8. Social marketing, safe sex and STIs

8.1 The STI focus

Readers will notice that although we have so far looked at many health risks that MSMs perceive they face (loneliness, depression, anxiety, violence, suicidality), they are all of the mental health type and not of the sexual health type.

This focus on mental health is not entirely consistent with the research evidence: while interview respondents generally talked about mental health before sexual health risks, survey respondents, when asked to nominate health risks, overwhelmingly nominated sexually-transmitted infections (STIs). However, their other survey answers provided plenty of information about their concern for other types of risks. As one respondent said,

> 'Lots of risks are considered before the risk of an infection, unless they or someone they know has had a scare (such as a bleeding bum, a painful dick, or feeling awful in ways they feel are related to an STI)'.

That notwithstanding, this research was commissioned by the Communicable Diseases Unit of Queensland Health, to focus on risks related to sexually-transmitted infections (STIs). For that reason, this chapter is structured around STIs, rather than other risks faced by MSMs.

8.2 The social marketing framework

Social marketing in Australia has a long and (given the foibles of human nature) very successful track record in achieving attitudinal and behavioural change. The discipline first cut it's teeth on the highly-successful Life. Be in it. Campaign in the mid-1970s. The Quit campaign, various alcohol reduction campaigns and the highly-successful HIV prevention education campaigns of the 1980s were all based on social marketing approaches.

At its simplest, social marketing defines a behavioural goal (such as 'have safe sex every time') then defines the interventions required to encourage a person to move along a spectrum from no adherence to the behaviour at all, to total adherence every time. The main interventions are logical, even commonsense, which is perhaps why social marketing approaches have been so successful.

At their simplest and generically, these steps are:

- put the issue on a person's radar (basic awareness raising and agenda setting)
- provide basic messages about why behaviour change is good for them (basic information)
- check they received and understood the messages (address distortions in hearing the message)
- find out what the barriers are to acting on these messages (understand the 'costs')
- provide information and motivation to help overcome the barriers (increase the sense of 'benefits')
- overcome barriers to change (work to make the cost: benefit ration work in favour of change)
- provide opportunities for positive behaviour (enable conforming action)

- encourage maintenance of behaviour and minimise relapses.

We outline this model because we believe it continues to be the best way to understand why people do not act in their own self-interest, which is to have safe sex every time – and to encourage them to change their behaviour.

8.3 The safe sex baseline

Before we look at how to change behaviour, let's look at Table 24 and what survey and interviewee respondents told us was happening in terms of sexual behaviours and condom use. The salient points are:

- about a half of respondents had had Internet or phone sex
- just under two thirds of respondents always or most times have oral sex
- about a third of respondents always or most times have anal sex
- the percentages of men always or most times having insertive anal sex and receptive anal sex are about equal.

TABLE 24: HOW RESPONDENTS HAD SEX WITH MEN IN THE PAST YEAR

Phone / Internet	**No.**	**%**
Always	4	2%
Most times	10	5%
Some times	52	25%
Almost never	31	15%
Never	111	53%
No answer	76	
Total	**284**	

Masturbating	No.	**%**
Always	60	27%
Most times	49	22%
Some times	87	38%
Almost never	10	4%
Never	20	9%
No answer	58	
Total	**284**	

Insertive anal intercourse	No.	**%**
Always	34	15%
Most times	51	22%
Some times	66	29%
Almost never	31	13%
Never	45	20%
No answer	57	
Total	**284**	

Receiving oral sex	No.	**%**
Always	62	27%
Most times	78	34%
Some times	73	32%
Almost never	6	3%
Never	12	5%
No answer	53	
Total	**284**	

Giving oral sex	No.	**%**
Always	70	30%
Most times	69	30%
Some times	66	29%
Almost never	10	4%
Never	15	7%
No answer	54	
Total	**284**	

Receptive anal intercourse	No.	**%**
Always	37	16%
Most times	44	19%
Some times	56	24%
Almost never	29	13%
Never	61	27%
No answer	57	
Total	**284**	

Table 25 shows when survey respondents wore a condom for particular types of sex acts. The salient points are:

- almost all respondents don't use a condom for Internet or phone sex or for masturbating
- eight in ten don't wear a condom for oral sex
- the rates of condom use for anal sex don't vary according to whether a respondent is inserting or receiving
- about two in ten respondents never use a condom for anal sex
- only about half the respondents always use a condom for anal sex.

We would emphasise that this research was not quantitative and steps were not taken to ensure the sample was representative of all men who have sex with men. As explained in the methodology, we believe it over-represents gay-identifying men and under-represents other MSMs. However, we expect it will be a small contribution to the statistical literature; and the broad picture above is consistent with what interview respondents told us.

TABLE 25: IF RESPONDENTS WORE A CONDOM DURING SEX

Phone / Internet	No.	%
Always	1	1%
Most times	1	1%
Some times	6	3%
Almost never	4	2%
Never	184	94%
No answer	88	
Total	**284**	

Masturbating	No.	%
Always	11	5%
Most times	1	0%
Almost never	8	4%
Never	191	87%
No answer	64	
Total	**284**	

Insertive anal intercourse	No.	%
Always	102	48%
Most times	38	18%
Some times	29	14%
Almost never	5	2%
Never	40	19%
No answer	70	
Total	**284**	

Receiving oral sex	No.	%
Always	17	8%
Most times	11	5%
Some times	15	7%
Almost never	21	9%
Never	158	71%
No answer	62	
Total	**284**	

Giving oral sex	No.	%
Always	21	9%
Most times	14	6%
Almost never	17	8%
Never	159	71%
No answer	60	
Total	**284**	

Receptive anal intercourse	No.	%
Always	111	52%
Most times	26	12%
Some times	26	12%
Almost never	4	2%
Never	47	22%
No answer	70	
Total	**284**	

The key point above concerns condom use for anal sex. A typical interview respondent comment was:

'My guess would be about 50-50 condom use … but how would you know?'

There is plenty of evidence of use, but not of how widespread use is. As a police respondent said,

> 'We do find open packets and used condoms around the beats, so they are being used there. But if people suspect we're around, they will be disposed of, because it's evidence.'

However, there were also plenty of opinions that use is low. As respondents said,

> 'From personal observation at the local sex-on-premises venue, it could be low … I don't remember seeing anyone take a condom from the container at the front door.'

The incidence of rectal gonorrhoea was also seen as evidence of widespread non-use.

The reasons why people might use or not use are discussed later in this section.

8.4 Are STIs / safe sex on the radar?

Many older readers no doubt remember the enormous visibility that HIV/AIDS had in the early 1980s, in no small part due to publicity about the death in 1984 of three Queensland babies infected with contaminated blood donated by a gay man.

The message was clear: homosexual sex (and, with the arrival of the Grim Reaper, possibly promiscuous heterosexual sex) meant death. That the issue was on the radar of the whole community was beyond doubt. Agenda setting around HIV/AIDS in the 1980s was a chaotic affair involving almost everybody: the media, politicians, medicos, insurers, the churches, celebrities and the gay community. The issue spread like wildfire and dominated the public consciousness for years.

Interview respondents felt that that high level awareness had now evaporated, and that HIV/AIDS has slipped off the community radar. It isn't talked about, it isn't in the papers or on the TV. As one respondent said,

> 'Men who identify as heterosexual haven't been in a situation where it's seen as a huge issue. Their exposure to messages has been quite limited. The last time that AIDS really invaded the heterosexual consciousness was with the Grim Reaper, and that's a long time ago now.'

8.5 The safe sex message

8.5.1 Penetration of messages

While agenda setting involved everybody, gay community campaigners were the first to move to the second of the social marketing steps: to provide information about the required behaviour change. The central message was: wear a condom, every time, for sex.

Interview and survey responses would indicate that this message has lived on, albeit in a sightly different form: 'wear a condom to prevent spreading HIV during anal intercourse'. Survey respondents gave as the only reason to wear a condom was to prevent the spread of STI and HIV (also called 'for disease / health / safety reasons'). And, as Table 26 shows, almost all respondents agreed that anal sex without a condom is very high-risk for catching HIV/AIDS.

TABLE 26: AGREEMENT WITH PROPOSITION THAT 'ANAL SEX WITHOUT A CONDOM IS VERY HIGH-RISK FOR CATCHING HIV/AIDS'

Agreement	No.	%
Strongly agree	193	85%

Agree	20	9%
Not sure	7	3%
Disagree	1	0%
Strongly disagree	6	3%
No answer	57	
Total	284	

Interview respondents were equally certain that this message was widely heard, among the whole community. They also felt that straight men had interpreted it as also applying to vaginal intercourse.

However, there is also the possibility that some have not heard the message. One respondent said,

> 'My experience is that some don't seem to have heard the condom message. After all, it's not on at the footy, or the races. And you don't see much condom use in straight porno.'

Another respondent talked of his concern about Asian students at the local university, many of them come from countries where they might not have heard the safe sex message.

They were less certain about whether men had extended the message to apply to other STIs: a reasonable uncertainty, given that condoms continue to be discussed (for example, through the recent [untrue] Vatican claims about the ability of HIV to pass through a condom) in the context of HIV.

This possible failure to extend the safe sex message to other STIs may not be a problem: interview respondents felt that HIV was the overwhelming concern of MSMs. As respondents said,

> Men generally are terrified of getting HIV. It's still commonly seen as a death sentence. As well, how on earth could they explain it to their partner?'
>
> 'All people are worried about is HIV. I think it's because of the campaigns and the concept that HIV is a death sentence.'
>
> 'If they're horny, the last things on their mind are gonorrhoea and syphilis. But HIV plays on my mind, and I'm sure that it plays on others' minds, too.'

One benefit of the social change model is that it helps us see that promoting the 'use a condom for anal sex

Given the widespread understanding of the 'use a condom for anal (and vaginal) sex to prevent HIV' message is just the first step in changing behaviours. However, it is an important step and should continue to be promoted. Given the recent challenges to the scientific validity of the message, information would do well to refer to scientific authorities until this challenge passes, and in a minor way that does not diffuse the message.

RECOMMENDATION

5. That, without diffusing the message that condoms protect against HIV, education efforts should cite the scientific source of this claim, and broaden it to include other STIs.

8.5.2 Three markers for knowledge

By way of testing levels of basic knowledge, the survey included three simple questions. The first – whether you can catch HIV/AIDS from mosquitos or not - has been an issue for some 20 years now, and has been so thoroughly discussed that it is the iconic indicator of at least a basic level of transmission understanding. As Table 27 shows, while two-thirds of respondents got the answer right (you can't catch HIV from mosquitos), almost a quarter weren't sure. And at least one was unconvinced:

> 'I'm sure that I can catch HIV/AIDS from mozzies. I don't kill them anymore I flick them away so I don't get blood on me.'

TABLE 27: AGREEMENT WITH PROPOSITION THAT 'I CANNOT CATCH HIV/AIDS FROM MOSQUITOES'

Agreement	No.	%
Strongly agree	137	61%
Agree	13	6%
Not sure	54	24%
Disagree	9	4%
Strongly disagree	12	5%
No answer	59	
Total	284	

It is hard to draw conclusions from this finding: it stands to reason that mosquitos may well spread HIV, and the explanation of why they don't (not enough blood is transferred) involves shades of grey in what is otherwise a very black-and-white topic. It may not be so much that people are uninformed, as that messages need to be crystal clear to really penetrate. As we have seen, ambiguities about whether oral sex is safe have distorted the safe sex message, as probably have efforts to water-down 'safe sex' into 'safer sex'. Accordingly, recommendation 4 refers to the need to ensure that messages are clear and unambiguous.

The need for clarity is also supported by answers to the second question. 'At what age is it legal to have anal sex with someone' is a black and white question, and again iconic in that it marks legal acceptance of homosexual behaviour. As Table 28 shows, there were more correct answers, and half the uncertainty, than with mosquitos.

TABLE 28: AGREEMENT WITH PROPOSITION THAT 'IT IS LEGAL FOR MEN OVER 18 TO HAVE ANAL SEX WITH EACH OTHER IN QUEENSLAND'

Agreement	No.	%
Strongly agree	154	68%
Agree	29	13%
Not sure	29	13%
Disagree	4	2%
Strongly disagree	11	5%
No answer	57	
Total	284	

As Table 29 shows, when the answer is black or white, and the issue is important, knowledge is good; nine in ten survey respondents knew there is no HIV vaccine.

TABLE 29: AGREEMENT WITH PROPOSITION 'THAT THERE IS NO VACCINE FOR HIV/AIDS TO STOP ME CATCHING IT'

Agreement	No.	%
Strongly agree	193	85%
Agree	8	4%
Not sure	20	9%
Disagree	2	1%
Strongly disagree	3	1%
No answer	58	
Total	284	

8.5.3 Distortions to the message

While the safe sex message once appeared crisp and clear, it appears to have suffered some distortions with the passing of time.

First there is the ambiguity about whether HIV is spread through oral sex, and about whether the safe sex message is to wear a condom (or indeed a dental dam) for oral sex. As Table 30 shows, while almost two-thirds of respondents felt that oral sex was low-risk for HIV, one quarter did not. In another question, survey respondents listed their main reason for not using a condom when having sex as not needing it for oral sex.

TABLE 30: AGREEMENT WITH PROPOSITION THAT 'GIVING, OR GETTING, A BLOW JOB IS LOW-RISK FOR CATCHING HIV/AIDS'

Agreement	No.	%
Strongly agree	74	33%
Agree	67	30%
Not sure	25	11%
Disagree	29	13%
Strongly disagree	32	14%
No answer	57	
Total	284	

To add to the uncertainty, some sexual health counsellors (perhaps mindful of other STIs) still emphasise the risk. As two told us,

> 'It's a myth that you can't get STIs through oral sex. They don't think about bad teeth or cut gums. They get shocked when you tell them, because they've never thought about it.'

> 'Most people wouldn't know about safe sex in terms of oral transmission … for example, that oral transmission of HIV is now estimated as 8% of cases, up from 2% previously[1].'

[1] There have been a number of studies done to try to assess the risk of HIV infection from oral sex. The percentage of cases of HIV infection from oral sex has varied widely in different studies. They have generally had low numbers, relied on respondents to self-report behaviour and have not fully detailed other behaviours and possible health risks (such as open sores in the mouth). The researchers do not endorse any claim made by any respondent, or vouch for its accuracy or authenticity, including the claims of rates of HIV infection from oral sex above.

Second, there are finer ambiguities which concern gay men but probably not MSMs. As one respondent said,

> '"Safe sex" has become blurred. It simply used to mean, "wear a condom for anal intercourse". Now there are many more variables. There's the different risks for insertive and receptive partners. There's the reduced risk by negotiating with your partner. And there's the variable risk according to viral load. But there's no understanding among these men of those issues.'

RECOMMENDATION

6. **That Queensland Health work with gay community health educators to develop a clear and consistent safe sex message relating to oral sex. The message should be based on the actual risk this type of sex involves and contain detailed information.**

8.5..4 Awareness of all health messages is low

Health education workers frequently note that men are commonly inclined to be unconcerned about their health until something goes visibly wrong with it. Respondents felt this inclination to be stronger among men from macho communities where the emphasis is on strength and self-reliance. This results in greater ignorance of sexual (and general) health issues. As respondents said,

> 'The problem is men's health behaviour and their reluctance to seek information about health.

> 'Men need to know more about sexual health issues. I was talking to a guy at the beat one night and he mentioned erectile dysfunction and a few other things that led me to strongly suspect he's diabetic. I suggested to him that he have it checked. If I hadn't been in a position to talk to him, he wouldn't have known.'

On the other hand, awareness of other diseases – gonorrhoea, syphilis, hepatitis C, chlamydia – was reported to be low. As respondents said,

> 'Many people are very casual, they don't care, they don't know what diseases are around.'

> 'Other STIs don't come into the equation. When they come in (to our sexual health clinic), they come in for an AIDS test.'

> 'Lots don't know the difference between HIV and AIDS. And they have no idea of any other STIs except the drip (gonorrhoea) and the clap (syphilis).'

8.6 Highlighting the benefits

8.6.1 Minimising the risk of catching an STI

Logically enough, the primary benefit of much health-promoting behaviour is that you won't fall victim to the consequences of the unhealthy behaviour. Thus, minimising the risks from having sex is a primary benefit of safe sex.

Table 31 shows what respondents see as the health risks of having sex with men. The are overwhelmingly catching an STI – with HIV/AIDS the most-mentioned STI by far.

TABLE 31: MAIN HEALTH RISKS RESPONDENTS PERCEIVE FACING FROM HAVING SEX WITH MEN

Risk	No	%
HIV/AIDS	100	35%
All STD/STIs	91	32%
Hepatitis	17	6%
None	16	6%
Herpes	9	3%
Gonorrhoea	9	3%
Genital warts	6	2%
Homophobic violence	6	2%
Pubic lice	5	2%
Depression	5	2%
Syphilis	5	2%
Flu/cold	4	1%
Don't think about it	3	1%
Aggressive partner	2	1%
Chlamydia	2	1%
Thrush	2	1%
Rape	2	1%
Blackmail	2	1%
Death	1	0%
General hygiene problems	1	0%

However, as Table 32 shows, two thirds of survey respondents felt that they were at low risk, or at no risk, of catching an STI. This also supports the evidence of interview respondents that MSMs do not rate the risk of STI infection highly.

TABLE 32: WHAT RESPONDENTS THINK IS THEIR RISK OF CATCHING AN STI

STI risk	No	%
None	23	10%
Low	128	57%
Medium	40	18%
High	18	8%
Don't know	15	7%
No answer	60	
Total	**284**	

While they may not rate their risk of catching an STI highly, over two-thirds of survey respondents were concerned about catching an STI, as Table 33 shows.

TABLE 33: AGREEMENT WITH PROPOSITION THAT 'I AM CONCERNED ABOUT CATCHING AN STI'

Agreement	No.	%
Strongly agree	101	45%
Agree	61	27%
Not sure	19	8%

Disagree	23	10%
Strongly disagree	20	9%
No answer	60	
Total	284	

Put together, the three tables add up to:

- MSMs feel that the main health risk they face are STIs generally, and HIV/AIDS specifically …
- … and two-thirds of them are concerned about catching something …
- … but two-thirds think their risk of catching something is little to none.

This means that, in practice, they see the benefits of having safe sex as fairly low, because they see the risk as fairly low.

8.6.2 Concern for female partners

MSMs have every reason to fear what catching an STI will do to their health. More worryingly, they could have to explain the STI to the wife / girlfriend. With HIV, they (if not their partner) know that it's spread mainly by anal intercourse, so this could be a very difficult situation. Even worse, they might infect their wife or girlfriend.

Opinions varied on how much concern MSMs have for their female partners in this situation. Some respondents felt that MSMs are motivated to use condoms by fear of giving an STI to the partner, and the consequences for their families. Other gay-identifying respondents with a heterosexual history were concerned about the STI implications for these men's wives or female partners, and in some cases very concerned and vocal about men's irresponsibility. Perhaps it varies from MSM to MSM or, as one respondent said,

> 'When they're new to it, they seem to be scared of taking something home, but after a while they become complacent.'

8.7 Understanding the barriers / reducing the costs

On the other side of the cost: benefit equation are the costs to an MSM of adopting safe sex. These are not just monetary costs, but all of the barriers that stand between them and safe sex.

Table 34 shows respondents' main reasons for not using a condom when having sex.

TABLE 34: RESPONDENTS' MAIN REASONS FOR NOT USING A CONDOM WHEN HAVING SEX

Not using	No.
Don't like them / less pleasure / don't like taste	24
Trust in partner (on looks, monogamous relationship, knowing them)	22
Don't need for oral	21
Don't have one on hand	9
Trust in partner (with testing strategy)	8
Heat of the moment	8
Depends on what partner wants	5
Under influence of alcohol/drugs	4
Don't need for masturbation	4

Don't worry / think about it	2
Status of partner	3
Costs money	1
Reaction against	1
I don't let them cum in me	1
Other	1

8.7.1 'I hate wearing them'

Top of survey respondents barriers to condom use, and often mentioned by interviewees, was that men 'dislike them / hate the thought of wearing them'. As two respondents said,

> 'One guy came in because he'd had sex with someone he had been told was positive. He'd been having sex with men for years and he'd never used protection. He told me, "If you want me to use condoms, you'll have to give me some Viagra, too!".'

> 'I think use is about 50-50. Condoms are widely seen to be a bit of a nuisance.'

8.7.2 Trust in partner

Table 35 shows why respondents think that they are at no, low, medium or high risk of catching a sexually-transmitted infection.

TABLE 35 : WHY RESPONDENTS THINK THEY HAVE A PARTICULAR LEVEL OF RISK OF CATCHING AN STI

Why?	None	Low	Medium	High
One partner and trust	3	10		
Only have 'clean' partners	4	21	2	
Other reasons	3	2		
Use a condom / have safe sex	4	46	4	
Don't know	1	2		
Don't have much sex	3	20	2	
Get regular checkups	1	2		
I'm careful'	1	14	3	
Don't have risky sex		11	1	
Don't use alcohol or drugs		1		
I'm in the country, not the city'		1		
Isn't much about to catch'		1		
It's out there'			1	
Don't always / sometimes use a condom			3	8
People don't tell the truth			1	
Can't tell by looking			1	
Have regular sex with different men			1	
Can't tell what he's got			1	1
Sex is risky			4	10
Don't use a condom for oral			1	
Partner has HIV			1	
Condom could break			1	

I swallow sperm			1	
I have an STI				3
I have to take what I can get				1

For a health educator, probably the most striking thing about the 'I hate wearing them' attitude is that is has no regard at all for the potential risks of unsafe sex, and leads to a strategy that is clearly unsafe

By contrast, 'trust in partner' not only recognises the risks but is in the man's mind a viable safe sex strategy. As Table 35 shows, the majority of those who think their risk is none, or low, are primarily putting their trust in having an uninfected partner.

This is either a monogamous, long-term partner (a strategy which is usually just based on trust, but might also involve regular testing) or what is thought to be a 'clean' partner. Knowing the partner from before, checking him out, talking to him about it, listening to his attitude, not having sex with men who have lots of partners, limiting one's number of partners, having regular partners, not having sex with strangers in dark venues and not having more than one partner at a time all appear to be part of this strategy.

It is very important to note that the 'clean partner' strategy is commonly combined with safe sex, which usually means using a condom. That is, the 'clean partner' strategy is used in addition to the condom use, as a sort of second line of defence. This is also what we presume respondents meant when they said that they were 'careful'. But there were hints that condoms were only used for anal sex: safe sex could also mean masturbating or, in many cases, having oral sex without ejaculation.

Typical comments made by respondents who felt themselves to be at no risk, or low risk, were,

> 'No risk really because I make sure we're both tested before we do it and we don't sleep with anybody else … I suppose if somebody was to lie to me, I could get something … no risk if it's safe and the person you're having sex with is clean and honest … none if you wear a condom, then you're right ... transfer of disease is obviously a risk, but if you wear a condom you should be relatively ok'

Also, 'I don't have sex much' and 'I only have clean partners when I do' are also two commonly-combined strategies.

8.7.3 'I don't need it for oral sex'

As we have previously seen, two-thirds of survey respondents believe that HIV is not transmitted through oral sex and appear to be unconcerned about (or ignorant of) the risks of other STIs.

8.7.4 'Don't have one on hand'

As Table 36 shows, eight in ten survey respondents don't have problems getting condoms confidentially.

TABLE 36: AGREEMENT WITH PROPOSITION THAT 'I FIND IT HARD TO GET CONDOMS CONFIDENTIALLY'

Agreement	No.	%
Strongly agree	9	4%
Agree	26	12%

Not sure	9	4%
Disagree	26	12%
Strongly disagree	151	68%
No answer	63	
Total	284	

As one respondent noted, most clubs and pubs have condom vending machines in the men's and you can also buy them in supermarkets. However, if we had asked whether they always have a condom on hand when they're having sex, the answer may well have been different. For example, as one respondent suggested, they mightn't be hard to get confidentially, but you still mightn't get them:

> 'Condoms might be available, but you don't want to go to the clinic to get them. It's the shame thing of admitting that you're going for a root. One community overcame that by having a condom tree, so that people could get their condoms privately.'

Despite the survey findings, some men do find confidentiality a major issue. As two said,

> 'How could he explain that he's carrying condoms if she's on the pill and he's had a vasectomy?'

> 'The supermarket sell them, but I could hardly turn up at the checkout that my niece or one of her friends is working at'.

8.7.5 The heat of the moment

Survey respondents acknowledged that in the heat of the moment, they didn't use condoms, a position strongly reinforced by interviewees:

> 'The safe sex message is understood, but it is a major step to put the thing on; they just forget when the hormones are raging. In the passion of the moment, it's something that can quite easily be overlooked.'

> 'I think they have this huge driving force to expel their lust at any cost, and that safe sex gets put on the back burner.'

> 'I'm highly educated – I know all the facts and the risks – but I've still had unsafe sex. When the opportunity for sex arises, nothing is as important as having sex … your number one priority is getting your rocks off.

> 'If guys are in from out of town for a "feast", they are inclined to try more and different things; they might overlook condoms in the rush to get off as many times as possible.'

> 'When its happening you just switch off.'

8.7.6 Depends on what the partner wants

This is an amalgam of several assessments.

In part, it involves negotiation: whether or not the MSM or his partner suggests or insists on protection. This in turn involves how strongly the culture (and peers) supports safe sex; the MSMs' desire and ability to negotiate and the pressure by one man on the other. There's not reason to be confident on any of these scores. As respondents said,

> 'If I don't offer a condom, it usually won't happen.'

'I think (condom use) is getting slack across the board. All the research indicates that when there's no peer group, it won't happen. Someone has to be there, asking them if they've packed a condom, if they're going to use it, if they used it'

Then there's the 'If he's that cute, I'll do anything' assessment. It's doubtful that many men will risk losing the object of their sexual desire by raising the unsavoury topic of a condom; or even more, whether they get to a stage where they're prepared to take anyone who comes along. As one respondent said,

'The average age of infection is low to mid-30s, and has been for a long time, and there hasn't been enough thought given to why. Maybe gay men have a mid-life crisis ten years before heterosexuals, related to a sagging body, an inability to find a lover, unfulfilled ambitions, a feeling that it's going to be hard to get what most people want – to settle down and be loved and respected by your family. Maybe this dramatically ratchets up the risk taking, along the lines of, ''if someone comes along, I'll just do it". And they might be rationalising this by saying, "Even if I get something, maybe I'll die of old age after all, what with all the cures and everything".

8.7.7 Under the influence of alcohol/drugs

We saw previously that environmental and interpersonal pressures lead to alcohol and other drug use, and to sex when drunk.

As Table 37 shows, four in ten survey respondents have been sometimes, most times or always under the influence when having sex with men in the last year. It is reasonable to believe that this is resulting in significant condom non-use.

TABLE 37: WHEN RESPONDENTS HAVE BEEN UNDER THE INFLUENCE OF ALCOHOL WHEN HAVING SEX WITH MEN, IN THE LAST YEAR

Regularity	No.	%
Always	7	3%
Most times	15	7%
Some times	71	32%
Almost never	38	17%
Never	92	41%
No answer	61	
Total	**284**	

8.8 Inaccurate assessments

The social marketing model is based on the proposition that people, provided with accurate information, will assess the costs and benefits of change and eventually act in their own self-interest. Despite modern cynicism about the nature of human nature, this is proved by a great amount of successful health education campaigning to be a sound proposition.

However, where it falls down is that people, given imperfect information, can make faulty assessments of costs and benefits: if they don't like the proposed behaviour change, they tend to inflate the costs and deflate the benefits of change. They also tend to inflate the benefits and deflate the costs of their current behaviour. If enough people feel the same way and talk to each other about it, these inaccurate assessments become more widely-held myths.

In terms of STIs, this results in many men assessing their risk as lower than it is, or could be. Note our 'could be' qualification: while 'my partner is clean' may well be an inaccurate assessment, it might equally be accurate and thus protect the man, particular when combined with other strategies.

8.8.1 Don't worry / think about it

Many interviewees felt that there was a very low awareness among straight men of the need to use condoms to prevent STIs. They felt that although there is plenty of information available in the background, condom use and safe sex are not issues for many straight men (and straight-identifying MSMs). This would suggest that the number of MSMs who just don't think about catching an STI is a lot higher than in the survey results.

Many respondents observed that for many men, it just doesn't matter. 'They just don't consider that safe sex is important', they ignore it', they're not interested' and 'they just think it will all be OK' were some common responses. As respondents said,

> 'I think that gays are generally more conscious. Bis don't see the need for them. They don't use them with women, so why should they use them with a guy?

> 'Lots of guys are too ashamed to talk to anyone about condom use. And it certainly doesn't occur to them to negotiate about it.'

> 'Because they don't talk about it, I don't think they perceive it. We are told repeatedly by guys on beats to shut up, all they want is sex.'

Others just simply haven't thought about it. As one respondent said,

> 'The key question to ask many men is, 'Have you ever thought that the person fucking you might have the AIDS virus'?

In terms of condom use, one respondent mentioned family planning research that indicates condom awareness and use is high among boys who leave school, but then slowly drops off the radar. Another suggested that as many MSMs lead dual lives, information they know and act on in their private life may not carry over into their secret life. And if it does, as one respondent reported, condoms are for stopping babies, and so not relevant for MSMs:

> 'I get the feeling that some younger heterosexual men might see condoms as things to stop babies with, rather than to stop STIs, that it's a birth control device only. We need to raise the profile of condoms as a way to prevent STIs' especially among young people.'

8.8.2 'It won't happen to me'

The first group of common assessments that can be risky are for MSMs to believe they won't catch anything. This can be for a number of reasons.

'IT'S A CITY POOFTER THING THAT DOESN'T AFFECT ME'

Many respondents reported that MSMs felt doubly-protected by not being gay, and not living in the big cities. Despite their behaviours, they see themselves as being a low or no risk group. As three respondents said,

> 'Most don't know anything about safe sex or STIs and especially HIV. They see it as a gay thing that doesn't apply to them.'

> 'Most are aware of AIDS and are concerned with it at some level, but there's an attitude that "It's a city poofter phenomena, and I'm not a city poofter".'

' If you're not gay, you can't get HIV. Only gays get HIV.'

One respondent pointed out the obvious problem this poses for health educators:

'A while ago, there was coverage on the news about the increase in STDs in Queensland. The pictures were of two guys holding hands walking along. These straight MSMs thinks, "Oh, that's gay stuff, it's a gay disease, it doesn't have anything to do with us, we don't have to worry about it".'

'I HAVEN'T CAUGHT ANYTHING SO FAR'

Several respondents reported the belief that, the longer a man doesn't catch anything, the more likely he is to feel he won't in future. As three respondents said,

'The thinking is that "If my history of catching something is low, then I expect that it will stay low".'

'They usually have a low level of worry about infection. It often comes as a great shock to them when they get an infection. Many seem to have managed for years without getting one. So the older men have an "it won't happen to me" mentality.

'Everyone's aware of STIs, but the myth is, "it's not going to happen to me", and equally, "You won't catch anything from me".'

As Table 38 shows, six in ten survey respondents have never had an STI, and might therefore feel their chances to be low. If their previously-treated STI is long-gone, they might also feel the same way.

TABLE 38: STIS RESPONDENT S HAVE EVER BEEN TREATED FOR

STI treated	No	%
None	168	62%
Gonorrhoea	30	11%
Chlamydia	15	6%
Warts	15	6%
Hepatitis	11	4%
HIV/AIDS	11	4%
Syphilis	11	4%
Herpes	8	3%
Don't know	2	1%

A variation in this thinking among gay men is the 'boy who cried wolf' syndrome. As one respondent said,

'Older gay men have heard the safe sex message for so long now, like a million times, that they've sort of written it off, they believe that it won't happen to them.'

'I DON'T HAVE MUCH SEX'

As we saw in Table 35, a significant number of survey respondents think their risk is low because they don't have much sex. As two respondents said,

'They think, "It's not really happening to me, I'll never catch anything, it won't happen to me. It's just something that happened at lunchtime. It's only once".'

'Some of them think that their low level of contacts protects them: "I only have sex three times a year, so I won't get anything".'

While those who know how Russian roulette works might smile, it is important to consider how this assessment works for the remote, isolated, straight-identifying MSM. The sex is infrequent; it is compartmentalised off into a moment's relief; everyday reality is macho, ocker. There is no reinforcement for any sense of risk. In the dry, dusty cattle country or in the mines, 'not much sex' may well seem like pretty effective protection.

'HE LOOKS HEALTHY'

We commented before that the 'clean partner' strategy is a popular way of reducing risk. His cleanliness might be assessed by what he says, or how he looks. As two respondents said,

> 'The most common myth is, "He looks really healthy, so he can't have AIDS, so I'll fuck him without a condom".'

> 'I know a guy who came from Sydney, has a partner, bare backs and hasn't been tested for two years. He says that if they don't look like they have HIV, then they mustn't have it. It's hard to know if this is a sincerely-held belief, or if it's just rationale for something he wants to do.'

Indeed, it's hard to know. As Table 39 shows, eight in ten survey respondents think they can't tell by looking at someone if they have HIV.

TABLE 39: AGREEMENT WITH PROPOSITION THAT 'YOU CAN'T USUALLY TELL BY LOOKING AT SOMEONE IF THEY HAVE HIV'

Agreement	No.	%
Strongly agree	150	67%
Agree	26	12%
Not sure	15	7%
Disagree	8	4%
Strongly disagree	26	12%
No answer	59	
Total	284	

Respondents reported some ways that men conduct the inspection:

> 'Many people feel themselves to be good judges of "who might have it [HIV/AIDS]' … "I only root boys who haven't been around … I can pick who has it (skinny, covered in sores etc).'

> 'You can tell by the colour of their lips if the person has HIV … I have picked a few.'

> 'I've heard a number of men say things like "I only want to have sex with fat people, because they don't have the bug", or "I didn't wear a condom because he was fat".'

'Clean partner' is a popular strategy, and not to be dismissed. A vigorous, strapping young man in dirty overalls pulls up in a ute, dog and farm equipment on the tray, and strides into the car park toilet. He doesn't look like he's done this before. He certainly looks 'clean' The temptation – and the temptation to believe – is strong.

'I'LL HEAR IF ANYONE IN TOWN HAS ANYTHING'

An important variation of the 'clean partner' strategy in regional, remote and isolated areas is that, given the tendency for everyone to feel like they know everyone else's business, many MSMs feel they would know if anyone in town was infected – particularly with HIV. As two said,

> 'I stick to locals because I know what they're like. You can ask your mates who they've been with, and whether they have anything.'
>
> 'Safe sex doesn't actually happen. There's a myth that "I'm in a small town, all my partners are from here, no-one's got anything so I can't catch anything".

This strategy obviously has its problems. As one respondent said, 'then someone goes outside this supposedly closed circle and catches something, and they become vulnerable'. Another problem is that like all myths, it undercuts a condom-using culture.

'I'M YOUNG AND INVINCIBLE'

It's common to feel invulnerable when you're young. As two respondents said,

> 'The young ones, being young, think that they're bullet-proof, invincible.'
>
> 'The younger ones (under 20) have the same attitude as bi guys … they're impulsive, a fuck's a fuck, it's over and done with, they won't get anything anyway.'

'I'M EDUCATED, I WON'T CATCH IT'

Several respondents reported their belief that highly-educated people feel more immune from catching STIs, especially HIV.

'MY BEHAVIOURS ARE SAFE'

As we have noted previously, many men view masturbation and oral sex as safe, and so don't use condoms.

There are also particular justifications of unsafe behaviours by informed gay men. As respondents said,

> 'If he is a top, he likely thinks that his risk of infection is low.'
>
> 'The HIV+ person who gets fucked without a condom thinks that he won't infect the guy fucking him, because he's being fucked, not fucking. However, he may not realise that if he has a high viral load, he is more likely to pass it on. And he doesn't stop to think that the guy fucking him might give him something, like chlamydia.'

8.8.3 The culture doesn't support it

The second group of risky assessments are that their culture doesn't support safe sex. If is a particular concern that the notion of a safe sex culture may be losing out to cultures that accept sex without a condom – in both gay and straight cultures.

THE INVISIBILITY OF HIV

A very powerful force for safe sex in the 1980s and 1990s was that many men were seen to be dying of AIDS, which gave gay culture many reasons to be pro-condom. This force has largely evaporated. As two respondents said,

> 'There seems to be a collapsing level of adherence to safe sex. I think it's partly due to the invisibility of HIV: most people with HIV are well, and you don't see the "walking corpses" that you used to. Especially if you're young, you may not know anyone with HIV (or may not be aware they have it).'
>
> 'Because HIV hasn't blown out, and is invisible for a lot of people, they think, "Do we really have to do this any more?" So they throw away the condoms.'

'Complacency seems to have set in. The talk has been of declining rates for so long, there's now a new generation of under 30s who weren't around during the horror period.'

THE RISE OF BAREBACKING

The rise of 'barebacking' was commented on by several respondents. As one said,

'I think condom use was fine until about two years, when barebacking became popular, because it was seen that there isn't that much risk in it. So it's seen as adding a bit of a thrill, a danger factor, so why not give it a go?'

'I think gay men are increasingly becoming conditioned to fucking without a condom. On *Queer as Folk*, for example, some use condoms and some don't.'

NOT PART OF THE MACHO IMAGE

We noted previously the view that straight culture is perhaps less condom-friendly that gay culture. As one respondent noted,

'I think that heterosexual culture is a lot less condom-friendly, judging by the number of unwanted pregnancies that occur.'

One respondent went further, saying,

'Guys I have sex with have the macho image, and using condoms isn't part of that image.'

Further again, one respondent explained his belief that in some cultures, 'it's unmanly to wear condoms':

'I found in Indonesia and East Africa that an STI was a badge of manhood. As one man said to me, "I know all about STDs and condoms and HIV, but if I have sex with a prostitute, I want to get right in there". They seem to have a different view of life, which is, "If I die at 30 of AIDS, then so be it".'

THE DOCTOR WILL FIX IT UP

Before HIV, a key part of popular sex culture for men was that the consequences of an STI was a trip to the doctor: that you could have fun, be unlucky and drop by the pox shop to be fixed up. This tradition lives on for straight men. As one respondent said,

'People expect that if they catch something, there will be symptoms and they will go to the doctor and they'll be dealt with. They'll use their local health service, or they'll go to the sexual health clinic if it's something that's personal and confidential.'

It also lives on, in a new form for gay men. In the same way that seeing friends and lovers die of AIDS was such a powerful motivator for safe sex, it may well be that seeing people live on through more effective treatments is a powerful demotivator for safe sex: that the pre-AIDS days of 'the doctor will fix me up' are returning. As two respondents said,

'He thinks that if he does get it, then he can get treatments to keep it under control. In these ways, he rationalises and so denies the risks, and is no longer afraid of it.'

'There's complacency about safe sex. The treatments are increasingly seen as reliable.'

As Table 40 shows, one third of survey respondents had heard of PEP, and one third weren't sure. One survey respondent compared it to a 'morning after pill'.

TABLE 40: AGREEMENT WITH PROPOSITION THAT 'THERE IS A TREATMENT AGAINST CATCHING HIV IF I GET TO A SPECIALISED HIV PRESCRIBING DOCTOR OR MAJOR HOSPITAL WITHIN 72 HOURS OF BEING EXPOSED TO HIV'

Agreement	No.	%
Strongly agree	52	23%
Agree	20	9%
Not sure	72	32%
Disagree	8	4%
Strongly disagree	71	32%
No answer	61	
Total	284	

8.8.4 Combinations mean living with risk

When these assessments are jointly held (as they usually are), there is a more powerful perception of being at low risk. The combinations are endless: I might be worried about HIV, but the consequences are down from a death sentence to a chronic, manageable infection; there's more rationalisations and justifications not to use condoms; I haven't caught anything yet and don't know someone who has. Am I likely to use a condom? Probably not.

Some other combinations mentioned were,

> 'The het married men tend not to be as aware or concerned about safe sex. They think that "it won't happen to me", but they're not sure why. It's a combination of "I need to get this out of my system", "it's a one-off thing", "it won't happen to me' and "all the infected people are in Brisbane or Sydney".'
>
> 'The attitude is, 'It's only once, and you look alright'.'
>
> 'They get involved in complex rationalisations: "If I'm HIV-, I'm straight acting and I'm a top, then I won't use a condom because I'm straight. I assume I'm safe because I'm not gay, I'm fucking him and he looks fit and healthy (in the dark!!!) … that is, he doesn't look AIDS-wasted.'

At some stage, it appears assessments (or combinations of assessments) mean that the cost-benefit ratio is not enough to ensure behaviour change, and the man accepts the risk. This is a well known outcome in health education, and may be becoming increasingly common with safe sex.