to report on an annual basis.

Surveys based on the periodic survey questionnaire have also been carried out in Melbourne in February, 1998, (Van de Ven et al., 1998a), Queensland in June, 1998 (Van de Ven et al., 1998b) and June, 1999 (Van de Ven, Prestage, Kippax et al., 1999), Perth in October, 1998 (Van de Ven et al., 1999a), and Adelaide in November, 1998 (Van de Ven et al., 1999b) and November, 1999 (Van de Ven, Prestage, Kippax et al., 2000). Queensland Gay Community Periodic Surveys covered Brisbane and the Sunshine Coast and Gold Coast in 1998. Cairns was included for the first time in 1999. Surveys based on the *SMASH* study questionnaire were carried out in Melbourne (*MMASH*, 1996) (Prestage, Kippax, Benton et al., 1996) and in the Brisbane region (*BRASH*, 1996) (Prestage et al., 1997).

Data for gay community attached men and non gay community attached men in the *Male Call 96* survey (October-December, 1996) (Crawford et al., 1998) are provided for both the whole of Australia and for selected cities in order to provide some comparison with results gathered from other parts of Australia. Nationwide information relating to people living with HIV comes from the *HIV Futures Study* of 1997 (Ezzy et al., 1998) and the follow-up, *HIV Futures II*, of 1999 (Grierson et al., 2000).

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

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

It should be noted that in general a sizeable proportion of homosexually active men report sexual practice with both regular and casual partners.

Tables 1.1.1 to 1.1.7 show the percentages of men who engaged in the above practices over the period 1996 to 1999. Information enabling an assessment of change in behaviour over the whole of this period is available only for Sydney men. It should be noted that data from the *SMASH* cohort in 1998 refer only to the first six months of 1998 as regular *SMASH* interviews ceased in mid 1998. *SMASH* data reported for 1999 are from self-complete questionnaires which were a much shortened version of the *SMASH* interview schedule. Moreover, the *SMASH* self-complete questionnaires used in 1999 included questions more akin to-though not exactly the same as-those of the *Gay Community Periodic Surveys*. For this reason, comparisons between 1999 *SMASH* data and earlier *SMASH* data need to be treated with caution.

Male Call 96 provides baseline data for 1996 which can be used to examine change from 1996 to 1998 or 1999 for those cities where periodic surveys were carried out in 1998 and/or 1999.

1.1.1. Percentage reporting regular, casual, and both regular and casual partners

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

The gay community samples (from both *Male Call 96* and from the other studies) show remarkable consistency in the percentages reported in Table 1.1.1. Around 60% of gay men report sex with a regular partner in the six months prior to each survey; around 75% report sex with a casual partner; and around 40% report sex with both regular and casual partners. There is no suggestion that these figures are changing markedly over time.

There is considerable variation from these figures when examining men who were not attached to gay community in the *Male Call 96* study. Non gay community attached men (NGCA) are much less likely than those attached to gay community to report sex with a regular partner (or partners). The two groups of men have very similar rates of sex with casual partners. It is clear from the *Male Call 96* data that the majority of men who have sex with men and who are not attached to gay community are engaging in male-to-male sex only with casual partners.

There is some variation from place to place regarding the percentage who reported engaging in sex with a casual partner. Perth and Adelaide periodic surveys had the lowest percentages and South Eastern Queensland (the *BRASH* study) the highest.¹

¹ The figure for the Sydney periodic survey in 1996 is also high due to the fact that the way questions were asked in this survey resulted in sometimes inconsistent data. The questionnaire was subsequently changed.

Table 1.1.1 Percentage of men who reported (a) regular partners, (b) casual partners and (c) both regular and casual partners¹

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
(a) Men with regular partner/s								
Australia (Male Call 96)								
GCA	2253	62.5						
NGCA	786	32.1						
Sydney								
SMASH	699	60.5	625	61.9	393	63.9	371	63.6
Periodic	2238	69.5	2630	62.0	3037	61.3	3343	65.8
GCA (Male Call 96)	513	56.9						
NGCA (Male Call 96)	138	36.2						
Melbourne								
MMASH	406	62.8						
Periodic					1891	64.3		
GCA (Male Call 96)	395	65.8						
NGCA (Male Call 96)	88	36.4						
Queensland								
BRASH	299	50.5						
Periodic					1341	61.6	1225	62.2
GCA (Male Call 96)	204	66.7						
NGCA (Male Call 96)	53	34.0						
Perth								
Periodic					846	62.3		
GCA (Male Call 96)	198	62.6						
NGCA (Male Call 96)	84	21.4						
Adelaide								
Periodic	552	65.4	463	63.5				
GCA (Male Call 96)	187	62.0						
NGCA (Male Call 96)	69	26.1						

¹ Based on responses to questions about sexual behaviour with regular and/or casual partners.

	1996 N	%	1997 N	%	1998 N	%	1999 N	%
b) Men with casual partner/s								
Australia (Male Call 96)								
GCA	2253	75.7						
NGCA	786	74.3						
Sydney								
SMASH	699	77.4	625	74.1	393	76.0	371	72.5
Periodic	2238	82.6	2630	73.5	3037	75.3	3343	70.1
70.1	513	81.9						
NGCA (Male Call 96)	138	77.5						
Melbourne								
MMASH	406	77.3						
Periodic					1891	72.0		
GCA (Male Call 96)	395	74.7						
NGCA (Male Call 96)	88	75.0						
Queensland								
BRASH	299	83.6						
Periodic					1341	71.7	1225	73.6
GCA (Male Call 96)	204	66.7						
NGCA (Male Call 96)	53	73.6						
Perth								
Periodic					846	65.1		
GCA (Male Call 96)	198	76.8						
NGCA (Male Call 96)	84	81.0						
Adelaide								
Periodic					552	60.5	463	61.8
GCA (Male Call 96)	187	74.3						
NGCA (Male Call 96)	69	75.4						

(c) Men with both regular and casual partners

Australia (Male Call 96)								
GCA	2253	41.3						
NGCA		786	16.0					
Sydney								
SMASH	699	43.2	625	41.7	393	44.9	371	41.8
Periodic	2238	57.0	2630	42.1	3037	42.6	3343	42.1
GCA (Male Call 96)	513	41.1						
NGCA (Male Call 96)	138	22.5						
Melbourne								
MMASH	406	41.9						
Periodic	1891	42.0						
GCA (Male Call 96)	395	43.3						
NGCA (Male Call 96)	88	20.5						
Queensland								
BRASH	299	37.1						
Periodic					1341	42.7	1225	42.4
GCA (Male Call 96)	204	38.2						
NGCA (Male Call 96)	53	11.3						
Perth								
Periodic					846	40.0		
GCA (Male Call 96)	198	44.9						
NGCA (Male Call 96)	84	9.5						
Adelaide								
Periodic					552	36.1	463	35.6
GCA (Male Call 96)	187	40.1						
NGCA (Male Call 96)	69	11.6						

1.1.2 Percentage engaging in any anal intercourse

The following table shows the percentage of men who reported that they had engaged in any anal intercourse with either regular or casual sexual partners-including anal intercourse without ejaculation ('withdrawal')(during the six months prior to the survey.

This indicator appears to be fairly stable for the period 1996 to 1999. Generally, around 80% of gay community attached homosexually active men engaged in any anal intercourse during the six months prior to interview. In *Male Call 96* (Crawford et al., 1998) it was reported that there had been an increase from 69.0% in 1992 to 79.7% in 1996 in the percentage of men engaging in anal intercourse. For gay community attached men in the *Male Call* studies, this increase was from 73.4% to 83.8%. In the *SMASH* study, levels were slightly lower than for the gay community attached men in *Male Call 96*, and these levels were fairly stable over time.

Table 1.1.2 Men engaging in any anal intercourse, 1996-1999

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	2253	83.8						
NGCA	786	68.1						
Sydney								
SMASH	699	76.0	624	78.7	393	78.6	371	80.1
Periodic	2238	82.5	2630	82.4	3037	83.5	3343	82.4
GCA (Male Call 96)	513	83.0						
NGCA (Male Call 96)	138	71.0						
Melbourne								
MMASH	406	82.5						
Periodic					1891	79.5		
GCA (Male Call 96)	395	86.3						
NGCA (Male Call 96)	88	63.6						
Queensland								
BRASH	299	81.9						
Periodic					1341	77.4	1225	80.7
GCA (Male Call 96)	204	84.8						
NGCA (Male Call 96)	53	67.9						
Perth								
Periodic					846	70.7		
GCA (Male Call 96)	198	74.2						
NGCA (Male Call 96)	84	63.1						
Adelaide								
Periodic					552	75.0	463	75.2
GCA (Male Call 96)	187	79.7						
NGCA (Male Call 96)	69	71.0						

1.1.3 Percentage engaging in any unprotected anal intercourse

The following table shows the number and percentage of men who reported that they had engaged in unprotected anal intercourse at last once in the six months prior to interview-including anal intercourse without ejaculation ('withdrawal')-with any male partner/s, regular or casual for the years 1996 to 1999. This indicator varied considerably from sample to sample and to some extent over time. Some of this varia-

tion reflects the difference between samples with respect to sex with regular partners as shown in Table 1.1.1(a) above. There was no consistent tendency for this indicator to increase or decrease over the observation period. The *SMASH* figure of 53.4% must be treated with caution, as noted above, because it was based on a different set of questions and is not directly comparable with the other data in the table.

From the *Male Call 96* survey, it can be seen that, compared with gay community attached men, men who are not attached to gay community were less likely to have unprotected anal intercourse. This is largely a reflection of the lower percentage of NGCA men who had sex with regular partners as shown in Table 1.1.1(a) above. In general, as seen in Tables 1.1.4 and 1.1.5 below, men are more likely to engage in unprotected anal intercourse with regular than with casual partners.

Table 1.1.3 Men engaging in unprotected anal intercourse, 1996-1999

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	2253	41.5						
NGCA	786	26.1						
Sydney								
SMASH	699	40.4	625	45.1	393	42.4	371	53.4 ¹
Periodic	2238	35.0	2630	39.8	3037	41.7	3343	43.1
GCA (Male Call 96)	513	38.0						
NGCA (Male Call 96)	138	21.0						
Melbourne								
MMASH	406	43.1						
Periodic					1891	36.8		
GCA (Male Call 96)	395	43.5						
NGCA (Male Call 96)	88	18.2						
Queensland								
BRASH	299	41.5						
Periodic					1341	38.3	1225	38.8
GCA (Male Call 96)	204	47.1						
NGCA (Male Call 96)	53	26.4						
Perth								
Periodic					846	36.1		
GCA (Male Call 96)	198	28.8						
NGCA (Male Call 96)	84	21.4						
Adelaide								
Periodic					552	41.7	463	39.7
GCA (Male Call 96)	187	41.2						
NGCA (Male Call 96)	69	29.0						

¹ Figure to be treated with caution; see text.

1.1.4 Percentage engaging in unprotected anal intercourse with casual partners

The following table shows the number and percentage of men who reported that they had engaged in unprotected anal intercourse-including anal intercourse without ejaculation ('withdrawal')-with casual partners during the six months prior to the survey for the years 1996 to 1999. To 1998, data from the *SMASH* cohort showed a pattern of stable behaviour for this indicator, with roughly 15% of men reporting one or

more episodes of unprotected anal intercourse with casual partners in the six months prior to interview. As noted above, 1999 SMASH data must be treated with caution.

Data from other sources provide evidence of similar levels of unprotected anal intercourse with casual partners. *Male Call 96* gave a figure of 15.3% for the whole Australian sample, and subsamples of gay community attached men varied little from this overall figure. There is a small (but statistically significant) increase from 14.0% to 18.5% in the *Sydney Periodic Surveys*, based on the total sample. More detailed analyses of these data pinpoint that the increase was not significant for four consecutive Fair Day samples, but was specific to men recruited from clinics and gay community venues (see '4 consistent sites' in Table 1.1.4). It was also found as reported in the *Male Call 96 Report* (Crawford et al., 1998) that this indicator had increased significantly from 11.5% in 1992 to 15.3% in 1996.

Values of this indicator from periodic surveys in Melbourne, Queensland, Perth and Adelaide taken in 1998 and 1999 on the whole differed little from the values for these areas found in *Male Call 96*. In the case of Perth, there is a slight (but non-significant) increase from 8.6% in the gay community attached sample from *Male Call* in 1996 to 11.8% from the periodic survey in 1998.

Table 1.1.4 Men engaging in unprotected anal intercourse with casual partners

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	2253	15.0						
NGCA	786	16.2						
Sydney								
SMASH	699	12.3	625	15.0	393	14.8	371	22.9 ¹
Periodic								
Total sample	2238	14.0	2630	18.3	3037	18.2	3343	18.5
4 consistent sites	1042	17.6	1168	25.3	1274	23.2	1103	27.3
Fair Days	1034	10.1	1088	12.3	1156	12.7	1436	12.5
GCA (Male Call 96)	513	15.6						
NGCA (Male Call 96)	138	11.6						
Melbourne								
MMASH	406	15.0						
Periodic					1891	13.4		
GCA (Male Call 96)	395	15.7						
NGCA (Male Call 96)	88	9.1						
Queensland								
BRASH	299	19.1						
Periodic					1341	14.0	1225	14.7
GCA (Male Call 96)	204	15.2						
NGCA (Male Call 96)	53	17.0						
Perth								
Periodic					846	11.8		
GCA (Male Call 96)	198	8.6						
NGCA (Male Call 96)	84	17.9						
Adelaide								
Periodic					552	14.1	463	12.1
GCA (Male Call 96)	187	15.5						
NGCA (Male Call 96)	69	18.8						

¹ Figure to be treated with caution; see text.

1.1.5 Percentage engaging in unprotected anal intercourse with regular partners

The following table shows the number and percentage of men who reported that they had engaged in unprotected anal intercourse-including anal intercourse without ejaculation ('withdrawal')-with regular partners during the six months prior to the survey for the years 1996 to 1999.²

There is a suggestion from the Sydney data (both *SMASH* and Sydney periodic surveys) that values for this indicator increased between 1996 and 1999. In the case of the Sydney periodic surveys this increase is statistically significant. Again, the 1999 *SMASH* data should be treated cautiously.

Data from other areas of Australia did not show a consistent pattern of either increase or decrease.

The Queensland samples showed great variation in values for this indicator-35.8% for the gay community attached men in Brisbane from *Male Call 96*, 26.4% for men in the *BRASH* study undertaken at much the same time, and approximately 30% for men in the Queensland periodic surveys of 1998 and 1999.

² The different samples that provided data for this indicator varied in terms of the percentage of men in the samples who reported sex with regular partners. The reliability of the information regarding sex with regular partners also varied. For data from the *SMASH*, *MMASH* and *BRASH* studies, and from *Male Call 96*, are more reliable since interviews were conducted either face-to-face or by telephone. Periodic survey data are less reliable since they come from self-complete questionnaires where inconsistencies cannot be questioned and remedied at the time.

Table 1.1.5 Men engaging in unprotected anal intercourse with regular partners

Source	1996		1997		1998		1999	
	N	%	N	%	N	%	N	%
Australia (Male Call 96)								
GCA	2253	30.8						
NGCA	786	12.3						
Sydney								
SMASH	699	30.5	625	33.7	393	33.6	371	40.4 ¹
Periodic	2238	27.9	2630	33.3	3037	30.4	3343	34.0
GCA (Male Call 96)	513	26.3						
NGCA (Male Call 96)	138	15.2						
Melbourne								
MMASH	406	32.8						
Periodic					1891	29.1		
GCA (Male Call 96)	395	31.1						
NGCA (Male Call 96)	88	10.2						
Queensland								
BRASH	299	26.4						
Periodic					1341	30.6	1225	29.9
GCA (Male Call 96)	204	35.8						
NGCA (Male Call 96)	53	11.3						
Perth								
Periodic					846	30.0		
GCA (Male Call 96)	198	22.2						
NGCA (Male Call 96)	84	4.8						
Adelaide								
Periodic					552	34.4	463	33.0
GCA (Male Call 96)	187	29.9						
NGCA (Male Call 96)	69	11.6						

¹ Figure to be treated with caution; see text.

1.1.6. Percentage engaging in anal intercourse with casual partners by serostatus

This table shows the number and percentage of men who engaged in unprotected anal intercourse with casual partners by serostatus during the six months prior to the survey for the years 1996 to 1999. It confirms that men who are HIV seropositive are more likely to engage in unprotected anal intercourse with casual partners than men who are HIV seronegative. Some unprotected anal intercourse reported by people living with HIV may be with partners who are also HIV antibody positive. Note, however, that information from *SMASH* (Grulich et al., 1998) showed that even if positive men who engaged in unprotected anal intercourse only with other positive men are removed, the remainder of positive men report more unprotected anal intercourse with casual partners than do negative men. This information is not available from other surveys.

Information comparable to that in the following table is not provided for unprotected anal intercourse with regular partners because it would be meaningful only if the data were further categorised according to the seroconcordance of the partners. In most of the studies, this would result in very small numbers from which to calculate percentages. Section 1.1.11 addresses the related issue of agreements reached between regular partners regarding protection for anal intercourse within and outside the relationship.

Table 1.1.6 Men engaging in unprotected anal sex with casual partners by serostatus¹

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia								
HIV Futures								
Positive	834	23.4			795	26.5		
Male Call 96								
Positive	152	25.7						
Negative	2209	13.7						
Sydney								
SMASH								
Positive	135	21.5	117	24.8	74	27.0	66	28.8
Negative	507	10.8	464	12.9	306	12.1	299	21.7 ²
Periodic								
Positive	391	26.1	566	32.0	613	31.5	607	34.3
Negative	1531	11.4	1777	14.5	2041	14.9	2381	15.2
Melbourne								
MMASH								
Positive	42	31.0						
Negative	323	14.9						
Periodic								
Positive					160	28.1		
Negative					1413	11.5		
Queensland								
BRASH								
Positive	36	19.4						
Negative	223	13.9						
Periodic								
Positive					113	23.0	101	19.8
Negative					1021	12.6	942	14.4
Perth								
Periodic								
Positive					45	24.4		
Negative					662	10.7		

table continues overleaf >

	N	%	N	%	N	%	N	%
Adelaide								
Periodic								
Positive					34	35.3	34	23.5
Negative					420	12.9	353	11.3

1This table excludes men whose serostatus was unknown, either because they reported that they had not been tested or because they did not provide information regarding serostatus. The difference between positive and negative men in the percentage who reported unprotected anal intercourse with casual partners is statistically significant beyond the 0.01 level except for the BRASH survey data, where the level of significance is 0.05.

2Figure to be treated with caution; see text.

1.1.7 Range of esoteric practices

Research at the NCHSR (Kippax et al., 1998) has indicated that there is a significant relationship between seroconversion and engaging in a range of esoteric practices which are not directly related to transmission of HIV. These practices include fisting, urolagnia, use of sex toys, cock rings, engaging in sadomasochistic (dominance/bondage) practices, and dressing up as part of fantasy. Although information in Table 1.1.7 confirms that there is a significant relationship between engaging in esoteric practices and engaging in unprotected anal intercourse, there is no evidence for change over time in the level of engagement in these practices.

The following table gives the number and mean score on a scale of esoteric practices for men who reported any unprotected anal intercourse and those who did not report any unprotected anal intercourse.

N refers to the number from which the mean was calculated.

Table 1.1.7 Mean of esoteric practices 1996-1999¹

Source	1996 N	Mean	1997 N	Mean	1998 N	Mean	1999 N	Mean
Australia (Male Call 96)								
Any unprotected anal intercourse	1141	2.21						
No unprotected anal intercourse	1898	1.47						
Sydney								
SMASH								
Any unprotected anal intercourse	283	2.02	282	2.10	172	2.46	198	2.19
No unprotected anal intercourse	416	1.26	343	1.33	221	1.34	173	1.21
Male Call 96								
Any unprotected anal intercourse	224	2.46						
No unprotected anal intercourse	427	1.63						
Melbourne								
MMASH								
Any unprotected anal intercourse	175	1.94						
No unprotected anal intercourse	231	1.19						
Male Call 96								
Any unprotected anal intercourse	188	2.20						
No unprotected anal intercourse	295	1.60						
Southern Queensland								
BRASH								
Any unprotected anal intercourse	124	1.52						
No unprotected anal intercourse	175	1.14						
Male Call 96								
Any unprotected anal intercourse	110	2.07						
No unprotected anal intercourse	147	1.09						

¹ The difference between the means for those who did and those who did not report unprotected anal intercourse was statistical significant beyond the 0.001 level for all studies except MMASH and BRASH.

1.1.8 Testing for HIV among homosexually active men

Table 1.1.8 shows that, among homosexually active men who are socially attached to gay community (GCA) a very large percentage, around 85% of those in each sample, have been tested for HIV. The only data for non gay community attached men (NGCA) come from *Male Call 96* which show that in the national sample, only 57.6% of such men had been tested. Data from *SMASH* are not included in this table as it is a cohort study. In general, with the exception of the Sydney periodic surveys, there appears to be a consistent slight decrease over time in the percentage of men tested, although differences are small.

Table 1.1.8 Percentage of men who had ever been tested for HIV

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	2253	84.3						
NGCA	786	57.6						
Sydney								
Periodic	2238	86.1	2630	88.9	3037	87.9	3343	90.1
GCA (Male Call 96)	513	88.7						
NGCA (Male Call 96)	138	58.7						
Melbourne								
MMASH	406	91.1						
Periodic					1891	83.0		
GCA (Male Call 96)	395	87.3						
NGCA (Male Call 96)	88	55.7						
Queensland								
BRASH	299	90.0						
Periodic					1341	84.9	1225	86.9
GCA (Male Call 96)	204	87.7						
NGCA (Male Call 96)	53	55.1						
Perth								
Periodic	846	82.9						
GCA (Male Call 96)	198	84.8						
NGCA (Male Call 96)	84	47.6						
Adelaide								
Periodic					552	84.6	463	84.9
GCA (Male Call 96)	187	87.7						
NGCA (Male Call 96)	69	55.1						

1.1.9 Frequency of testing for HIV-negative men

One of the ways in which some homosexually active men have responded to the HIV/AIDS epidemic is to monitor their own HIV antibody status by a series of HIV antibody tests. Table 1.1.9 gives information from a number of studies regarding recency of testing for HIV. The question asked was 'How long is it since you had a test for HIV?': the percentages are derived by counting those whose responses indicated that they had been tested within six months prior to the respective surveys. These data indicate a small decline in the frequency of testing.

Table 1.1.9 Homosexually active men who are HIV negative: tested for HIV within the six months prior to the survey

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	1762	59.0						
NGCA	445	50.1						
Sydney								
SMASH	507	50.4	464	45.7	310	50.0	299	37.1
Periodic	1525	55.1	1771	51.5	2035	49.8	2381	48.3
GCA (Male Call 96)	409	57.9						
NGCA (Male Call 96)	78	59.0						
Melbourne								
MMASH	323	49.3						
Periodic					1413	44.6		
GCA (Male Call 96)	318	57.9						
NGCA (Male Call 96)	49	48.9						
Queensland								
BRASH	223	58.8						
Periodic					1021	52.4	942	50.7
GCA (Male Call 96)	155	72.3						
NGCA (Male Call 96)	37	62.1						
Perth								
Periodic					662	45.2		
GCA (Male Call 96)	158	49.3						
NGCA (Male Call 96)	44	52.3						
Adelaide								
Periodic					420	46.7	463	44.2
GCA (Male Call 96)	151	60.2						
NGCA (Male Call 96)	37	43.2						

1.1.10 Testing among men under 25

One of the findings from *Male Call 96* (Crawford et al., 1998) was a significant decline in 1996 compared with 1992 in the percentage of young men under the age of 25 who had been tested. Table 1.1.10 confirms that even among young men who are gay community attached, around 25% remain untested. Sydney periodic survey figures suggest that there may have been a further decline since 1996, although the change in percentage is not statistically significant.

Table 1.1.10 Men under 25 ever tested for HIV

Source of information	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	429	77.5						
NGCA	90	38.9						
Sydney								
Periodic	298	79.0	278	75.5	320	72.2	346	76.9
GCA (Male Call 96)	93	81.7						
Melbourne								
MMASH	55	83.6						
Periodic					286	63.6		
GCA (Male Call 96)	58	82.5						

Queensland						
BRASH	78	78.2				
Periodic			233	73.8	212	76.9
GCA (Male Call 96)	54	75.9				
Perth						
Periodic			119	73.9		
GCA (Male Call 96)	35	74.3				
Adelaide						
Periodic			103	70.9	74	74.3
GCA (Male Call 96)	34	70.6				

1.1.11 Agreements among homosexually active men with regular partners regarding unprotected anal intercourse

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

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

The data are consistent across a number of studies in suggesting that around 70% of men in seroconcordant relationships have an agreement to have only 'safe' sex (that is, to have no unprotected anal intercourse outside the seroconcordant relationship). There is some suggestion from the data across time for *SMASH* and Sydney periodic surveys that this percentage may be increasing but so far this result is not statistically significant. Among non concordant couples, the percentage with an agreement to have only 'safe' sex-that is an agreement to have no unprotected anal intercourse at all (either within the relationship or with casual partners)-is around 40% in most samples, but sometimes lower, especially in 1999 data. Of those without safe sex agreements, both concordant and non concordant, some had agreements which allow the possibility of unsafe sex; some had no agreements, and some did not answer the question/s. Lack of a safe sex agreement does not necessarily imply unsafe practice.

Table 1.1.11 Men with regular partners with 'safe sex agreements' by seroconcordance¹

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call)								
Seroconcordant	1061	70.7						
Non concordant	457	33.3						
Sydney								
SMASH								
Seroconcordant	274	79.9	263	79.8	167	86.2	146	81.5
Non concordant	93	47.3	93	45.2	68	45.6	85	32.92
Periodic								
Seroconcordant	677	69.3	815	69.6	847	72.6	1029	73.1
Non concordant	415	39.5	421	39.2	534	38.6	707	30.7
Male Call								
Seroconcordant	223	69.5						
Non concordant	89	30.3						
Melbourne								
MMASH								
Seroconcordant	148	80.4						
Non concordant	49	42.9						
Periodic								
Seroconcordant					545	72.8		
Non concordant					351	30.5		
Male Call								
Seroconcordant	202	70.8						
Non concordant	65	24.6						
Queensland								
BRASH								
Seroconcordant	88	76.1						
Non concordant	33	42.4						
Periodic								
Seroconcordant					395	75.2	368	75.0
Non concordant					228	28.1	229	30.1
Male Call								
Seroconcordant	102	78.4						
Non concordant	40	42.5						
Perth								
Periodic								
Seroconcordant					224	71.9		
Non concordant					134	33.6		
Male Call								
Seroconcordant	84	70.2						
Non concordant	52	40.4						
Adelaide								
Periodic								
Seroconcordant					171	67.8	146	79.8
Non concordant					83	27.7	74	40.5
Male Call								
Seroconcordant	75	65.3						
Non concordant	43	41.9						

¹ In SMASH, MMASH and BRASH surveys, questions regarding partner's serostatus were different from those included in other surveys.

² Figure to be treated with caution; see text.

1.2 Other studies

A limited amount of information is available about other populations during the period covered by this report. For young heterosexual people, the only data available on an yearly basis come from the annual surveys of students in a course at Macquarie University carried out by the NCHSR. Data have been collected since 1988 and have been reported in previous Annual Reports (National Centre in HIV Social Research, 1999; National Centre in HIV Epidemiology and Clinical Research, 1999). Data for the period up to 1995 were published earlier (Rodden, Crawford, Kippax et al., 1996; Crawford, Turtle & Kippax, 1990). Data from two other studies conducted in 1999 are also reported: the *Living as Men* study conducted by NCHSR and ARCSHS (funded by the Australian Research Council) and the survey of Melbourne Sex Industry Exposition attendees conducted by researchers at ARCSHS.

1.2.1 Sexual behaviour and condom availability of first year university students

Table 1.2.1 contains data from the annual surveys of students in a course at Macquarie University for the period 1996 to 1999 inclusive. There is little indication of change over this period in any of the indicators. Fluctuations in the percentage of students who use condoms 'always' for sex with either regular or casual partners appear to be compensated for by similar fluctuations in the percentage of students who do not have such partners or who do not engage in sexual intercourse. The percentage who reported sometimes engaging in unprotected intercourse with a regular partner (the sum of the percentages who reported 'never', 'sometimes' or 'most times' using condoms) remained fairly stable over the four years (around 22-25%). For casual partners, only around 5-8% of students reported any unprotected intercourse.

There are fluctuations in the percentage of men and women reporting that condoms are available. These results need to be seen in the context of the whole period from 1988 to 1999 over which data have been collected. The total picture suggests an increase from 1988 to 1993, followed by a fairly stable value at around 60% for men and 40% for women (see *Annual Surveillance Report*, NCHECR, 2000 and Rodden et al., 1996).

Table 1.2.1 Sexual practice among 17 to 19-year-old¹ first-year university students

	1996 N=377	1997 N=381	1998 N=336	1999 N=206
Male	97	85	92	52
Female	280	296	244	154
Number of partners ever	%	%	%	%
0	44.9	39.3	45.2	42.2
1	24.9	26.7	23.5	27.7
2-4	21.4	27.5	26.5	21.8
>4	8.8	6.4	4.8	8.3
Ready access to condoms²				
Male	52.6	56.0	65.4	58.8
Female	42.2	30.3	40.6	44.0
Condom use with regular partner in the last month				
Never	12.8	14.9	10.4	14.6
Sometimes	4.4	4.6	5.4	4.4
Most times	4.7	6.2	5.1	5.3
Every time	10.0	18.6	13.4	14.1
No partner or no intercourse	68.1	55.7	65.8	61.7

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	N	%	N	%	N	%	N	%
Condom use with casual partner in the last 6 months								
Never	1.9		2.4		1.2		2.9	
Sometimes	1.1		0.8		1.2		1.5	
Most times	2.8		1.3		3.9		3.9	
Every time	11.3		9.4		8.9		7.8	
No partner or no intercourse	82.9		86.1		84.8		84.0	
Sexual practice, ever								
Vaginal sex	50.4		56.7		49.1		51.0	
Regular partner	47.4		54.2		46.5		50.0	
Casual partner	23.4		21.0		14.3		16.5	
Anal sex	3.0		7.6		5.7		5.8	
Regular partner	2.6		6.1		4.8		5.8	
Casual partner	0.3		1.8		1.8		0.5	
Any form of sex (oral, vaginal, anal)	60.6		66.4		57.4		60.7	

1 Includes 17-year-old students turning 18 in the year.

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

1.2.2 Living as Men

The *Living as Men* study (Lambevski et al., 2000) is a combined quantitative-qualitative study of constructions of risk, health, bodies and pleasure of mostly professional men, aged between 25 and 45, and living in Sydney and Melbourne. The study explores the interface between masculinity and risk in terms of the following: the labour market and workplace, body image, interpersonal style of communication, and enjoyment and pleasure. Participants for both arms of the study were recruited from three types of social sites: gyms; dance clubs and dance parties; and activist organisations.

Only aspects of the quantitative data are presented here. From 1999, 1412 men completed surveys for the *Living as Men* study. These men were from Sydney (N = 782; 177 heterosexual, 605 gay/bisexual) and Melbourne (N = 630; 230 heterosexual, 400 gay/bisexual).

Table 1.2.2 shows condom use with regular partners and casual partners. On the whole, there were only small differences between Sydney and Melbourne men. An exception was condom use with regular partners, where Melbourne heterosexual men (43.1%) were more likely than their Sydney counterparts (33.1%) to report never having used a condom in the six months prior to completing a questionnaire. This finding is counterbalanced by differences between the cities in sometimes having used a condom, resulting in little difference between Sydney and Melbourne men in terms of always having used a condom with regular partners.

An inter-city difference was also found among HIV negative gay/bisexual men: those in Melbourne (42.9%) were more likely to have 'no casual partners or no intercourse with such partners in the last 6 months' than those in Sydney (32.3%). This difference largely accounts for the marked discrepancy between Sydney and Melbourne in the percentages of HIV negative gay/bisexual men always using a condom with casual male partners.

There were differences between HIV negative and HIV positive gay/bisexual men in the percentages engaging in any unprotected anal intercourse (calculated by summing never or sometimes used a condom). HIV positive gay/bisexual men were less likely to have any unprotected anal intercourse with regular partners (approximately 40%) than their HIV negative counterparts (approximately 50%). HIV positive gay/bisexual men were more likely to have any unprotected anal intercourse with casual male partners (approximately 45%) than their HIV negative counterparts (approximately 25%). The difference in terms of casual male part-

ners was largely accounted for by the finding that HIV positive men were much more likely to have had casual male partners in the six months prior to completing a questionnaire.

Table 1.2.2 Condom use by heterosexual and gay/bisexual men in Sydney and Melbourne: Living as Men study, 1999

	Heterosexual HIV negative ¹	Gay/bisexual HIV negative	Gay/bisexual HIV Positive
SYDNEY	N = 170	N = 411	N = 194
Condom use with regular partners in last 6 months			
Never	33.1	32.2	22.5
Sometimes	30.7	19.4	14.1
Always	17.5	28.0	34.6
No partner or no intercourse	18.7	20.4	28.8
Condom use with casual female partners in last 6 months			
Never	13.4	11.4	7.7
Sometimes	17.1	5.2	1.8
Always	17.1	6.0	6.0
No partner or no intercourse	52.4	77.4	84.5
Condom use with casual male partners in last 6 months			
Never	11.6	11.2	10.5
Sometimes	-	10.4	29.5
Always	-	46.1	40.5
No partner or no intercourse	88.4	32.3	19.5
MELBOURNE	N = 228	N = 334	N = 66
Condom use with regular partners in last 6 months			
Never	43.1	32.7	22.7
Sometimes	24.4	19.4	19.7
Always	16.0	25.5	33.3
No partner or no intercourse	16.4	22.4	24.2
Condom use with casual female partners in last 6 months			
Never	18.5	10.1	8.3
Sometimes	11.7	6.8	-
Always	14.9	9.4	6.7
No partner or no intercourse	55.0	73.6	85.0
Condom use with casual male partners in last 6 months			
Never	10.7	14.5	9.2
Sometimes	0.5	14.2	40.0
Always	1.0	28.4	30.8
No partner or no intercourse	87.9	42.9	20.0

¹ There were nine HIV positive heterosexual men in the sample, 7 in Sydney and 2 in Melbourne. These men are not included in this table.

1.2.3 Sex Industry Exposition (Melbourne)

At the sex industry exposition held in Melbourne in December 1999, researchers from ARCSHS collected 2435 surveys completed by attendees. The participants were aged from 17 to 97 years (mean = 30 years). 46.4% were male, 53.3% female and 0.2% transgender. 61.6% were employed full time and 79.9% had an educational level of HSC or higher. 84.6% described themselves as heterosexual, 4.5% as homosexual and 6.3% as bisexual (1.9% unsure, 1.3% something else). The mean age of first sex was 17.1 years.

When asked about their most recent sexual experience, 91.3% of the males had had sex with a female, 7.9% had had sex with another male and 0.8% had had sex with a transgender person. Of the females, 93.9% had had sex with a male, 6.0% had had sex with another female and 0.2% had had sex with a transgender person.

Table 1.2.3 shows the percentage of 'Sexpo' attendees *not* using a condom with their most recent sexual partner (only for those who had vaginal or anal intercourse). Most men used a condom with casual partners, especially male partners. Few men used a condom with regular partners, especially female ones. Only about half the women used a condom with their most recent casual male partner, about a quarter with their most recent regular male partner.

Table 1.2.3 1999 Melbourne 'Sexpo' attendees not using a condom with most recent sexual partner

	Men N=1041		Women N=1086	
Partner type	n	%	n	%
Casual male	14	14.3	125	46.4
Casual female	168	35.1	8	75.01
Regular male	27	66.7	932	75.4
Regular female	682	73.0	42	88.11

1 Women who used condoms with female partners may have done so for various reasons, e.g. in conjunction with the use of sex toys or for fisting.

The image features a solid black background with a series of thin, white, dotted lines forming a complex geometric pattern. These lines intersect to create various rectangular frames of different sizes, some of which are nested within others. The pattern is primarily located in the upper-left and middle-left portions of the page, leaving the right side and bottom right corner relatively clear for text.

LIVING WITH HIV

2. LIVING WITH HIV

On a national basis, only one study *HIV Futures*-conducted initially in 1997 (Ezzy et al., 1998) and repeated in 1999 (Grierson et al., 2000)-provides reliable information on both sexual practice and treatment uptake for people living with HIV and AIDS, including representation of people from all categories of HIV transmission.

Regional information is available from other surveys, notably the Positive Health (*pH*) cohort study conducted in Sydney by NCHSR with input from ARCSHS for a smaller Melbourne arm. The first round of face-to-face interviews for the *pH* study were conducted in 1999. Of the participants, 362 were from Sydney; 56 from Melbourne; and 7 from elsewhere.³ There were 367 gay/bisexual men, 17 heterosexual men, 4 lesbian/bisexual women and 15 heterosexual women (22 others). Sexual practice questions were not included in the *pH* interview schedule.

2.1 Sexual practice

With respect to sexual practice, only two data points (1997, 1999) are available on a national basis for people living with HIV, and so trends over time cannot be fully assessed at this stage. The number of responses from women in the *HIV Futures Study* to questions regarding unprotected intercourse is too small to give reliable data, as are the number of responses from men who had female partners.

The *HIV Futures Study* indicates no change in the percentages of HIV positive men engaging in unprotected intercourse with casual male partners (see Table 2.1). With regular male partners, however, there was an increase in this practice between 1997 and 1999, with HIV positive regular male partners *and* with HIV negative regular male partners.

Table 2.1 Unprotected intercourse among people living with HIV/AIDS¹

	1997				1999			
	Men N=834		Women N=84		Men N=828		Women N=89	
Partner type	n	%	n	%	n	%	n	%
Casual male	371	53.7	6	50.0	414	52.1	10	10.0
Casual female	18	39.0			22	47.4		
Regular male (HIV positive)	146	68.5	13	61.5	123	83.4	12	61.6
Regular male (HIV negative)	199	21.0	15	46.7	125	34.7	25	41.7
Regular female (HIV positive)	5	60.0			11	70.0		
Regular female (HIV negative)	23	13.0			13	28.6		

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

Sexual practice among homosexually active men who are HIV seropositive from other studies (Table 1.1.6 above) also shows a relatively high level of unprotected anal intercourse among these men. Data from the *SMASH* cohort regarding the percentage of positive men who report unprotected anal intercourse show no distinct pattern of change over time. Information from periodic surveys in Sydney suggests that there has been an increase in this percentage (Table 1.1.6 above).

³ As most of the *pH* participants were from Sydney, *pH* data in the Tables are reported under 'Sydney'.

2.2 Self-ratings of health

In various studies, HIV positive people were asked to rate their health as 'excellent', 'good', 'fair' or 'poor'. Table 2.2 shows the percentage of people reporting 'excellent'/'good' overall health. Over time, HIV positive people tended to report better overall health, notably men in the *SMASH* cohort.

Table 2.2 Self ratings of health as 'excellent'/'good'¹

Source	1996		1997		1998		1999	
	N	%	N	%	N	%	N	%
Australia								
HIV Futures			914	71.7			949	72.8
Sydney								
SMASH	135	70.4	117	78.6	73	80.8		
pH							425	76.5

¹ Rather than 'fair'/'poor'.

2.3 Treatment uptake

Positive homosexually active men in Sydney and Melbourne took up combination antiretroviral therapy very quickly. Evidence regarding the effectiveness of these treatments became widespread in the second half of 1996. As shown in the data from the *SMASH* cohort (Table 2.3), uptake was rapid. By the end of 1997, 63.6% of positive men were on combination therapy. High levels of uptake were also reported in other parts of Australia. In the national sample from the *HIV Futures Study*, 73.5% of positive people reported being on combination antiretroviral therapy in 1999, a figure corroborated by data from other studies throughout Australia in 1999. The different percentages in Table 2.3 to some extent reflect different definitions of 'combination antiretroviral therapy' as indicated by the footnotes to this table.

Table 2.3 People living with HIV/AIDS on combination therapy

Source	1996		1997		1998		1999	
	N	%	N	%	N	%	N	%
Australia								
HIV Futures			893	77.7			952	73.5
Sydney								
SMASH ¹	135	22.3	118	63.6	74	60.8	66	77.3
Periodic ²			265	74.7	606	72.4	602	71.3
pH ¹							425	72.2
Melbourne								
MMASH ³	42	40.5						
Periodic ²					138	78.3		
Queensland								
BRASH ³	36	27.8						
Periodic ²					112	68.8	100	67.0
Perth								
Periodic ²					45	62.1		
Adelaide								
Periodic ²					34	64.7	34	73.5

¹ 'Combination therapy' means more than two antiretrovirals.

² 'Combination therapy' means 'combination antiretroviral therapy'

³ 'Combination therapy' means more than one antiretroviral.

Data from the *HIV Futures Study* indicate that almost two-thirds of participants ($N = 948$, 63.1%) used combination antiretroviral therapy continuously since uptake. Of those using combination antiretroviral therapy at the time of the 1999 survey, approximately one-third had ever stopped using therapy ($N = 696$, 63.1%). Between the 1997 and 1999 data collections for the *HIV Futures Study*, there was a significant increase in the percentage of participants who had never used combination antiretroviral therapy (1997 $N = 914$, 6.1% vs. 1999 $N = 953$, 13.5%; $p < .01$).

2.4 Treatment experiences

A significant consideration for people on combination therapy is the experience of side effects. Data on side effects were available from the *HIV Futures* and *pH* studies. In both studies, at least half the participants reported any side effects, as shown in the following table. As indicators of side effects, the experience of (a) diarrhoea or nausea and (b) anxiety or depression or fear were computed. In the *pH* study, approximately two-thirds of the participants reported at least one of the side effects in these groupings. In the *HIV Futures study*, the experience of diarrhoea or nausea was reported by approximately one-third of participants. The lower percentage in *HIV Futures* was attributable to the way the question was asked, as an open-ended ('please specify') question, so the figure would be an underestimation of participants' experience of side effects.

Table 2.4 Experience of side effects by people on combination therapy

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
(a) Diarrhoea/Nausea								
Australia								
HIV Futures			694	35.5			700	33.5
Sydney								
pH							336	70.8
(b) Anxiety/Depression/Fear								
Sydney								
pH							336	67.9
(c) Any side effects								
Australia								
HIV Futures			693	68.0			708	54.8
Sydney								
pH							336	73.8

2.5 Compliance

Adherence to antiretroviral regimens is an important issue. An indicator of adherence-having missed any doses 'during the last two days'-was available from the 1999 *HIV Futures* and *pH* studies. On this indicator, approximately 80% of the participants missed no doses. In the *HIV Futures study*, missing doses was related to the belief that medication gave an unwanted reminder of HIV status, and to the presence of depressive symptoms. Data from the *HIV Futures study* show that almost half of those currently taking antiretrovirals experienced difficulty taking pills on time. In the *pH* study, approximately one-third of participants experienced difficulty taking pills on time (see Table 2.5).

Table 2.5 Experience of taking pills

Source	1996		1997		1998		1999	
	N	%	N	%	N	%	N	%
(a) Missed any doses during last two days								
Australia								
HIV Futures							700	15.9
Sydney								
pH							336	22.3
(b) Experienced any difficulty taking pills on time								
Australia								
HIV Futures							699	47.8
Sydney								
pH							336	34.8

2.6 Post-exposure prophylaxis

The Post-exposure prophylaxis (PEP) study commenced in 1999. The purpose of this observational study is to document requests for PEP, and monitor the implementation of NSW guidelines recommending HIV post-exposure prophylaxis for non-occupational exposures. The social arm of the study, as with the Seroconversion study described below, collects detailed in-depth accounts of the risk-exposure event in order to provide discursive understandings of risk.

The 37 accounts collected in 1999 provide some insights into the ways in which HIV transmission risk is constructed - post Vancouver (1996), i.e. in the presence of antiretroviral therapies and the possibility of post exposure prophylaxis. Most requests came from homosexually active men, most of whom identified as gay, and in the great majority of accounts, the sexual practice understood to be the risk event was anal intercourse - both insertive and receptive. Approximately 50% of those requesting PEP stated that they knew their sexual partner to be HIV positive.

In general the results indicate that PEP is being requested in situations in which the risk is realistic. Issues of love, trust and responsibility are central to the stories. For men in regular relationships, condom breakage plays an important role, and for these men PEP acts as a safety net. What is of concern, however, is that within serodiscordant regular relationships (which as other studies have shown are predictive of seroconversion), PEP may be used to rationalise 'no condoms' especially in the presence of 'undetectable' viral load. Within casual encounters, the issues become more focused on responsibility. There is less certainty, more ambiguity.

With regard to both regular and casual sexual encounters, there is some evidence that HIV negative men in some circumstances rely on the alleged comparative safety of the insertive position. There is also some reliance on withdrawal as a harm minimisation strategy. Past risk taking that has not led to HIV infection also plays a role in current risk taking.

Whether availability of PEP blunts the safe sex message and leads to more risk taking is difficult to assess. It is difficult to separate the impact of PEP from the more general impact of treatments and issues around 'undetectable' viral load.

2.7 Seroconversion

The Seroconversion study was begun in 1995. There was a break in interviewing in 1997-1999 but interviewing has recommenced. One of its major aims is to document and analyse the discursive understandings of risk as they are used in men's accounts to explain the event they believe to be the seroconversion event. Changes over time in these accounts provide insight into changing notions of risk. Approximately 90 seroconverters have been interviewed.

The findings from this study indicate that seroconversions are as likely to occur within regular relationships as in casual encounters, with around 50% of the men believing that HIV transmission had occurred within a regular relationship, some of which were known by the partners to be discordant for HIV. This finding has been confirmed by a prospective analysis of Sydney Men and Sexual Health data (Kippax et al., 1998) that found that one of the strongest predictors of seroconversion among this group of men was being in a relationship with a known HIV positive partner.

The most common reasons given by men in regular relationships for their seroconversion were couched in terms of love and intimacy and in terms of a breakdown of trust and communication. On the other hand, men who believed their HIV seroconversion occurred in a casual sexual encounter were more likely to account for their infection in terms of 'being out of control'-because of desire or lust, drugs or too much to drink.

The most common practice associated with seroconversion was receptive anal intercourse followed by insertive anal intercourse. Very few men believed that they had seroconverted because of oral-genital sex.

2.8 Contact with the epidemic

There is little quantitative information available regarding what impact the changing nature of the HIV/AIDS epidemic has had on behaviour. Two indicators of the degree of contact with the HIV epidemic which may be important in monitoring change are 'knowing people with HIV' and 'ever knowing anyone who died following AIDS'. These indicators were included in various studies including the *SMASH* cohort study, the *BRASH* and *MMASH* surveys, and the periodic surveys in some State capital cities. In Table 2.8 data on these indicators are presented separately for HIV negative and HIV positive men.

Information from *SMASH* shows that HIV positive men in Sydney have continuing high levels of contact with the epidemic. HIV positive men in other parts of Australia also have high levels of contact with the epidemic although somewhat less than their Sydney counterparts.

Information from *SMASH* shows that in terms of 'knowing anyone with HIV', HIV negative men in Sydney have high levels of contact with the epidemic but that over time there is a downward trend. HIV negative men in other parts of Australia have less contact with the epidemic-on both indicators-than their Sydney counterparts.

Table 2.8 Indicators of contact with the HIV epidemic

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
(a) Knows anyone with HIV								
Sydney								
SMASH								
HIV negative men	564	96.1	508	95.3	322	95.0	299	92.3
HIV positive men	135	100	118	100	74	100	62	100
pH								
HIV positive men							425	97.6
Melbourne								
MMASH								
HIV negative men	323	85.5						
HIV positive men	42	97.6						
Queensland								
BRASH								
HIV negative men	223	83.4						
HIV positive men	36	97.2						
Perth								
Periodic								
HIV negative men					649	77.8		
HIV positive men					45	95.6		
Adelaide								
Periodic								
HIV negative men					406	75.9	345	75.4
HIV positive men					34	100	33	97.0
(b) Ever knew anyone who died following AIDS								
Sydney								
SMASH								
HIV negative men	564	87.1	508	91.9	322	95.0	299	94.6
HIV positive men	135	92.6	118	98.3	74	98.6	66	100
pH								
HIV positive men							425	62.6 ¹
Melbourne								
MMASH								
HIV negative men	323	70.6						
HIV positive men	42	90.5						
Queensland								
BRASH								
HIV negative men	223	69.5						
HIV positive men	36	83.3						
Perth								
Periodic								
HIV negative men					652	60.4		
HIV positive men					44	88.6		
Adelaide								
Periodic								
HIV negative men					406	62.9	342	62.6
HIV positive men					34	91.2	33	81.8

¹ Not comparable with other data as this figure is based on knowing 'in the last 12 months' anyone who died following AIDS, rather than 'ever'.

An abstract geometric design featuring a black background with white lines. The lines form a grid-like structure with several rectangles and squares of varying sizes. Some lines are solid, while others are dashed. The design is minimalist and modern.

DRUG RELATED BEHAVIOUR

3.1 Homosexually active men

3.1.1 Homosexually active men and recreational drug use

Use of recreational drugs among homosexually active men is high for those attached to gay community (Table 3.1.1). This information comes from *Male Call 96* and also from the *SMASH*, *BRASH* and *MMASH* studies. Close to 70% of these men (more among men in the *SMASH*, *pH* and *Living as Men* studies) reported using at least one non-prescription drug in the six months prior to the survey. Use of more than one such drug was reported by around 65% in the *SMASH* and *pH* cohorts and around 50% in Melbourne and Brisbane surveys.

Recreational drug use is one variable which shows strong regional variation, though the level of use as measured in the percentages reported here appears to be fairly stable over the time period observed. Differences between cities are highlighted where data were collected from more than one city for the same study. An example is the *Living as Men* study which provided evidence that recreational drug use was at a much higher level in Sydney than in Melbourne (see Table 3.1.1).

Table 3.1.1 Recreational drug use among homosexually active men

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
(a) Any drug use								
Australia (Male Call 1996)								
GCA	2253	58.7						
NGCA	786	36.6						
HIV Futures ¹	738	71.1						
Sydney								
SMASH	699	77.5	625	80.3	393	77.9	371	81.4
Periodic							3343	70.5
GCA (Male Call 96)	513	68.8						
NGCA (Male Call 96)	138	46.4						
pH							367	84.2
Living as Men ²						528	82.4	
Melbourne								
MMASH	406	69.7						
GCA (Male Call 96)	395	60.0						
NGCA (Male Call 96)	88	31.8						
Living as Men ²						310	74.8	
Queensland								
BRASH	299	71.2						
GCA (Male Call 96)	204	50.5						
NGCA (Male Call 96)	53	39.6						

table continues over leaf >

	N	%	N	%	N	%	N	%
(b) Used more than one drug								
Australia (Male Call 96)								
GCA	2253	36.8						
NGCA	786	12.8						
HIV Futures ¹							738	36.8
Sydney								
SMASH	699	63.7	625	62.7	393	64.1	371	63.3
Periodic							3343	51.0
GCA (Male Call 96)	513	52.4						
NGCA (Male Call 96)	138	19.6						
pH							367	61.9
Living as Men ²						528	69.9	
Melbourne								
MMASH	406	50.7						
GCA (Male Call 96)	395	39.7						
NGCA (Male Call 96)	88	11.3						
Living as Men ²						310	49.0	
Queensland								
BRASH	299	48.5						
GCA (Male Call 96)	204	27.5						
NGCA (Male Call 96)	53	9.4						

1 Gay and homosexually active men only.

2 Gay and homosexually active men only. Of 254 heterosexual men in Sydney, 55.9% used at least one drug (other than alcohol) and

3 7.0% used more than one drug. Of 320 heterosexual men in Melbourne, the corresponding percentages were 39.1% for at least one drug and 14.1% for more than one drug.

3.1.2 Homosexually active men and injecting drug use

A minority of homosexually active men reported using a needle to inject drugs in the six months prior to the survey (Table 3.1.2). Again, gay community attached men were much more likely to report such use. A much higher percentage of men who took part in the Brisbane and region study (*BRASH*) in 1996 reported injecting. This was not the case for those Brisbane men who took part in *Male Call 96*, and may reflect a recruitment bias. A much higher percentage of men in the *pH* and *HIV Futures* studies reported injecting, although the latter study asked about injecting 'in the previous 12 months' so this figure is not directly comparable to the others in Table 3.1.2.

The longitudinal data available from *SMASH* suggest that the level of injecting drug use has remained relatively stable over the reporting period.

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

Source	1996 N	%	1997 N	%	1998 N	%	1999 N	%
Australia (Male Call 96)								
GCA	2253	5.4						
NGCA	786	1.8						
HIV Futures ¹							716	13.5
Sydney								
SMASH	699	9.6	625	10.7	393	12.0	371	7.8
Periodic					836	12.4	3343	7.6
GCA (Male Call 96)	513	6.8						
NGCA (Male Call 96)	138	2.2						
pH							367	16.9
Living as Men ²							524	3.6
Melbourne								
MMASH	406	5.9						
GCA (Male Call 96)	395	6.8						
NGCA (Male Call 96)	88	1.1						
Living as Men ²							309	4.8
Queensland								
BRASH	299	15.7						
Periodic					1341	8.7	1225	9.1
GCA Male Call 96)	204	3.4						
NGCA (Male Call 96)	53	0.0						
Adelaide								
Periodic					539	8.9	463	7.7

1 Gay and homosexually active men only. Data are for IDU in last 12 months.

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

3.2 Methadone injection in New South Wales

The *Methadone Injection in New South Wales* study was conducted between August and December 1999. Participants (N = 206; 65% male, 35% female) were those who had injected methadone at least once in the month prior to interview. They ranged in age from 16 to 53 years (*mean* = 32 years). Nearly all participants (96%) had tested for hepatitis C and overall 70% reported testing positive to the antibodies. Similarly, nearly all participants (95%) had tested for HIV with less than 2% tested positive to the antibodies. Eighty-two per cent of participants said that they were currently on a methadone program with slightly more people attending public rather than private clinics (55% vs. 45% respectively). Generally, the people interviewed had low levels of education and were unemployed, long-term injecting drug users with poor health.

In relation to their general drug use, 15.4% of participants had 'always', 'usually' or 'sometimes' reused someone else's equipment (see Table 3.2). With regard to methadone injecting equipment, about one in five participants (20.7%) reported reusing someone else's injecting equipment either 'sometimes' or 'always'. In relation to the reuse of a participant's equipment by someone else, almost a third of all participants (30.6%) reported that they 'always', 'usually' or 'sometimes' passed on their previously used methadone injecting equipment to others.

Access to methadone injecting equipment (10ml/20ml barrel syringes and butterflies withdrawn from NSW Needle/Syringe Programs in late 1998) was described by participants as difficult, with nearly a quarter (23.3%) saying that they could not get big barrel syringes and butterflies anywhere. A third (32.0%) reported having to access this equipment from a pharmacy outside their local area. In comparison, only 17.0% accessed this equipment from a local pharmacy, while just under a quarter (22.8%) of participants cited friends as a source. Just over a quarter (26.2%) of participants reported accessing injecting equipment from potentially unsafe sources such as friends, partners and dealers.

In all, 65.5% reported an increase in their reuse of personal methadone injecting equipment and 9.7% said they reused other people's equipment more since changes to Needle/Syringe Program policy were implemented. Just over one in ten participants (11.2%) indicated a trend towards the use of homemade butterflies and big barrel syringes in order to overcome access difficulties.

Table 3.2 Reuse of other's drug and methadone injecting equipment (N = 206)

Frequency	Reuse of other's drug injecting equipment		Reuse of other's methadone injecting equipment	
	n	%	n	%
Always	2	1.1	7	3.6
Usually	1	0.5	-	-
Sometimes	26	14.3	33	17.1
Never	153	84.1	153	79.3

The image features a dark, textured background with a series of thin, white, overlapping rectangular lines. These lines form a grid-like structure, with some lines extending across the top and others forming a larger frame in the center. The overall effect is minimalist and architectural.

THE CURRENT CLIMATE

4. THE CURRENT CLIMATE

In the fifteen years since Australia first responded to HIV, several changes have occurred. Time itself means that many have become used to living with the epidemic—they no longer live with a constant sense of crisis. Those who were young then are now older and the young have become newly sexual and may be trying out non-prescription drugs. The announcement at the 11th International AIDS Conference in Vancouver in July 1996 of the comparative success of new combination antiviral therapies added to this sense of post-crisis. New therapies have lessened the burden for most people living with HIV and AIDS: there are fewer deaths and, despite often serious side effects, less debilitating illness among PLWHA.

4.1 HIV optimism-scepticism

There has been some concern that the relative success of new combination antiviral therapies may have an impact on safe sexual practice. Early data on beliefs about the efficacy of these new therapies in reducing the burden of illness and reducing the risk of HIV infection because of lowered viral load indicated that the majority of men were sceptical rather than optimistic. While men were more optimistic with regard to treatment efficacy, the great majority was sceptical about lowered viral load reducing the risk of HIV infection. Nevertheless, a small minority of men were optimistic with regard to new therapies reducing the risk of HIV transmission and they were more likely to engage in unprotected anal intercourse with their partners.

In 1999, a scale of HIV optimism-scepticism (Van de Ven, Crawford, Kippax et al., 1999) was developed by researchers at NCHSR and subsequently used in a number of studies. Participants responded to 12 items (e.g. 'A person with undetectable viral load cannot pass on the virus' and 'I'm less worried about HIV infection than I used to be') on a four-point continuum of strongly disagree (=1), disagree (=2), agree (=3), strongly agree (=4). Total scores could range from a highly sceptical 12 (strongly disagree on all items) to an optimistic 48 (strongly agree on all items).

The HIV optimism scale was included in periodic surveys in Sydney and Queensland, and in the *Changing Times* study (Rodden, 1999) which involved an advertisement and questionnaire inserted in the *Sydney Star Observer*. Scale means for 1999 are presented in Table 4.1. As shown, homosexually active men in the various studies were on average quite sceptical about HIV treatments reducing infectivity. The mean scores indicate that on average the men either strongly disagreed or disagreed with each item.

Table 4.1 Mean scores on HIV optimism scale¹

Source	1996		1997		1998		1999	
	N	Mean	N	Mean	N	Mean	N	Mean
Sydney								
Periodic							821	20.0
Changing Times							186	19.3
Queensland								
Periodic							1051	19.3

¹ Scale developed in 1999.

Data from periodic surveys in various cities revealed a significant relationship between sexual risk practice and optimism in the context of new HIV treatments (Van de Ven, P., Kippax, S., Knox et al., 1999). For example, such a relationship was evident in data from the 1999 Queensland Gay Community Periodic Survey (Van de Ven, Prestage, Kippax et al., 1999). Among men with regular partners, those who had any unprotected anal intercourse with these partners had a higher mean score (20.2) than those who had no unprotected anal intercourse or no anal intercourse *per se* (18.7; $p < .001$). Similarly, for men with casual partners, those who had any unprotected anal intercourse with these partners also had a higher score (21.3) than those who had no unprotected anal intercourse or no anal intercourse *per se* (18.9; $p < .001$).

4.2 Clinical markers

The aim of the *Clinical Markers* study was to explore gay men's thinking about anal intercourse and risk in the presence of medical technologies (e.g. highly active antiretroviral therapy and viral load testing). It involved thematic analysis of semi-structured, face-to-face, in-depth interviews with 56 gay men in Sydney and Brisbane. Interviewees were recruited across a broad age group and then further selected to ensure representation of both HIV positive and HIV negative gay men.

While most of the **HIV negative men** provided accounts of their sexual practices that conform to HIV/AIDS education, that is, they stated they always use condoms unless they are certain of negative seroconcordance, based on 'talk, test, test, trust', a few did provide accounts of having UAI. For these few, casual unprotected anal intercourse (UAI) took place as a result of: negotiation to achieve minimal risk, including taking only the insertive position without condoms; not being able to get a casual insertive partner to wear a condom; a type of spontaneity, described as 'heat of the moment' or 'heart took over' with a known partner whose status was uncertain. Unlike the accounts of UAI by positive men (discussed below) negative men demonstrated a reluctance to report their practice of UAI. For those who reported the latter two types of experience, there was considerable confusion in their explanations of what took place and why.

Clinical markers were not directly influential in the accounts of the few negative men who had had UAI with a casual partner or a regular partner whose serostatus was not certain. Knowledge of treatments and associated testing was limited to those already working or in direct association with the HIV/AIDS education field. Most expressed the view that HIV positive people pose a transmission risk no matter what their viral load. However, some men in serodiscordant relationships did indicate viral load is influential in risk assessment.

The **HIV positive men** who practised anal intercourse included those who: always use condoms; use them when insertive but leave it to their casual partner to decide when receptive; use them with a known negative partner but not with a casual partner who 'consents' to UAI; or use them with a casual partner but not with a negative regular partner. Casual UAI, aimed at a positive-positive encounter, involved a range of factors such as reading non-verbal clues like the partner's age and whether UAI was an unspoken norm in the sexual space of a venue.

None of the positive interviewees directly discussed the role of clinical markers in their use or non-use of condoms. Nevertheless, some did make reference to viral load in relation to the notion of risk, although this was expressed with uncertainty. There was some evidence to suggest that low or undetectable viral load may produce a reduced sense of 'infectivity.' The willingness and ability to provide clearly articulated accounts of UAI, combined with a range of factors employed to reduce the risk of transmission, provided strong evidence that individually tailored risk minimisation strategies are employed by positive men when engaging in anal intercourse, including UAI. These risk minimisation strategies were imbued with a notion of responsibility. However, understandings and practice, in relation to responsibility, varied. There was clear evidence that, within the notion of what constitutes being responsible or engaging in 'shared responsibility,' there may be a whole set of assumptions based on notions of individual agency and informed choice.

The study provided evidence of a marked difference in attitudes and approaches to minimising risk amongst gay men. The most significant difference is that between positive and negative men who could be described as two separate sub-cultures, informed and positioned in different ways according to serostatus, but engaging in what may be a shared sexual space. The difficulty some negative men displayed in speaking about UAI combined with general lack of knowledge about clinical markers (including debates on levels of infectivity) contrasts strongly with the thinking and practices of positive men. While positive men are confronting the challenges posed by treatments and grappling to interpret test results with regard to 'infectivity,' negative men are generally not aware of this change to the lived experience of being positive. The 'assume your partner is positive' and 'shared responsibility' messages may also be contributing to different, even contrary, sexual practice. Positive men may well proceed with UAI on the basis that a negative partner would introduce a condom. Negative men may no longer believe their partner is likely to be positive and may also assume that a positive partner would use a condom.

The background of the entire page is a dark, textured surface. Overlaid on this are several thin, white, dotted lines that form a complex geometric pattern. These lines intersect to create various rectangular and square frames of different sizes. Some lines are solid, while others are dotted, creating a layered and intricate visual effect. The pattern is most dense in the upper left quadrant and becomes sparser towards the bottom right.

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