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Publication details:
Report No. NCHSR Monograph 9/2001
1-875978-49-6 (ISBN)

Publication Date:
2001

DOI:
https://doi.org/10.26190/unsworks/1195

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ISBN 1-875978-49-6

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Acknowledgements

Commissioned and funded by Queensland Health.

Facilitated by Queensland AIDS Council (QuAC).

Review and helpful comments on an earlier draft were provided by Chris Clementson, Stephen Gallagher, Joseph Jewitt and Susan Kippax.

We specially thank the 13 educators who agreed to be interviewed and shared their reflections on practice.

Introduction

Educators of gay and other homosexually active men have worked hard for some time to remain relevant to their constituents. A perception exists within AIDS Councils and within the AIDS sector more generally that sections of gay community have disengaged from HIV-related issues. Hence, the question of educators' relevance is a burning one. Related to this is a strong and accurate belief among educators that gay and other homosexually active men are highly informed about HIV transmission and prevention and know that using condoms during anal intercourse prevents HIV transmission. This recognition has had a major impact on HIV educators' perception of their role in the epidemic. For educators to reengage gay men with HIV there is a perception that HIV be repositioned within a broader health agenda.

It was imperative in the mid-to-late 1980s to inform gay men of the need to use condoms and water-based lubricant, and to tell them how to use them in order to prevent HIV transmission. For over a decade condom promotion was dominant in the creation of gay men's safe sex culture. Gay and other homosexually active men now know how and why to use condoms. Condom-related education remains important, for example, among the newly sexually active and among groups where the practice of condom usage has not been established.[1] Also important is that condoms and safe sex be constantly reinforced among those who already use condoms. In general, however, the normalisation of condoms has been achieved and AIDS Councils are now reassessing their role in HIV education against a background of the safe sex culture they were instrumental in establishing. AIDS councils are now having to redefine their roles and responsibilities in response to the changing needs of their homosexual[2] constituencies and the changing nature of the epidemic.

At the same time, a trend has emerged in recent years of increases in unprotected[3] anal intercourse in casual sexual encounters between men. This suggests that more work is still to be done, but exactly what needs to be done is a vexed question that researchers and educators are currently bringing into sharper focus.

This report documents what one group of educators is currently thinking and doing around identified educational challenges and adopted pedagogical approaches. Our hope is to build upon that base to produce a more textured and coherent understanding of the broader context within which HIV education is delivered. It is for this reason that we have placed the contemporary challenges educators identified into historical perspective. This it is hoped will be achieved through

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[1] For example, in some Australian Indigenous communities sexual relations often take place between sistergirls (aka sistagirls; see footnote 5) and their heterosexually identified sexual partners.

[2] The term homosexual, as used here, denotes any biological men who has sex with other men (i.e. with a focus on behaviour). Other terms such as gay, bisexual, transgender and heterosexually-identified-men-who-have-sex-with-men will be used to denote categories of identity rather than practice.

[3] The term 'unprotected' is unfortunate for implying anal intercourse without a condom is necessarily unsafe (i.e. lacking protection). Some forms of unprotected anal intercourse afford protection by means other than condoms, as with negotiated safety. 'Unprotected' anal intercourse is not equivalent to unsafe sex. For reasons of convention we continue to use the term unprotected, but only in the limited sense of anal intercourse without a condom and not in the broader sense of being inherently unsafe.

commentary on the invention and transformation of safe sex knowledge and culture, and through consideration of how past efforts may fruitfully inform present endeavours, while recognising that what was appropriate in the past may no longer be so. We have also elaborated and embedded the challenges identified by educators within the broader context of HIV social research, policy and education.

Background

In Australia (and for almost a decade) it is no longer acceptable to speak of unprotected anal intercourse *per se* as unsafe sex, a claim that was taken for granted early in the epidemic. Around 1990 researchers, predominantly in the United States, reported that gay men were 'relapsing' into unprotected anal intercourse (e.g. Stall *et al.*, 1990). The term was used inconsistently between those who adopted it but 'relapse' generally referred to scenarios within which men who initially changed their behaviour toward safe sex were reverting (occasionally or permanently) to unsafe sexual behaviour.

A seminal paper (Kippax, Crawford *et al.,* 1993) interrogated the concept of relapse in relation to Australian gay men. It was thought that much of the unprotected anal intercourse that was being classified as relapse might be differently accounted for if one looked at the whether the unprotected sex was 1) occurring in regular or casual relationships, 2) between partners of the same or different serostatus and 3) based on clear agreements between sexual partners about the sex that they had within and outside their relationships. When taking into account these three factors, at least in relation to Australian data, it was found that a proportion of what was being labelled as 'unsafe sex' or sexual 'relapse' could be accounted for by men in seroconcordant relationships negotiating to dispense with condoms on the basis of knowing each other's serostatus. The term used to describe this complex pattern was *negotiated safety*—now a familiar concept, nationally and internationally (Kippax *et al.,* 1997; Davidovich *et al.,* 2000; Crawford *et al.,* 2001).

Over the last five years in Australia, social researchers have documented small but significant upward trends in unprotected anal intercourse among homosexually active men (NCHSR 2000; NCHECR 2000). Corresponding increases have been reported in San Francisco, London, Vancouver and Amsterdam (Ekstrand *et al.,* 2000; Dodds *et al.,* 2000; Hogg *et al.,* 2001; Stoite *et al.,* 2001). In Australia the increases were detected among a range of homosexually active men: gay and non gay identified; gay community and non gay community attached; and within regular and casual sexual encounters (Van de Ven *et al.,* 2001a; Van de Ven *et al.,* 2001b). Casual sexual encounters have been highlighted as a particular concern.

What underpins the increase in unprotected anal intercourse, especially among casual partners? The Australian increases and those elsewhere coincided with the wide-spread introduction of highly active antiretroviral therapies (HAART) in 1996 and the emergence of the concept of post-AIDS in 1995 (Dowsett, 1995). Post-AIDS, or post-crisis as it has been refigured, is now a familiar concept to most researchers, educators and others working in HIV prevention with homosexual men.

The increase in unprotected anal intercourse and the emergence of HAART were initially linked in 1997 in a front-page news story in Australia's most widely read and influential gay and lesbian newspaper, the *Sydney Star Observer* (O'Grady, 1997). The logic underpinning the association was that new HIV treatments engendered *optimism* among gay men about the quality of life and life expectancy of those infected with HIV (HIV as a chronic but manageable illness). Moreover, the suggestion was that gay men's fear of becoming HIV infected or of infecting others had been

reduced, which in turn led to more unprotected anal intercourse. The HIV optimism thesis has subsequently been supported by empirical social research that suggests HIV optimism was at least *one* factor associated with the recent increases in unprotected anal intercourse in Australia (Van de Ven *et al.,* 2000).[4] A French study found that HIV positive men were three times more likely to engage in unprotected anal intercourse with partners of unknown or negative HIV status following their uptake of protease inhibitors (Miller *et al.,* 2000).

A second discursive stream to emerge positions the increase in unprotected anal intercourse with casual partners as related to gay men's adoption of increasingly *sophisticated strategies* of risk reduction. This understanding emerged out of qualitative in-depth interviews with gay men in Brisbane and Sydney (Rosengarten *et al.,* 2000). The narratives revealed that some gay men adopted a range of HIV risk reduction strategies based upon the 'clinical markers' of viral load and HIV testing. The strategies include:

- Negative men being insertive only with casual and regular partners
- Positive men being receptive only with casual and regular partners
- HIV positive men engaging in unprotected anal intercourse with partners of unknown or different HIV status on the basis of having a low or undetectable viral load
- Positive men engaging in unprotected intercourse with other positive men.

The extent to which these strategies are being employed is not yet well understood. Recent quantitative analyses have shown that men who 'disclose' their HIV status to casual partners are far more likely to engage in unprotected anal intercourse than men who did not disclose, and that some unprotected casual intercourse is exclusively between HIV positive men (Prestage *et al.,* 2001). Other analyses have confirmed an association between the sexual position men adopt and their HIV serostatus. Namely, when engaging in unprotected anal intercourse with regular or casual partners, some HIV positive men tend to be receptive only and some HIV negative men tend to be insertive only—a distinct pattern termed 'strategic positioning' (Van de Ven *et al.* in press).

The available evidence suggests that the recent increases in unprotected anal intercourse do not constitute a wholesale abandonment of safe sex by many of those engaging in unprotected casual anal intercourse (Van de Ven *et al.* in press). This evidence raises the possibility that some of the recent increases in unprotected anal intercourse may be accounted for by gay men adopting risk reduction strategies, in a similar vein to the adoption of negotiated safety a decade or so ago. How deeply the parallels run, and the potential for negotiation around unprotected *casual* intercourse is, however, questionable.

The parallels between negotiated safety with *regular* partners and *casual* risk reduction strategies are:

- Both phenomena emerged from the ground up insofar as significant numbers of gay men themselves reported behaviour that fell outside of then recommended safe sex guidelines. Detailed analysis of practice subsequently uncovered patterns of sexual behaviour that suggested some form of HIV risk reduction strategy. Gay men's behaviour presaged educators' reconsidering gay men's education in light of emerging social research data.

[4] Although the link between HIV optimism and unprotected anal intercourse is only an *association*, this association has been read erroneously by some as *causal*.

- Ostensibly 'unsafe' practices, although below the threshold of recommended sexual safety, were nevertheless relatively safe in comparison with other practices.
- Men engaging in risk reduction behaviours were *at some level* aware that the risk they were taking had less of a margin of safety than was recommended within published safe sex guidelines. Some men, however, considered the reduced margin of safety to be safe enough or worth the risk.

The two strategies are quite different in that:

- Negotiated safety is grounded in *regular* relationships whereas the other risk reduction strategies are grounded in both *casual* and *regular* encounters. At the level of casual encounters this has more profound implications in terms of trust and being able to negotiate with one's partner.
- Negotiated safety involves a complex though specific strategy whereas some of the other risk reduction strategies have multiple components each of which has different risk implications that need to be considered in isolation and as a whole.
- Most importantly, negotiated safety involves *partners known to be of the same serostatus* whereas the other risk reduction strategies sometimes involve *partners of different HIV status*.

The similarities between negotiated safety and other risk reduction strategies are overshadowed by the differences. Casual risk reduction strategies, although sometimes grounded in some form of risk reduction, may not reach a threshold of safety that would admit them into the realm of 'safe sex'. It is easy to dismiss these strategies but there is an important reason why discussion should not be foreclosed around risk reduction strategies and casual sex. Some gay men have spoken by their actions, and if the trend toward unprotected casual intercourse continues, the urgency with which education needs to respond will increase (especially if changes in behaviour are followed by increases in new infections).

As a contribution to the response, this project aimed to document current challenges as perceived by *educators* of gay and other homosexually active men. It also sought to identify existing educational frameworks informing pedagogical practice of educators. Whereas HIV educators with the Queensland AIDS Council (QuAC) were the key informants, the challenges they highlighted would be very much relevant to the challenges faced by other HIV/AIDS education organisations, locally and elsewhere.

Method

Thirteen educators of gay and other homosexually active men (all those approached) were interviewed, from Brisbane as well as regional areas. All of the interviews were taped and thematically analysed. The interviews were semi-structured and covered a range of themes, including:

- Current challenges in gay and other homosexually active men's education
- Responses to the challenges
- Primary sources of information about the epidemic
- Perceptions of how education works.

A number of discourses emerged out of the interviews and the relative importance or weight given to each discourse in writing this report is indicated by the following criteria:

- The number of educators referring to a given discourse
- The importance educators attributed to the discourse
- The duration of relevant experience of the educator within the organisation and within the sector
- The direct relevance of the discourse to the educator's area of expertise and responsibility.

One or more of the above criteria are referred to when appropriate and where confidentiality can be maintained. By applying the above criteria this report attempts to faithfully represent how educators engaged with the themes outlined in the semi-structured questionnaire. However, it should not be supposed that the interviewer is absent from the report: the nature of the interview process, especially when semi-structured, necessarily involves an exchange of views (inter-views). Having said that, the primary purpose of the interviews was for the educators to express their understanding of the work they do.

Both the interviewer and interviewed are immersed within the same field (HIV) and, therefore, our objectives, ways of talking and ways of doing intersect at certain points: different and (at best) complementary perspectives within the same field. The same is true of how educators sit in relation to each other: although intersecting at certain points their work is also different. There were three identifiable target groups that characterised educators:

- Brisbane gay identified men
- Non gay identified or non gay attached men who have sex with men (regional and Brisbane based)
- Brisbane and regionally based Indigenous gay men and sistergirls[5].

[5] 'Sistergirl' (aka sistagirl) is an identity adopted by some Aboriginal and Torres Strait Islander people that includes male-to-female transgender people, men who present as women in different settings and in some communities gay men. The breadth of the identity varies with community context such that more traditional communities in Northern Australia are likely to have a broder definition encompassing gay men, while urban communities confine the use of the term to transgender people only.

Each of the above clusters relates to the target group for which the educators were responsible; to the specific context within which education took place; and to the understandings educators had of their constituents' needs and their engagement with the HIV epidemic.

Participants in this project were guaranteed confidentiality and this report seeks to honour that guarantee. Maintaining confidentiality, however, posed some difficulty given the relatively small number of people who were interviewed and the specialised target groups or identifiable localities within which each educator worked. In a few instances where a person made an important point but which might expose their identity, permission was sought from that person to make the necessary point.

To further maintain confidentiality we have limited the use of direct quotes and have structured the report around the challenges raised by educators, ensuring that each educator's perspective is represented. However, the report is not limited to what the educators stated. It also critically engages with those perspectives, a form of engagement that was highly valued by some of the educators in relation to their own and others' work.

The analysis of the interviews is based upon themes rather than individuals, which may give an impression that the views of educators were homogenous. Although there was a high degree of agreement around some issues, this was not always the case. In addition, problems identified by some workers were not identified by others—even among those working with the same target populations.

It is difficult for researchers to enter an organisation for a short period of time and to grasp the complexities of the organisation, especially when the organisation is experiencing significant change in staff and education priorities. The accuracy and usefulness of the challenges identified herein significantly depend upon the sources of information. At the same time, although we as researchers may have entered the organisation as relatively 'nave', we are also immersed in the same sector and share an HIV prevention background. It is against the shared background that this report is situated. The educators have deepened our understanding of the organisation and the sector as a whole, and we, in turn, reflect that understanding back, not simply as mirror image, but as an image worked upon, sharpened and placed in a broader contemporary and historical context.

Challenges identified by educators

Educators of gay men, non gay identified men, non gay attached men and Indigenous gay and sistergirls identified a broad range of challenges. These challenges—*as identified by the educators themselves*—are listed below in dot-point form. Although there was an obvious logic in dividing the challenges according to the educators' target group and regions, some of the challenges raised were relevant to different education fields. We have placed each challenge where it was of primary importance, as recognised by the educators themselves.

Gay identified men

Challenges (identified by the educators themselves) in gay men's education included:

- The need to re-engage gay men with HIV and AIDS in the face of gay men's apparent disengagement. Low seroprevalence, treatments optimism, low or undetectable viral load, gay men's high levels of safe sex knowledge and the invisibility of AIDS were thought to be key to understanding this phenomenon.
- Gay men are highly knowledgeable in relation to HIV transmission: knowing subjects who have emerged out of a generation of exposure to safe sex education and practice. The challenge for educators was to talk straight, not to tell gay men what to do in dogmatic fashion, yet to ensure that gay men have the best possible information to enable informed choices.
- HIV education needs to ensure that gay men's level of knowledge remains appropriate to the current context within which sex takes place. As gay men increasingly push the envelope of safe sex, educators need to ensure that education addresses safe sex which sits on the outer limit and beyond the limit. The current 'grey area' has been positioned as *casual*/unprotected anal intercourse in the context of new HIV treatments, a post-crisis mentality and increasing rates of unprotected anal intercourse. In the past, the safe sex line was drawn at protected anal intercourse and, following the introduction of negotiated safety, the line shifted to include unprotected anal intercourse with regular partners. Gay men are again forcing educators and others within the sector to rethink this line. The challenge then was for educators to engage gay men at a level that is relevant to their practice and to ensure that it is to the benefit rather than the detriment of a sustainable safe sex culture, whilst recognising that safe sex is a living and transforming concept.
- The harm minimisation strategies men are adopting include positive men taking the receptive role, negative men taking the insertive role, positive men having unprotected sex on the basis of a low or undetectable viral load, withdrawal before ejaculation, and disclosure of serostatus (in casual encounters). With the exception of viral load testing, none of the above strategies is particularly new. The newness of the phenomena is the overall increase in unprotected casual anal intercourse rather

than the practices themselves. Although gay men may have a relatively sophisticated understanding of safe sex, those who are adopting risk reduction strategies within the context of casual unprotected sex are operating at the limit of that sophistication. Educators spoke of the lack of epidemiological research addressing specific risks gay men are taking when engaging in unprotected anal intercourse. For example, if current safe sex guidelines pinpoint withdrawal as unsafe but gay men continue to engage in the practice, educators want to be able to point toward the relative safety or risk of the practice.

- Gay men's challenge to the limits of what is ordinarily regarded as safe sex has necessarily shifted the educational terrain. As gay men's sexual practice increasingly goes beyond recommended guidelines, condom-based education needs to be extended to address the risks associated with different forms of unprotected anal intercourse in the 'post-crisis' environment. A major challenge in making this shift, which is already occurring, is to ensure that risk reduction strategies are addressed in a way that does not undermine the basic safe sex message.
- The challenge to understand the multiple forms of unprotected anal intercourse that gay men are adopting. Many educators recognised that some men were minimising the risk of HIV transmission when engaging in unprotected anal intercourse, though they also believed that the consciousness with which men employed those strategies varied widely. Men are dispensing with condoms with more and less strategic consideration. There is a challenge to understand how deliberate men's strategies are, and how those strategies sit in relation to some men's desire to not use condoms.
- The context of education is ever changing. For example, the current increase in unprotected anal intercourse is probably fed by a number of conditions, and these conditions may change. Individual risk taking was thought by some educators to be 'rewarded' insofar as the risks individuals were taking were not, in general, leading to new HIV infections. However, it was noted that if there were a progressive failure of treatments in the context of greater risk taking, this could well lead to increased new infections riding on the back of a partially diminished safe sex culture. In this sense, educators need to have a sophisticated understanding of how individual and collective risk interrelate in ways that might diminish or increase HIV transmissions.
- Repositioning HIV in the broader context of gay men's lives and what matters to them. This includes a broader general and sexual health focus. On the one hand this idea recognised that gay men were disengaging from HIV but that HIV needed to remain on the agenda and inserted into material that gay men were interested in. On the other hand, a shift toward a broader health focus was a tacit (and sometimes explicit) recognition that HIV is no longer a crisis for most gay men, and as a consequence, resources needed to be redirected into a broader general and sexual health agenda for gay men.
- Repositioning gay men's sexual health may be at odds with funding priorities and with the current *National HIV/AIDS Strategy* (Commonwealth of Australia 2000). This necessitates getting current funding bodies to accept a broader focus or to seek additional sources of funding to enable a broader and less hindered focus to emerge.
- Being able to more finely target specific subgroups of homosexually active men. For example, mature age men are more likely to be dealing with issues such as impotence, heart disease and prostate cancer—issues which may provide a context

in which to position HIV. If more general and relevant information were not included it was suggested that people would not be interested.

- Ensuring that HIV education is relevant to positive and negative men while taking care to not additionally burden positive men with responsibility; at the same time acknowledging that positive men are key to minimising HIV transmissions.
- Overcoming the perception among Queensland gay men that HIV is an "old man's" or "Southerner's disease" whilst recognising that Queensland is indeed a low prevalence State.
- The discrepancy between negative and positive men's health literacy with regard to HIV and AIDS. This included HIV negative men not having a good understanding of the HIV positive experience in the new antiretroviral context. It was thought that although negative gay men had grasped the idea that being HIV positive was no longer as serious as it once was, it was also thought that education needed to be truthful about the negative consequences of becoming positive. This included medication side effects, the rigour required to maintain adherence and the prospect (for some, the reality) of treatment failure. All this needs to be achieved without further stigmatising positive men.
- Many of the educators expressed a need to better understand the mechanics of HIV transmission, particularly in relation to the post-crisis HIV prevention context. Educators were uncertain about how risk reduction strategies might be incorporated into education campaigns. The great majority of educators saw little scope in 'promoting' most of the existing unprotected risk reduction strategies gay men were thought to increasingly be adopting when engaging in sex with casual partners or within serodiscordant relationships.

Non gay identified or non gay community attached men who have sex with men

The major challenges identified by regional workers and those working with non gay identified or non gay community attached men who have sex with men were as follows:

- Educating against a backdrop of institutionalised homophobia, including homophobia within the 'general' population. This challenge poses a structural hurdle in accessing homosexually active men through health promotion activities (i.e. creating the necessary structures to enable safe sex to occur or to deliver HIV prevention education). In the past, significant energy and resources have been allocated to dealing with this concern, particularly through guest lectures to school students about issues of HIV/AIDS and gay-related discrimination. Recent changes within QuAC have reoriented this focus away from homophobia and back toward 'at-risk' target groups.
- With the shift of emphasis away from heterosexual homophobia to homosexually active men, the challenge of reaching hidden target populations is amplified. In rural and remote areas of Queensland most MSM belong to hidden social and sexual networks and the opportunities for penetrating these networks is limited. The problem of access was twofold. Firstly, gay men were not approaching AIDS councils and, secondly, AIDS councils found it difficult to reach out to these target groups. The traditional means of education—beat work and peer education—were

thought to be somewhat successful but not entirely so. The primary difficulty related to the absence of enduring, dedicated gay venues and organisations. There was not the 'critical mass' of engaged homosexually active men to support such a structure. Indeed, in at least one region the AIDS council was the only identifiable 'gay' organisation. Regional areas will probably never achieve the critical mass of engaged men to sustain a visible homosexual subculture. Even Brisbane, to some extent, faced this problem.

- In regional areas, educators need to target multiple populations and to be multi-skilled, though exactly what skills were needed was not well articulated. It was thought necessary in regional areas to have one's finger on the pulse of multiple constituencies. Indeed, there was a management expectation that this be so and that educators would have the necessary wherewithal to do multifaceted community development work, which was frequently not the case. It was also suggested that this expectation be weighed against the relevance of some of the issues of their core constituents, and to the reality that rural educators ended up sitting in on meetings relating to "queer this and gay that", as one educator put it. Such meetings were considered time consuming and didn't necessarily have relevance to their core business. The challenge was to ensure that educators are sufficiently skilled, able to access appropriate professional development and involved in relevant work-related activities (activities which were often different from 'mainstream' gay ones).
- In some regional areas gay men (and others within the broader population) were thought to be more conservative than gay men in Brisbane. Some men in these areas found some of the campaign representations (both text and images) too confronting.
- One of major barriers to doing any form of community work was to overcome homosexually active men's reluctance to use AIDS council offices and services. There were issues around confidentiality and not wanting to be seen in an AIDS council office or with a person who works from one. This was especially pronounced in regional areas although Brisbane was also thought to experience the problem. This kind of disengagement is different from the other form identified, primarily because it has been there from the very beginning of the epidemic and relates to a different demographic group.
- It is increasingly difficult to get volunteers involved in education programs. Training and managing volunteers is labour intensive and exacerbated by high rates of drop-out. It is important but difficult to get gay men involved in particular areas (e.g. in peer education).

Indigenous gay men and sistergirls

Challenges identified by the Indigenous educators (those working with Indigenous gay and homosexually active men / Sistergirls) included:

- The overall increases in unprotected anal intercourse *per se* were regarded as a gay community attached men's issue (i.e. a White mainstream gay issue) with little relevance to Indigenous gay men and sistergirls. It should be remembered, however, that there are significant points of social and sexual intersection between Black and White, especially in urban settings. The increase in unprotected anal intercourse among gay community attached men has emerged from the base of a firmly

entrenched safe sex culture. In contrast, unprotected anal intercourse in remote settings was perceived to be the norm. In Indigenous communities, men (gay or otherwise) will not use condoms, "period". Gay men negotiate with peers while sistergirls have to negotiate with ostensibly straight men.

- Establishing a safe sex culture in sex between men, especially between sistergirls and their heterosexually identified partners. This was seen as distinct from *knowing* what safe sex is. Sistergirls were thought to be knowledgeable about HIV-related risk, but due to the broader context within which sex was enacted they were unable to put that knowledge into practice.
- Creating the environment within which to speak about sistergirl issues was also thought to be a challenge. Although sistergirls engaged in sex, they did not necessarily talk about it. The mainstream Indigenous community was especially reluctant to discuss sistergirl issues—"They are just not interested." This lack of engagement was partly thought to be a consequence of HIV having not yet penetrated into the communities being targeted.
- The educators suggested that family and a person's place within their family was first and foremost in terms of Aboriginal and Torres Strait Islander identity. Who "you've been doing and how you've been doing it" is of secondary concern. This is generally true but also specifically the case for most Murri sistergirls: Murri first and then sistergirl or gay. Family structures and the place within the family was the primary source of a person's respect within a community. As such, education interventions need to accommodate the centrality of Murri (or Aboriginal or Torres Strait Islander) identity and address sexuality-based issues in such a way that they are compatible (rather than at odds) with familial structures and loyalties.
- Access to HIV and sexual health services was difficult for potential clients as workers frequently knew their clients. The educators suggested that confidentiality was not a high priority among many sexual health workers (Indigenous or White) and that this situation discouraged people from presenting for information or treatment.
- Keeping sistergirl issues a priority on the service providers' agenda was identified as a challenge and required constant contact with the providers to reinforce the importance of such issues.
- Racial prejudice among White gay men was identified as a major concern. This was especially a problem for Indigenous men involved in predominantly White gay settings. Homophobia within Indigenous communities was also identified as a major concern, with attitudes being expressed along the lines of, "They're all just sickos".
- Despite the homophobia experienced by sistergirls within their communities, the educators claimed that most sistergirls were nevertheless respected within their communities. This respect, however, had less to do with being sistergirls *per se* and more to do, for example, with being employed (where unemployment is generally high). Sistergirls' respect seemed also to be contingent upon their keeping a low profile with regard to their sexual activities, which served to hamper open discussion and other education efforts.
- Sistergirls reported to educators that the less attention drawn to them the better. In light of this, educators conducted a retreat with sistergirls from a range of communities—a retreat which addressed one problem but created another. The retreat provided a forum within which to gain an understanding of the day-to-day

lives of sistergirls and the issues that were important to them. The retreat also provided a space of relative freedom from the broader issues that may have disrupted open dialogue among sistergirls and between sistergirls and educators. Although the sistergirl retreat was considered to be one of the more successful interventions conducted by educators, many people within the wider Indigenous community resented the additional service sistergirls received. This discontent was expressed through comments such as, "Who are these AIDS councils, why are they here, and why do sistergirls get this extra service when everyone else doesn't?" There was also a suspicion among the general community about what the sistergirls were doing at the retreat, with some suggestions that it was an "orgy" or something "similarly inappropriate".

- Interactions between sistergirls and their sex partners were characterised as "short and sweet" and as "a quick bang in the bushes with some man who is not getting it from his wife". This was often the only source of sexual interaction and/or affection sistergirls received. If the choice was between sex without condoms and no sex at all, the choice was likely to be the former. If sistergirls asked their sex partners to use condoms, their partners would most probably decline the sexual encounter. It was also suggested that although there were many challenges vis--vis sistergirls and making their sexual interactions safe, the sistergirls themselves were thought to be generally happy with the situation and were an HIV-aware group. This awareness, however, did not necessarily translate into or enable safe sex or safe sex negotiation with their sex partners.
- Certain men (heterosexually identified and often married) were known by sistergirls as potential sexual partners and sistergirls shared this information among themselves. The rest of the community, however, was kept in the dark. Sistergirls' sexual partners were identified as the biggest barrier to developing a safe sex culture among homosexually active men within Murri communities. Getting access to and providing these men with education was therefore regarded as a high priority. However, public discussion about such matters would cause a great deal of friction within communities, including the spectre of violence. Any exposure of sistergirls' sexual partners, no matter how well intentioned or accidental, had the potential to disrupt families and communities. Sistergirls were adamant that their sexual partners should not be targeted as it would undermine the possibility of their sexual interactions and put them in personal danger. One educator suggested that the solution was to *indirectly* target relevant men through existing sexual health workers within Community Health Clinics (operated by Queensland Health). That is, *all* men should receive sexual health and safe sex education that also contained information relevant to homosexually active men. Problems associated with such an approach, however, were that existing sexual health services are almost exclusively focused upon clinical work, and as mentioned above, homophobia and a lack of confidentiality limited community access to services. It was said that a part of the reason for the absence of education and prevention components was that resources were already stretched: service providers were struggling to provide basic services relating to contact tracing and treatment.
- Educators identified other social problems within some Aboriginal communities as a significant challenge. From the communities' perspective, the most pressing issues related to fresh water, housing, education, employment and substance use, among others. These problems were conceptualised as emerging out of

colonialism/invasion and the creation of Aboriginal missions. Local Aboriginal councils are now attempting to use their influence to better the whole community. They were reported to be under a great deal of pressure from within to get things moving, and sexual health was not a high priority and consequently sistergirls are further marginalised.

- The issue of sexual assault, sometimes at a young age, was identified. Providing a safe environment for sistergirls (e.g. a safe house) was considered important. But even this measure was thought to be beyond QuAC's resource capabilities (and perhaps jurisdiction). There was talk of applying "band-aids" to intractable problems and that raising sensitive issues would ensure exclusion from working within the communities to be served. The best possible role QuAC educators could play in this context, it was argued, was as an advocate on behalf of sistergirls (e.g. by encouraging other service providers to tackle the issues).

Workplace-related challenges

Educators identified a number of workplace challenges. These included:

- Ensuring an organisational structure that has the flexibility to respond to current issues; for example, in being able to redistribute resources where they are most needed.
- "Resources, resources, resources". Given the limited resources channelled into education it was suggested that different groups should be targeted for a period of time and focus then shifted to other groups. Some educators, given limited resources, argued for better prioritisation of major issues following principles of best practice and for less though better quality educational work.
- Overcoming a prevailing idea among some regional health bureaucrats and to some extent from "old-style educators" that people seroconvert because they lack understanding or are "stupid".
- Improving staff retention and professional development to ensure that an organisational memory and a skilled workforce informed current educational practice.

Commentary

This section draws out the dominant themes raised by the educators themselves about current challenges facing gay and homosexually active men's education. Our commentary places the themes in broader context, firstly by framing the challenges within the concept of post-crisis. This is followed by a more detailed analysis of individual post-crisis manifestations, namely disengagement with the epidemic, increases in unprotected anal intercourse and the adoption of perceived risk reduction strategies.

We do this, again, in terms of the three core groups of educators: gay, non gay identified, and Aboriginal and Torres Strait Islander men. The dominant focus is on gay men because that is where increases in unprotected anal intercourse have been most evident. Sexual behaviours among Indigenous men have not been well studied, but our interview data are consistent with a proposition that unprotected anal intercourse is at least as prevalent among sistergirls. For some educators, the recent increases in unprotected anal intercourse recede in importance against the more basic challenge of simply *reaching* homosexually active men. The notion of disengagement from the epidemic is somewhat academic given that lack of engagement has been an ongoing problem.

Post-crisis

In 1995, Dowsett introduced the concept of post-AIDS (Dowsett, 1995), a concept that was more fully developed a year later (Dowsett and McInnes, 1996). Post-AIDS encapsulated the idea that many gay men, especially younger gay men, no longer regarded the AIDS epidemic as a *crisis* and that their disposition was out of step with that of the AIDS sector which still operated in 'crisis mode'. There was significant debate about the use of the term Post-AIDS as it could be taken to imply that the AIDS epidemic was over. Post-crisis was put forward as an alternative (Murphy 2001) and this terminology was used by most of the educators we interviewed. We use both phrases interchangeably to suit the context but never to imply that AIDS is over.

The emergence of effective HIV antiretrovirals was given prominence at the XI International Conference on AIDS held in Vancouver in 1996, one year after the coining of 'Post-AIDS'. Post-AIDS also emerged independently of research that detected increases in unprotected anal intercourse between men. These facts are brought to readers' attention to loosen the tight bond that has come to be established between the rise of effective treatments, increase in unprotected anal intercourse and a post-crisis mentality among gay men and others within the sector.

Today, we are far from the formative years of the epidemic. During the early 1980s a great deal of effort was necessarily expended on three areas: convincing gay men that a crisis was upon them; establishing a 'safe sex' culture; and developing this culture without certainty about the modes of HIV transmission. However, the early state of crisis can be retrospectively seen as becoming less of a crisis as 'safe sex' became integrated into gay male sexual culture. The late 1980s and the early

1990s became years of consolidation[6]. When in 1996 it was declared, "We are already living post-AIDS" (Dowsett and McInnes, 1996:10), the indication was that Post-AIDS was not new but that our identification of it was.

The emergence of post-crisis related to a number of factors. Dowsett and McInnes identified the continued low HIV seroprevalence among gay men who "were not waiting desperately for [AIDS] to end, or longing for the good old days so that condoms could be thrown away for good" (Dowsett and McInnes, 1996: 10). The applicability of post-AIDS to the city of Adelaide was questioned insofar as there may never have been a sense of crisis in Adelaide, which relative to Sydney has low HIV seroprevalence, less visibility of PLWHA and fewer gay men who know PLWHA. These same reflections were raised by all of the educators of gay men in Brisbane and by some of the educators outside Brisbane.

More generally, the post-crisis turn was not simply recognition of gay men's general mood but was also reflected in the statistical data over many years. There was a steep decline in HIV incidence from a high of nearly 3000 in 1984, about 1000 in 1988, to around 500 in 1992 through to the present day. Moreover, there were few AIDS diagnoses in 1984, gradually increasing to a high point of around 1000 in 1994, after which diagnoses gradually declined to around 200 in 1999 through to the present time. (Note that AIDS diagnoses began its decline before the introduction of protease inhibitors in 1996.) Additionally, since the late 1980s gay men had been using condoms most of the time with their regular and especially casual partners, and particularly in serodiscordant sexual encounters.

The notion of post-AIDS did not rely on increases in unprotected intercourse or an emergence of specific risk reduction strategies. Indeed, the earlier configuration pointed to gay men's widespread acceptance of condoms, that an occasional slip-up was tolerable and that under certain conditions it was quite safe or safe enough not to use condoms. Since 1996, however, a number of new conditions have emerged that have been interpreted within the post-crisis frame. In particular, the educators we interviewed attributed post-crisis to:

- Increases in unprotected anal intercourse
- Advent of HAART
- Generalised optimism permeating gay men's understanding of the epidemic.

These interpretations have elsewhere been incorporated in the post-crisis frame (Rofes, 1998).

Disengagement

The idea that gay men have disengaged from HIV education is not new. In 1997 Parnell commented, "Most gay men are no longer enthused about education because most of the time they don't need what it can offer" (1997: 5).

For educators to simply insist on condom usage is to risk being ignored or dismissed. Although there is nothing new about this problem it is one that has been exacerbated under the conditions within which HIV education is now delivered. Educators recognised gay men's disengagement by

[6] The idea of the consolidation of uncertainty has been borrowed from Epstein who documented the consolidation of scientific knowledge between 1984 and 1986 that HIV caused AIDS (Epstein, 1996). Medical consolidation provided one of the firm bases upon which effective social responses in HIV prevention could proceed and it was in 1986 that condoms became central to safe sex.

their increasing lack of attendance at QuAC events and the difficulty of attracting and retaining volunteers. The reason for the disengagement was thought to be gay men's perception that they already know what needs to be known. (It may also be the case that the phenomenon of lack of participation and volunteering is being felt across the community sector and may not be specific to AIDS Councils.)

On the one hand educators agreed that gay men were knowledgeable about safe sex, but on the other hand they felt that patterns of sexual engagement which risked HIV transmission were not necessarily based on deliberate individually-adopted strategies. The dilemma for educators responding to increases in unprotected intercourse was posed as:

- How do educators engage gay men in HIV education—posters, forums, newspaper articles?
- To what extent do gay men need to be engaged with HIV education? Are they capable enough and simply need gentle reminders or are they moving toward inevitable rises in new infections?
- What sort of HIV education should gay men be given? Just the facts or recommendations around safe/unsafe categorisations within hierarchies of risk?

Educators reported a sense of crisis and its source is partly due to their constituents' calm. As gay men redefine HIV/AIDS in their own lives, so too are AIDS Councils and other AIDS organisations. For example, the AIDS Council of New South Wales (ACON) has signalled its intention to focus more on gay and lesbian health, as outlined in the statement *Strategic Directions: 2000-2003*. This redefinition within AIDS Councils is quite deliberate though complicated by a *National Strategy* which requires a clear link to be made between programs and HIV prevention.

If gay men themselves are living post-crisis, in the sense that they know how to prevent HIV transmission and no longer feel overwhelmed by having HIV in their midst, the epicentre of crisis has shifted from HIV to educators. The crisis for educators was seen as one of relevance to their constituents. Educators positioned the challenge in two ways. Firstly, gay men's disengagement with HIV was read as complacency and considerable energy has being channelled toward thinking about how to reengage gay men with the epidemic. Educators recognised that men would not engage with HIV in isolation from other more engaging topics, and that a precondition of engagement was that education be premised upon a broader focus within which HIV was embedded. Secondly, educators accepted (with some reservation) that most gay men were quite knowledgeable and capable. (Whilst "capable", the dilemma may be more obviously portrayed in regards to increases in other sexually transmissible infections, and it is here that gay men's sexual health education may best be positioned.)

Risk management

Most educators were well aware of increases in casual unprotected anal intercourse and cited a range of factors for the increases—post-exposure prophylaxis (PEP), viral load, insertive and receptive modes of anal intercourse, HIV optimism, and decreased visibility of AIDS. Educators did not perceive the upturn in unprotected anal intercourse as a crisis, partly because there have not been corresponding increases in new infections. Important exceptions to this rule are an increase in new infections in Victoria for the year 2000 (NCHECR 2001) and increases in parts of Canada (Calzavara *et al.,* 2000) and the United States (McFarland *et al.,* 2000).

Educators recognised that there was little epidemiological data about the relative risks associated with particular risk management strategies such as those based on modality (insertive versus receptive) of anal intercourse and HIV status—strategic positioning (Van de Ven *et al.* in press). Additionally, little is known about the extent to which gay men are *consciously* adopting such strategies. Educators believed that the 'health literacy' of gay men was highly divergent. Gay community attached men, and especially the positive men in their ranks, were thought to have higher levels of literacy than other men.

The importance of ensuring that health literacy is improved was well illustrated in recent behavioural data showing men's widely divergent expectations about HIV positive men disclosing their status to sexual partners before having sex (Van de Ven *et al.,* 2001b). Forty per cent of HIV positive men expected their partners to disclose whereas 80% of HIV negative men expected such disclosure. By contrast, 84% of negative men, as opposed to 12% of positive men, also stated that they sometimes or (mostly) always avoided having sex with HIV positive men. The different disclosure expectations between positive and negative men set the sexual stage for diametrically opposed assumptions in precisely the situations where HIV transmission occurs. Moreover, the expectation and avoidance configurations set up a double bind for positive men.

Data from the Periodic Surveys in Sydney over the last five years indicate that the relative frequencies of strategic positioning have been steady. The Periodic Surveys ask men not what they *think* but what they *do*. The Clinical Markers (Rosengarten *et al.,* 2000), PEP and Seroconversion studies (Kippax, Hendry et al., 2000) get men to describe their protected and unprotected sexual encounters and to place those encounters in spatial, emotional, relational and social context. The interview material supports the general pattern that was found in the Periodic Surveys and suggests that some gay men are deliberately employing a range of risk management strategies (other than condom usage) in casual as well as serodiscordant regular situations.

Interviews with gay men in serodiscordant couples have indicated that men are using low or undetectable viral load counts as justification for not using condoms. The possibility of men making viral load-based risk reduction decisions was detected as early as 1996 (Smith, 1998). It should be remembered that like negotiated safety many of the unprotected risk reduction strategies adopted by gay men are not new. Withdrawal and taking the insertive position in anal intercourse have long been recognised and resisted as acceptable safe sex strategies.

Viral load and increases in unprotected anal intercourse were suspected at the outset to be causally linked. In response to that suspicion QuAC produced four posters addressing several themes. Each poster contained the message "Anal sex without a condom is still the most common way to contract HIV" or "Using condoms is still the safest way to have anal sex". Similarly and around the same time, ACON placed full-page community announcements in Sydney's (then) two major gay and lesbian newspapers.[7] The first stated that "Condoms still remain the safest way to have anal sex" and the second stated "It is crystal clear that anal sex without a condom with casual partners will still put you at extremely high risk of HIV infection". In 1998 ACON also developed a campaign poster that recommended, "While we are still in the dark about viral load, keep a condom on".

[7] The announcements appeared in the Sydney Star Observer (No. 350, 17 April 1997; No. 358, 12 June 1997) and Capital Q (No. 236, 18 April 1997; No. 244, 13 June 1997).

ACON has recently published a pocket pamphlet which asks, "Do you sometimes fuck without condoms?" It begins by reaffirming the centrality of condoms and then goes on to talk about a number of factors that impact on the risk of HIV transmission when condoms are not used, including:

- Presence of STIs
- Viral load
- Assumptions about HIV status of partners
- Likelihood of coming into sexual contact with an HIV positive person
- Greater numbers of sexual partners means greater likelihood of HIV exposure.

The Terrance Higgins Trust in the UK has recently produced gay education materials, *Facts for Life*, which address issues of HIV risk management such as withdrawal and modality of anal intercourse (Devlin 2001). We are witnessing a decentring of condoms, which began with negotiated safety (entirely effective, correctly applied) and is now being picked up in relation to casual anal intercourse and also in the context of serodiscordant couples (effectiveness not guaranteed).

"A well meaning conspiracy of silence has prevented gay men learning the whole truth about safe sex and their relative chances of getting HIV" (Goddard, 1994). Conspiracy aside, there has in the past been a reluctance to differentiate between, for example, the relative risks of insertive and receptive anal intercourse. The primary focus of Goddard's article was on Koopman's epidemiological study and findings around the probability of HIV transmission during the various stages of HIV infection. Koopman reported that a person is most infectious during the 'window period', between HIV infection and the production of HIV antibodies, least infectious during the long asymptomatic period, and then increasingly infectious at late stages of HIV disease (Koopman *et al.,* 1992). Even when a person is most infectious, Koopman and colleagues estimated that a person had 1/100 to 1/300 chance of becoming infected from a single episode of unprotected anal intercourse. During the asymptomatic period the chances of infection were estimated to be substantially lower (Jacquez et al., 1997). Quantification of the relative risks of infection are rare with few exceptions (Vittinghoff *et al.,* 1999).

Prominent Sydney sexual health physician Basil Donavan summarised the mood of Goddard's article in the following way. He suggested that maximum condom uptake was achieved around 1987[8] but that once gay men realised that the storm of AIDS would not pass soon, they looked for ways to not use condoms:

> *Many men are now playing the odds trying to find rational ways of minimising the use of condoms (which so many find unsatisfactory) without incurring unacceptable risk. The problem is that they are playing the odds without knowing what the odds are … I think we need to get more sophisticated … we need to give people more credit for their intelligence. I'm a great advocate for letting the truth out. (cited in Goddard 1994: 96)*

[8] Data form the National Centre in HIV Social Research suggest that maximum uptake was in fact sometime after 1987 (Kippax 2000).

Beyond gay communities

Although some challenges facing educators of 'mainstream' gay men intersect with the challenges face by Indigenous gay men, sistergirls and MSM, there are also many areas of disconnection. In the interviews the disconnections were greater than the intersections. The current preoccupations for gay men's sexual health are not the same as those of Indigenous gay men and sistergirls or of MSM. In particular, the recent increases in unprotected anal intercourse with casual partners were either not recognised or were positioned as interesting but not relevant to other target groups.

Some of the educators, typically those less closely linked to 'mainstream' gay community, articulated why the increases were irrelevant. The data informing the increase in unprotected casual intercourse emerged out of the Periodic Surveys in Sydney, Melbourne, Brisbane and Perth. The recruitment of subjects for these surveys was drawn primarily from gay community events and social and sex venues. Qualitative studies of the same phenomena have also tended to focus upon men with close attachment to gay community (Rosengarten *et al.,* 2001; Slavin *et al.,* 1998; Significant Others, 1997).

Recent research, however, has indicated that the increases in unprotected anal intercourse has been across the board (Van de Ven 2001b). This finding perhaps has greater relevance to non-Aboriginal men with low levels of attachment to gay community than to Indigenous men (who are poorly represented in the data). To date, there has been no qualitative research that specifically explores what might be underpinning the increases among non gay identified and non gay community attached men. The notion of risk management strategies did not resonate with educators of MSM and Indigenous gay men and sistergirls.

Educators of Indigenous men reported that their constituency is knowledgeable of the sexual modes of HIV transmission. Nevertheless, it was reported that men who have sex with the sistergirls tend to be married and heterosexually identified. These men often refused to use condoms. As one educator noted, whereas gay men typically negotiate condom use with peers, sistergirls typically 'negotiate' condom use with ostensibly straight men. The sexual context required the development of complex condom-based strategies, recognising that sistergirls' negotiating power was structurally limited. Educators identified the sistergirls' partners as the ones in need of education, just as sistergirls needed to find ways to enhance their capacity to negotiate or bargain with their sexual partners.

A major challenge for educators of non gay identified or non gay community attached men was access. These men are immersed within a larger heterosexual population within which they lacked visibility. In this context there are limited points of effective contact.

This group of educators was generally unconcerned and, on occasion, unaware of any post-crisis scenario. In a sense, the low HIV prevalence rates and lack of engagement with HIV among this group has always been the norm.

The workplace

The primary focus of the project was on educators' perceptions of current educational challenges. However, many educators also raised issues relating to the workplace.

The response was mixed in terms of whether or not existing work cultures were conducive to dealing with a changing sexual culture among gay men. Educators felt supported in some aspects of their work and unsupported or resisted in others. This points toward the inherent difficulty of trying to find a new way of approaching gay men's education in accord with a changing educational context, and of the need to critically reflect on the work that has been done and needs to be done.

Geographic areas and target groups were important factors in determining what educators identified as educational challenges. Regional-based workers are expected to be multi-skilled and able to engage in youth education, volunteer training, outreach, venue liaison (if such exist) and campaign implementation. The target population includes the entire homosexually active population within their region (gay or non gay identified, and gay or non gay community attached). In Brisbane the same problem was said to exist, though the opportunity to specialise was greater—as regional MSM worker, education manager, education team leader, beat worker or Brisbane educator (i.e. gay men's educator). The problem with the need to be multi-skilled, especially in rural areas, is that some areas of work are attended to and others neglected. The capacities of the workers will determine what gets done rather than the needs within the region.

Information sources

Educators who worked in Brisbane benefited from being surrounded by other educators with whom ideas and problems could be shared. In regional areas, educators tended to work in relative isolation. The distinction between collegial support and isolation is relative. Regional educators are connected to other educators by formal channels, such as bi-monthly state-wide teleconferences. Despite this, regional educators did not regard the teleconferences as conducive to discussing substantive educational issues. National and especially state-wide education conferences were also identified as points of contact with others within the field, as was distance management from Brisbane, and here too problems were identified stemming from the tyranny of distance.

A lack of financial resources meant that regional educators had limited access to email and internet services. One regional office, for example, had email access in the front office (but not access to the Web) but it regularly failed and was not readily accessible. As a consequence there was a reliance on telephone, facsimile and postal modes of communication. Internet and email access can be seen as a means of ameliorating the isolation of regional workers from management and other forms of collegial and information-based support. Such access is an important workplace issue given the dispersed and diverse configuration of regional target populations; the growing popularity of internet communication in regional areas (and therefore as a means of targeting homosexually active men); and the growing importance of work related internet communication. The 2000 review of what was then called RRAP (Regional Response Action Plan) recommended that "QuAC and Queensland health explore the feasibility… of establishing a website to advertise the telephone information service; [and] provide men with information, education and support for safe sex practices…" (Wise and Evans 2000: 17). This recommendation included the provision of a chat room for regional men to establish social support networks.

Simply being in daily close proximity with other educators does not ensure a productive interaction between colleagues (working in isolation may have certain benefits). Specialisation divided workers. For example, a beat educator may share more in common with other beat workers around the State or Nation than with an educator of gay men within the same office.

There are multiple though finite pathways through which educators become sensitised to emerging and existing educational challenges. A number of formal and informal pathways were mentioned. They included:

Regular formal sources:

- Annual State-wide and National AIDS Education conferences
- Fortnightly team meetings
- Project meetings (including supervision)
- Monthly education teleconferences
- Bi-monthly newsletters.

Irregular formal sources:

- Journals
- Research conferences
- Newsletters
- Research presentations within QuAC
- Training sessions.

Informal sources:

- General internet searches
- Visiting favourite websites (for those who had access)
- Talking with colleagues
- Reading books
- Interaction with client groups (informal in the sense that client groups are not subject to research)
- Discussions with friends
- Reading mainstream and gay media.

Educators reported formal and informal sources to be important. Among regional and Indigenous educators, informal sources of information tended to predominate, primarily because they often worked in isolation from other educators and, in the case of Indigenous workers, their greatest challenge was establishing a presence within communities. As noted elsewhere, information was often subsidiary to gaining the trust of targeted groups and communities. Some sources were considered more salient than others. Academic journals and books had limited currency. Organisations such as AFAO, AIDS councils (especially ACON) and the National Centre in HIV Social Research (NCHSR) were the most commonly cited sources of information. Most educators mentioned AFAO as a primary source of campaign and educational material, and it was recognised that the role of QuAC, in part, was to implement campaigns developed at AFAO. Research from the NCHSR also had a strong presence within QuAC, as a source of monitoring and interpreting HIV/AIDS in relation to homosexual men, especially gay men.

In the past, attempts were made within QuAC to institute a formalised State-wide educators' reading group as a means of establishing a culture of reading within QuAC. The attempt had limited success, perhaps because it was overly ambitious. Some educators, however, are self-motivated readers of a wide variety of materials that relate to the HIV epidemic. Others, when asked about how they gained information, spoke of documents, reports and books "passing across their desk". The latter passive mode of becoming informed was their primary means of access to written material. However, accessing 'paper' documents within QuAC lacked coordination and formalisation, such as a library might provide.

The National and State-wide gay education conferences tended to focus more on 'mainstream' gay issues, which regional and Indigenous workers found problematic. For educators of urban gay men these conferences were a valuable means of becoming aware of and synthesising current issues.

Some educators argued for the creation of stronger links between projects within the organisation. Intersections between different target groups (such as gay, MSM, rural, regional, remote, Indigenous, NESB and beat users) could be put to good use.

Educators' work

We were interested in gaining an understanding of the pedagogical frameworks within which educators operated and the pedagogical practices they employed. In general the primary models of education employed were peer education and community development. However, the articulation of the logic underpinning these health promotion models was limited. In this section we discuss educators' perceptions of their roles, including the *form* and *content* of education campaigns and how one comes to *know* something.

Educators tended to see themselves as specialists whose job was to *inform* gay men of the possible risk they might be taking vis--vis HIV. In particular, the role of educators was seen as stimulating HIV-related discourse among their constituents rather than telling them what to do.

Form and content of education

Several factors determine the current form education takes. In 1998, following the recommendations of an internal evaluation of QuAC's gay and homosexually active men's education, peer education was reprioritised as the most appropriate form of gay men's education. This is in keeping with the recommendations of the *National HIV/AIDS Strategy*. There was a sense that too much emphasis had been placed on education that did not specifically target gay men, such as in delivering homophobia talks to school students.

Another influence on the form education took was the educators' background, both personal and professional. Although many educators had post-secondary education, only three related to education, one to health promotion, and one to primary health care. The questions relating to 'how education works' were found to be the most difficult for educators to answer, and this partly reflected a general absence of health promotion qualifications. Some educators entered the organisation via volunteer work, and interestingly, the volunteers reported passing through a more formal and extensive induction process than those who entered the organisation as employees. There may be an assumption that workers who enter in a paid capacity have the prerequisite understandings or skills to fulfil their responsibilities.

Many educators were clearly dissatisfied with condom distribution and with poster and pamphlet-based campaigns in meeting current educational challenges. For those educators experiencing poster and condom distribution fatigue, fresh educational approaches were considered desirable. This desire to invent or employ new forms of education related to the broader problem of gay men's disengagement from the epidemic. The old ways were no longer thought to work. Perhaps underpinning this idea was that few men were bothering to look at or pick up campaign materials. Also key to identifying disengagement was the difficulty in getting gay men to participate in QuAC events and maintaining an education-specific volunteer base. HIV education, it was thought, needed to be conceptualised within the broader context of gay men's lives. There is nothing new about this. Younger and older gay men's groups have always been conceptualised in

such a way, under the rubric of community development. What is perceived to be new is disengagement with HIV. As a consequence, it was perceived to be increasingly necessary that the sugar coating of what actually interests gay men disguise the pill of HIV-related health education.

One of the common concerns expressed by educators was a lack of knowledge about *relative* risks. Surprising, given that gay men are now positioned as highly knowledgeable and skilled safe sex practitioners. But what gay men and educators (and researchers for that matter) do not fully understand are the relative risks associated with unprotected sex in different contexts (high versus low viral load, risk per contact, receptive and insertive, etc).

Ways of knowing

We asked educators about their sources of information. In retrospect it may have been more fruitful to frame those questions in terms of how they knew what they knew rather than the source of their information. Although people could often articulate from where any given information was obtained and rank its importance, that told us little about how it came to be regarded as meaningful and relevant to their work practices. For example, when an educator stated "there is no visible gay community in this town", that understanding didn't emerge so much out of information, but out of an immersion in Brisbane and a lived recognition that gay men are geographically dispersed and lacking a visible centre (or ghetto); that there are limited gay specific services; that many men are reluctant to identify as gay; and that many people and some organisations display open hostility toward gay men.

Educators know through experience. When one educator stated that outreach was more effective at some beats than others, we asked how that was known. First, he argued that anal intercourse was facilitated or hindered according to the kind of beat and that outreach should be delivered where high risk is most likely to occur. Second, establishing contact with beat users was said to be more conducive at some beats than at others. Anal intercourse is less likely at shopping mall beats as they offer less scope for privacy and more chance of being caught *flagrante delicto*. For the same reason, it is difficult to establish non-intrusive contact with beat users at such beats. Beats that are in relatively more private spaces, such as in parklands, offer greater scope for anal intercourse between men and are more conducive to verbal communication. The knowledge of this educator is informed by an intimate knowledge of the dynamics of beats and their use.

The relatively low emphasis educators gave to personal observations and experience may have related to a perception that researchers are perceived as hostile to these ways of knowing. It is our opinion, however, that personal observations and experience have an important place in coming to know things and to informing educational practice (Duffin, 1998). However, this pathway needs to be 'in dialogue' with a sound research base.

One educator noted the "the strange way your life becomes your work". This is especially true when the ranks are drawn from the communities served (as is often the case). Being a part of the community, though, is not sufficient accreditation to serve that community. It may be a solid base upon which to build a comprehensive educational understanding and practice. However, there are dangers associated with immersion or passionate engagement with a given culture. What one knows may be taken for granted, or a tendency may emerge to generalise one's personal experience and the experience of one's friends to others who share or are presumed to be a part of the same community.

Self-reflexive practice

Some effort and considerable concern have been directed toward establishing successful professional work practices, centred on getting educators to critically engage and reflect on their own and the work of others (Dowsett and McInnes, 1996). The need for such reflection arose out of a perception that educators were not sufficiently exposed to relevant social and other research that could inform their educational work. Some strategies QuAC instituted to meet this need are:

- Setting up a reading group based on key educational issues or thought. All educators were given a set reading, were asked to write a brief report on the reading, and to discuss the reading in bi-monthly teleconferences.
- Instituting processes for work planning and project planning. This included project workers submitting a background rationale, aims and objectives, and evaluation for each of their projects. This process was also intended to encourage 'peer mentoring' insofar as work plans and project plans were submitted for general comment.

Tension is intrinsic to workplace relations at one time or another, and the important thing is that this be a *productive tension*. There was some talk among educators of differences in working styles that caused unproductive tensions. Some workers felt over-managed to the point where too much time was devoted to justifying the work they did or wanted to do rather than engaging with their target groups. On the other hand, it was thought important by others that educators critically scrutinise the projects they developed by providing the rationales that informed them.

There is of course no single solution to the management of tension. A work culture which encourages critical reflection and an openness to the ideas of others may engender a working environment that is responsive to changes in the epidemic (i.e. to the educational challenges that educators face). This was most certainly the view held by some of the workers. It is perhaps in the post-crisis context that the reflexive educator is most needed, as was suggested by Dowsett and McInnes (1996).

Final word

There was much uncertainty among educators in interpreting the increases in unprotected anal intercourse among gay men, and this may be a reflection of a broader uncertainty within the HIV sector and among some gay men themselves. The increases were generally understood by educators to be multifaceted but especially related to gay men's HIV optimism in the context of more effective treatments. Optimism was seen to be related to a perception that new treatments had reduced positive men's infectiousness, overall and individually. In addition, HIV optimism related to a disease now being considered chronic and manageable rather than fatal. The increases in unprotected anal intercourse were also perceived by educators to be a shift toward gay men's adoption of a number of risk reduction strategies not involving condoms.

There was also considerable doubt among educators about the feasibility of openly responding to risk reduction strategies other than condoms when men engage in anal intercourse with casual or serodiscordant regular partners. A major aspect of this hesitation is related to the relative risks of protected and unprotected anal intercourse in various circumstances.

Relative to other groups, we currently have quite extensive data relating to gay community attached and gay identified White men. There is far less data relating to non gay community attached and non gay identified men. In relation to Aboriginal and Torres Strait Islander men and sistergirls there is a dearth of research in relation to homosexual cultures. Of particular interest would be to map the different sexual cultures in urban, rural and remote settings, especially in relation to sex among Indigenous, and between Indigenous and non-Indigenous, men.

Community development underpins the Australian response to homosexually active men's education, especially for gay identified men. There is a need to rethink and restate what community development is in relation to health promotion, given that many participants in the study did not refer to community development in our interviews. The reason for this absence may have been that the model operated in the background (i.e. was taken for granted). Is community development about building self-esteem and a sense of belonging to a group, both of which are assumed to strengthen men's resolve to engage in safe practices? Or is community development about 'developing' new or existing networks of gay men as a vehicle for education (i.e. a medium for the message)? It may be that both of these aims inform community development theory and practice. This is particularly pertinent in regional and rural areas where many participants struggled to recognise a 'community' and, at best, could only point to semi-closed groups of homosexually active men who operated within a broader network of groups which may or may not intersect. It seems that a key task is to find or to build communities through which education might be delivered.

It would be very worthwhile to undertake similar in-depth interviews in other States/Territories to further draw out educators' current experiences to corroborate or expand on those documented herein from Queensland.

References

AFAO (1998). *The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators*. Sydney: Australian Federation of AIDS Organisations.

Calzavara, L., Burchell, A., Major, C., *et al.* (2000). *Increasing HIV incidence among MSM repeat testers in Ontario, Canada, 1992–1998*. XIII International AIDS Conference, Durban, July. (Abstract ThOrC718.)

Commonwealth of Australia (2000). National HIV/AIDS Strategy, 1999-2000 to 2003-2004: Changes and challenges. Canberra: Author.

Crawford, J., Rodden, P., Kippax, S., & Van de Ven, P. (2001). Negotiated safety and other agreements between men in relationships: Risk practice redefined. *International Journal of STD & AIDS*, 12, 164-170.

Davidovich, U., de Wit, J., Albrecht, N., *et al.* (2001). Increase in the Share of Steady Partners as a Source of HIV infection: A 17 year study of seroconversion among gay men. *AIDS*, 15: 1303-08.

Davidovich, U., de Wit, J.B.F. & Stroebe, W. (2000). Assessing sexual risk behaviour of young gay men in primary relationships: the incorporation of negotiated safety and negotiated safety compliance. *AIDS*, 14, 701-706.

Devlin, W. (2001). Changing the Norm—Reducing harm, not policing behaviour. *Fifth International AIDS Impact Conference*. Brighton, UK, July. (Abstract 26.1.)

Dodds, J.P., Nardone, A., Mercey, D.E. *et al.* (2000). Increase in High Risk Sexual Behaviour among Homosexual Men, London 1996–8: cross sectional, questionnaire study. *BMJ, 320*, 1510–1511.

Dowsett, G. (1995). Australian perspective on HIV/AIDS health promotion. *New South Wales Health Promotion Conference*, Sydney, 8-10 November, 1995.

Dowsett, G. and McInnes D. (1996). Gay community, AIDS Agencies and the HIV Epidemic in Adelaide: Theorising "post-AIDS". *Out There Too: Social Research & practice forum*, Adelaide: HIV/AIDS Programs Unit, South Australian Health Commission.

Duffin R. (1998). Research and Knowledge: A reflexive space. In D. McInnes (Ed.), *Cultural Analysis and HIV/AIDS: A dialogue between educational practitioners and researchers in the field of HIV/AIDS* (forum proceedings). Sydney: Research Centre in Intercommunal Studies

Ekstrand, M.L., Stall, R.D., Paul, J.P., *et al.* (2000). Gay men report high rates of unprotected sex with partners of unknown or discordant HIV status. *AIDS,* 13: 1525–1533.

Epstein, S. (1997). *Impure Science: AIDS activism and the politics of knowledge*. Berkley and London: University of California Press.

Goddard, M. (1994). Being Honest About AIDS Prevention. *Outrage*, September 1994: 14-16, 96.

Hogg, R.S, Weber, A.E., Chan, K., *et al.* (2001). Increasing incidence of HIV infections among young gay and bisexual men in Vancouver. *AIDS*, 15: 1321-1323.

Jacquez, J.A., Koopman, J.S., Simon, C.P. *et al.* (1997). Role of the primary infection in epidemics of HIV infection in gay cohorts. *Journal of Acquired Immune Deficiency Syndromes*, 7: 1169-84.

Kippax S, Connell RW, Dowsett GW, *et al.* (1993). *Sustaining Safe Sex: Gay communities respond to AIDS*. London: The Falmer Press.

Kippax, S. (2000). Sexual Behaviour in the Era of AIDS: Changes among Australians' Sexual Practice 1986-1999. *6th Asian Congress of Sexology: Sexuality in a Changing Asia*, Kobe, Japan.

Kippax, S., Crawford, J., Davis, M., *et al.* (1993). Sustaining safe sex: A longitudinal study of a sample of homosexual men. *AIDS*, 7: 257-263.

Kippax, S., Hendry, O., Grulich, A., et al. (2000). Narratives of risk taking: accounts of seroconversion and reasons for post-exposure prophylaxis. 12th Annual Conference of the Australasian Society for HIV Medicine, Melbourne. (Abstract 2D-69.)

Kippax, S., Noble, J., Prestage, G., et al. (1997). Sexual negotiation in the AIDS era: negotiated safety revisited. AIDS, 11, 191-197.

Koopman, JS., Simon, CP., Jacquez, JA. *et al.* (1992). HIV transmission probabilities for oral and anal sex by stage of infection. *VIII International Conference on AIDS*, Amsterdam, Netherlands.

McFarland, W., Schwatcz, S., Kellog, T., *et al.* (2000). Implications of Highly Active Antiretroviral Treatment for HIV Prevention: The case of men who have sex with men (MSM) in San Francisco. *XIII International AIDS Conference*, Durban, July. (Abstract MoPpD1127.)

McInnes, D., Bollen, J., Couch, M., *et al.* (2001). *Considering Australian Gay Communities in HIV Health Promotion*. Sydney: Institute for Cultural Research, University of Western Nepean.

Miller, M., Laurence, M., Boufassa, F. *et al.* (2000). Sexual behavior changes and protease inhibitor therapy. *AIDS*, 14: F33-F39.

Murphy, D. (2001). Keeping it Safe: Maintaining gay safe sex practices in the light of treatment for HIV. *AFAO/NAPWA Discussion Papers*, (2)1.

NCHECR (2000) Annual Surveillance Report: HIV/AIDS, hepatitis C & sexually transmitted infections in Australia. Sydney: National Centre in HIV Epidemiology and Clinical Research.

NCHECR (2001) HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual surveillance report. Sydney: National Centre in HIV Epidemiology and Clinical Research.

NCHSR (2000) Annual Report of Behaviour: HIV/AIDS, hepatitis C & related diseases in Australia, 2000. Sydney: National Centre in HIV Social Research.

O'Grady (1997 April). Safe sex slips: gay men ditch condoms of casual sex. *Sydney Star Observer*, No 350: 1

Parnell, B. (1997). Certain Movement Forward into Something We're Not Sure of: Avoiding further HIV transmission amongst gay men in Australia. Melbourne: McFarlane Burnett Centre for Medical Research.

Prestage, G., Van de Ven, P., Grulich, A., *et al.* (2001). Gay Men's Casual Sex Encounters: Discussing HIV and using condoms. *AIDS Care*, 13: 277-284.

Rofes, E. (1998). Reviving the Tribe: Regenerating gay men's sexuality and culture in the ongoing epidemic. New York: Harrington Park Press.

Rosengarten, M., Race, K., Kippax, S. (2000). Touch Wood, Everything will be OK: Gay men's understandings of clinical markers in sexual practice. Sydney: National Centre in HIV Social Research.

Significant Others Marketing Consultants (1997). *Unprotected gay anal sex in Sydney in 1997*. Unpublished report for the NSW Health Department, June.

Slavin, S., Kippax, S., Race, K. (1998). *The Sex Culture Project*. Sydney: National Centre in HIV Social Research.

Smith, G. (1998). Critique and Cultural Analysis. In (ed.) David McInnes, *Cultural Analysis and HIV/AIDS: A dialogue between educational practitioners and researchers in the field of HIV/AIDS* (forum proceedings). Sydney: Research Centre in Intercommunal Studies.

Sobo, E. J. (1999). Cultural Models and HIV/AIDS: New anthropological views (Editorial), *Anthropology and Medicine*, 6: 5-15.

Stall, R., Ekstrand, M., Pollack, L. *et al.* (1990). Relapse from Safer Sex: The next challenge for AIDS prevention efforts. *Journal of Acquired Immune Deficiency Syndrome*, 3: 1181-87.

Stoite, I.G., Dukers, N.H., de Wit, J.B., *et al.* (2001). Increase in sexually transmitted infections among homosexual men in Amsterdam in relation to HAART. *Sexually Transmitted Infections*, 77: 184-186.

Van de Ven P., Kippax S., Crawford J. *et al.* (in press). In a minority of gay men, sexual risk practice indicates strategic positioning for perceived risk reduction rather than unbridled sex. *AIDS Care*.

Van de Ven P., Prestage G., Crawford J. *et al.* (2000). Sexual risk behaviour increases and is associated with HIV optimism among HIV-negative and HIV-positive gay men in Sydney over the 4 year period to February 2000. *AIDS*, 14: 2591-93.

Van de Ven, P., Kippax, S., Crawford, J. *et al.* (2001a). Increasing proportions of Australian gay men engage in unprotected anal intercourse with casual and with regular partners. *Fifth International AIDS Impact Conference*, Brighton, UK.

Van de Ven, P., Rawstorne P., Crawford, J., *et al* (2001b). *Facts and Figures: 2000 Male Out survey*. Sydney: National Centre in HIV Social Research.

Vittinghoff, E., Douglas, J., Judson, F., *et al.* (1999). Per-contact risk of human immunodeficiency virus transmission between male sexual partners. *American Journal of Epidemiology*, 150, 306-311.

Wise, M. and Evan N. (2000). *The implementation of the regional response action plan in Queensland: a review of progress and directions for the future*. Sydney: Australian Centre of Health Promotion, Department of Public Health and Community Medicine, University of Sydney.