9. Information and messages about STIs

9.1 Information does make a difference

Social marketing approaches seek to encourage behaviour change primarily through the provision of information and attitudinal messages at each stage of the spectrum we explained in the last chapter. This information needs to be targeted to particular groups at particular stages of change: as one respondent said,

> 'Messages need to be much more specialised. Education campaigns need to be much more strategic and appropriate to particular audiences.'

In the early stages, messages are primarily informational, to set an agenda, explain what the desirable behaviour is and the benefits of change.

In the middle stages, information must be more specific, to address particular barriers to action; and to explain the actions required. Motivational messages must also be used to address barriers.

Strategically, information and motivational messages generally aim to:

- create a supportive environment for behaviour change: that is, to create the impression or convey the actuality that the person's broader community supports the desired behaviour

- increase interpersonal pressure for change: often by giving friends, family or trusted advisors (such as GPs) the tools (such as minimal interventions) to work with the person to achieve change

- increase the person's belief in, and ability to, resist the pressures to engage in undesirable behaviour, and to take control of their lives.

Of course, to believe in the social change model, you also have to believe in the proposition that people will change their behaviour as a result of receiving information and motivational messages.

By way of testing this proposition, Table 41 shows, for respondents who had got information about safe sex, or identifying and treating an STI, what degree of difference it made to how they felt or acted. Three quarters of respondents felt it had made a lot of difference, or a bit of difference.

TABLE 41: DEGREE TO WHICH INFORMATION AND ADVICE MADE A DIFFERENCE TO HOW RESPONDENTS FELT OR ACTED

Amount	No.	%
A lot	41	25%
A bit	74	45%
No opinion	23	14%
Not much	39	23%
Not at all	30	18%
No answer	118	
Total	284	

Table 42 gives good reason to believe that providing information and motivational messages does make a difference to attitudes and behaviours. It shows that the most common response was pro-safe sex (to be more careful, and to have more safe sex, or always safe sex). The other most common responses were to increase personal empowerment (by raising confidence and assertiveness, and reducing concern and alarm), which is an important part of the behaviour change model.

TABLE 42: IF THE INFORMATION OR ADVICE RECEIVED DID MAKE A DIFFERENCE, HOW

Difference	No.	Common comments
More careful / cautious	19	about who I sleep with … about people not wanting to use protection … I'm more choosy now … I don't rim now … now I'm more aware, I never take risks … I want to be more responsible and careful, and look after myself better … increased education and awareness will always make one more cautious ...
More / always safe sex	18	I used more safe sex practices after getting information … I always use or ensure a condom is used for anal sex unless it is with my partner who I trust fully … I have started to use condoms more … I found out that a blow job is not safe sex: I would make sure now I had a condom on ... I don't rim anymore ... I made sure I wore condoms and used more lube ...
Less concerned / alarmed	12	I have an easier state of mind, therefore more pleasure … it clarified the relative risks of various sexual activities, put my mind at ease with respect to a couple of specific 'sexual' events … I just know what to do now and how to go about things … it was good to talk to someone ... it reassured me that I was doing the right thing ..... If anything it made me less afraid of HIV+ people ...
No / not much difference	10	I sort of already know the information because I have acquired it over the years … it confirmed my beliefs
More aware	7	I learnt some things I didn't know … it got me thinking about how I have sex with people, kept me aware and informed, in the loop, up to date …
More confidence / more assertive	6	I didn't care when someone didn't want to wear a condom, I just told them to leave … I was a lot more prepared and confident about being safe and using condoms, and I refused to have sex with someone who wouldn't use a condom, who looked unwell … more assertive and confident in making decisions ... made me feel as though I was not the only one out there looking for this kind of information ...
More concerned / alarmed	3	I think that the information made me worried since it was overly-cautious about oral sex. I mean, there are lots of people having oral sex every day without contracting STDs. I prefer information that is backed by reliable and quantified risk factors (e.g. 1 in 1000 participants in sexual activity x contract disease y). Then I can make an informed choice.
Vaccinations & testing	1	I got a vaccine for Hep A and B, started suggesting to sex partners who I know have many partners to get tested

This belief in the efficacy of interventions was reinforced by respondents, who believed that one of the most important interventions is to get across to MSMs that they are at risk: and that basic information has a powerful effect. As respondents said,

> 'HIV is a very significant risk at present. They need to be told, "You're at risk, you need protection".'

> 'With many guys, there's a real lack of awareness that they're in a high-risk group. MSMs are often alarmed when I tell them the figures about sexually-transmitted infections.'

> 'Quite a few ask about transmission risks … and I'm more than happy to frighten them.'

We saw in Table 41 above that information and advice received in the last 12 months had made little or no difference to about four in ten survey respondents. Presumably, this would often be because they learned nothing new in the last 12 months. This is consistent with Table 43 below, that shows that about half the respondents feel that they know as much as they need to know. This is not surprising with a sample, that tended to be gay-identifying. But equally, about half felt they needed to know more (or weren't sure). And, as the previous table showed, they may well change their behaviour if they do know more.

Table 43 also shows that almost one third of survey respondents do not feel they know enough about recognising an STI. Given that this is fairly basic information, it may be that there is an unmet demand for information (which is also suggested by Table 44 below).

TABLE 43: AGREEMENT WITH PROPOSITION THAT 'I KNOW AS MUCH AS I NEED TO KNOW ABOUT RECOGNISING A SEXUALLY-TRANSMITTED INFECTION'

Agreement	No.	%
Strongly agree	42	19%
Agree	60	27%
Not sure	48	22%
Disagree	42	19%
Strongly disagree	28	13%
No answer	64	
Total	284	

9.2 What do they want to talk about?

As we saw at the start of this chapter, information and motivational messages need to be provided at each stage of the behaviour change spectrum. While these messages should be 'what we want to tell them', consistent with each stage, messages should also pay close heed to 'what they want to know', and why they want to know it.

9.2.1 About STIs

Table 44 shows what respondents talked about, if they talked to someone about safe sex, or about identifying and treating an STI. As well as talking about safe sex and STIs, the third most common theme was about dealing with their sexuality, and the fourth was around oral sex issues.

TABLE 44: IF RESPONDENTS TALKED TO SOMEONE, WHAT DID THEY TALK ABOUT?

Topic	No.
STIs generally	21
Safe sex	11
Dealing with my sexuality	7
Oral sex issues	6
HIV issues	4
General conversation	4
Didn't talk	3
Went for testing	3
Anal sex issues	3
Recognising symptoms	3
Medical issue	2
Treatment and diagnosis	4
Don't remember	1
General health and sex	1

Table 45 provides more detail about what they would like to know more about STIs, if they would like to know more. It shows that the most sought-after information is detailed information about STI transmission and prevention. Specifically, they want to know how to recognise symptoms in themselves and others; and they want greater clarity about the safety or otherwise of oral sex.

TABLE 45: IF RESPONDENTS WANT TO KNOW MORE, WHAT THEY WANT TO KNOW ABOUT STIS

Topic	No.	Typical comments
Nothing	23	Nothing … I know most of it … Not really keen on knowing more b/c I think it will spoil it for me. I won't be game to go near anybody …
Detailed information about STI transmission and prevention	21	Any information would be good … Just about infectious diseases, how they can happen and what you can get … what each of the STIs are and what long-term and short-term problems are associated with each and what treatments are available ... what chlamydia is ... what it looks like, how you catch it, how to treat it, and if it's totally curable ... the risk profile for different sexual activities … including how to prevent catching something … what are the risks of getting HIV through someone's semen … what realistically is the risk of catching HIV if you have brief anal sex without a condom in foreplay (prior to any ejaculation)
How to recognise symptoms - in yourself	11	What are the real step-by-step signs that you might have any of the infections? More details are needed. Not just skirting around the problem with general things like 'a rash'. What does it look like? There are thousands of different rashes.
How to access services confidentially	8	where I can go confidentially to get tested for HIV without having to give my name or details … where I can go confidentially to get tested for HIV without having to give my name or details …
How to recognise symptoms - in others	7	About if the person I am having sex with has a disease' … What the symptoms look like. You could use this to check out the other guy and protect yourself. They might say they're negative, but if the condom breaks, you're fucked … Perhaps some pictures of what infections look like or what symptoms should you be on the lookout for ...
Other	6	HIV vaccine trials … when it's safe not to use a condom for anal sex … the risk of getting cancer of the anus from having unsafe sex … the difference between genital warts and skin tags ... if you get HIV from docking (foreskin penetration) ... the effect of tongue piercing on HIV transmission ...
How safe is giving oral sex	5	What's the chance of giving a blow job & getting an STD (statistics) … I wanted to know if it was alright to swallow … How do I reduce the risk of catching diseases other than HIV/AIDS and Hepatitis C from sexual partners while performing oral sex? What are the actual risk rates and factors? I know that all activity carries some risk but that's part of life. If I have an operation to remove my appendix that carries risks but they are quantifiable. So what is the rate of transmission of disease and what groups of men, activities etc are more likely to increase the risk? ...
How safe is oral sex (role unspecified)?	5	
Everything / nothing specific	5	
How safe is getting oral sex?	1	
If what I know is current	1	

Interviewees indicated that questions are either specifically related to their immediate situation, or about STIs in general:

> '"I've got these lumps / this rash … who do I see about it?".'

> '"What is HIV/AIDS / syphilis / gonorrhoea? What are the different STIs (pox, clap)? How would I know if I've got them? How do they work? What do they do to the body? Do we have them in town here? Will they recur? Will I need follow-up?".'

While the survey shows demand for STI information, respondents were not sure about how strong this demand is.

> 'They don't ask much and don't say much. They're one time. They come in, report their symptoms, get a dose of medicine and move on.'

It's also worth noting their reasons for wanting the information. As respondents said,

> 'I find the 25-35 married ones a bit more open and inquisitive, especially if they've thought about it a bit. They ask about diseases. They don't want to take anything home. They have their wife and family and want to take care of them.'

> 'They search around for where to place the blame for their infection … "How could I get this? I'm always so careful".'

> 'What do they ask? "My girlfriend / boyfriend told me I have to get a chlamydia test. How much do you charge? I don't have a Medicare card".'

> 'I've had people come in hysterical over a cup that had some blood on it. Some of the advice I give is very basic transmission stuff. They haven't accessed the available information.'

Their comments remind us that while demand for STI information might be high among those who recognise their risk and want to do something about it – and among those who think they might have an STI - many MSMs aren't quite at that stage on the behaviour change spectrum. As one respondent said,

> 'I don't get much demand for information about STIs or safe sex: it doesn't come up on the first level of talking.'

> 'Some ask about police matters.'

9.2.2 Where can I get sex?

Not surprisingly, many interviewees reported that the main thing MSMs want to know is where they can find men for sex. As one respondent said,

> 'When we advertise to promote our (country support organisation), we get a very strong percentage that are looking for quick sex. They don't really want to discuss anything.'

9.2.3 Someone to talk to

We saw in Table 44 that 'dealing with my sexuality' was the third most-nominated topic of discussion. This supports the widespread belief among health educators that an effective personal response to safe sex depends on the person resolving questions and confusions about their sexual identity.

While many MSMs only want to find men for sex, others want information about where to meet men socially, not for sex. They want to know about social groups they can join, and where else they can have social contact.

9.3 Accessibility of messages

A key purpose of this research was to investigate whether or not current safe sex and STI information is accesible to MSMs. There are two elements to accessibility: physical accessibility and cultural accessibility.

9.3.1 Physical accessibility

Table 46 shows that eight out of ten survey respondents know where to go to get information about safe sex and recognising and treating an STI.

TABLE 46: AGREEMENT WITH PROPOSITION THAT 'I KNOW WHERE TO GO FOR INFORMATION ABOUT SAFE SEX AND RECOGNISING AND TREATING AN STI

Agreement	No.	%
Strongly agree	126	57%
Agree	50	23%
Not sure	18	8%
Disagree	16	7%
Strongly disagree	12	5%
No answer	62	
Total	284	

Table 47 shows how much of the information and advice that respondents wanted did they receive. About three-quarters of respondents received all or most of what they wanted.

TABLE 47: HOW MUCH OF THE INFORMATION AND ADVICE RESPONDENTS WANTED DID THEY RECEIVE

Amount	No.	%
All of it	78	37%
Most of it	75	36%
A bit of it	40	19%
None	16	8%
No answer	75	
Total	284	

Despite the high level of awareness among survey respondents of information sources and their satisfaction with information, interview respondents generally felt that information services were difficult to access. The difference may partly be explained by the significant number of survey respondents recruited through networks.

Interviewees felt that information should be easier to obtain, and that there was 'next to nothing' available in many places. As respondents said,

> 'In the small country towns, it's very difficult to get information about STIs. The phone book will refer you to Cairns or Townsville, but if you're in a remote town, there's nowhere to get that information.'
>
> 'The mine health service doesn't test for STIs, and don't provide printed information. It's mostly blokes here. There's information about pregnancy and breast cancer, but nothing about STIs'.
>
> 'There's nothing much that catches your eye, day-to-day … there's not enough visibility … there's not much available.'
>
> 'I know a guy in his mid-20s who lives in a remote beach township. He won't be tested, and won't take medicines because they're not herbal. He can't access the clinic because he doesn't have the transport or the money.'

Where information is available, it is usually not in the mainstream. It may be in gay meeting places. Or it may be in sexual health clinics, which people may or may not feel comfortable visiting (and almost certainly won't visit until they suspect a problem). As one respondent said, and as we have seen,

> 'These men have no connection to the gay community. They don't go to nightclubs or access QuAC. They don't identify with the gay lifestyle. They just have sex with other blokes.'

There is also the issue of literacy. Many written survey responses indicated significant literacy problems and reminded us that information should be very simple and very clear, and make maximum use of clear, unambiguous pictures. As one respondent said, 'Lots of people can't, or don't, read'.

9.3.2 Psychological accessibility / cultural context

As important as physical access to information is providing information that MSM can relate to, feel comfortable with and can share with others.

Table 48 shows that only one in ten survey respondents have ever seen words or pictures about safe sex that made them feel uncomfortable.

TABLE 48: WHETHER RESPONDENTS HAVE EVER SEEN WORDS OR PICTURES ABOUT SAFE SEX THAT MADE THEM FEEL UNCOMFORTABLE

Response	No	%
Yes	25	12%
No	181	88%
No answer	78	
Total	284	

Table 49 shows what it was that made them feel uncomfortable, where they saw it and why it made them feel uncomfortable. As we can see, responses fell into three main categories: gay images, graphic images of symptoms and (closely related to the second), information about the consequences of infection.

Interviewee responses, while confirming these factors (and adding some), indicated that these concerns are much more widespread than the very small number of survey responses would suggest. This is partly explained by the sample makeup but also because these factors may not cause discomfort with, so much as disconnection from the message.

TABLE 49: MATERIAL THAT MADE RESPONDENTS UNCOMFORTABLE, AND WHY

What was the info?	Where did you see it?	Why did it make you feel uncomfortable?
'Gay' images		
Explicit photos of men's arses in poster and talking about fucking.	QUAC office.	Sex is being so very explicitly pushed. It's embarrassing. I'm afraid of my sexuality perhaps.
Two guys wanted to have sex and didn't have a condom.	In a magazine	Straight people will say 'fucking poofters they do stuff like that.
"More guys have sex with guys than you think. Try it you might like it."	A photocopy of a Victorian AIDS Council poster sent to me by a friend.	Because it was put up in Victorian schools and seemed to be more of a recruiting poster than a safe sex message.
Pretty boy images		You find it harder to identify will full-on camp, feminine, out in the open people.
Graphic images of symptoms		
Pictures of diseases	in books	It's okay to be told about it but not see it … makes me feel uncomfortable
Pictures of diseased genitals	High school	They were obscene and looked painful and disgusting
Graphic pictures and direct words	In medical centres, gay venues -	It just presented the real fats of life if you play around

I have seen things I didn't like in videos	In videos at my friends place	Too graphic
Graphic photos of Aids	brochures, TV	Scary
Grim reaper ad	TV	Too graphic and a bit harsh, nightmares, very wrong.
About catching AIDS	Media	Who wants to die or infect partner?
Photos of diseases	Internet	Looked bad
Information about the consequences of infection		
Pictures of gonorrheae or syphilis on someone's penis that looked ghastly	Posters a sauna in Sydney	made you aware of what could happen if you did not take precautions … made me feel that I would need to be on the alert
Information about diseases / what they do to you	Pamphlet off doctor	Knowing that I could get affected by it I suppose
Pictures in material at Bodyline	Bodyline.	Because it made me afraid of all STIs
In a brochure about STIs	Doctors office	I found the brochure helpful but very graphic
Information about having sex without protection	In a magazine	Because I had had sex without protection, and it worried me
Other		
The new safe sex manifesto	Magazine ... Internet	Its fascist propaganda...It says gay sex is unacceptable outside monogamous relationship ... yeah right ... get stuffed!
General (straight) safe sex info	Nephew's high school project about condoms and safe sex	It assumed that all sex was between male and female couples
Condom adverts	Everywhere - on packets, newspapers, mags, TV	It's always heterosexuals advertised, not 'others'.
Safer sex brochures that say 'fuck'	QuAC	We are not animals. The language is demeaning
Information that oral sex is risky	In a book and online	It was overly cautious. Experience tells me that the risks are low, but I have no way of quantifying them.
'Dirty sex' to do with people doing strange things - not willing to elaborate	Video & books	To look at it on video at nightclub was sickening. I wouldn't have that kind of thing.

GAY IMAGES ARE UNLIKELY TO WORK

Many respondents felt that information aimed at gay men – which was felt to be the bulk of the information available – would not appeal to straight MSMs, or would turn them off. This information was felt to be posters, leaflets, postcards and other printed material with young, attractive men; heavily 'made over' men; and men having real or simulated sex or in sexually-proactive poses.

The main reason given for the lack of appeal was that most straight MSMs simply do not see themselves as gay. They do not identify with images of men in affectionate, and/or public, embrace. The underlying message of many materials is that it's happy, healthy and desirable to be gay which, as we have seen, is not an acceptable proposition for most regional, remote and isolated MSMs. As respondents said,

> 'My feeling is that very few of the safe sex posters in clubs or saunas work for 'heterosexual' men, because they picture two men together, and most of them don't identify being with together a guy. It's just a lust thing. '
>
> 'While the homoerotic images have some appeal for out gay men, they just increase the sense of guilt about being found out that most of these men have.'

> 'Posters of boys kissing won't work, it's "queer". You may as well have a picture of two gay boys with handbags.'

Even more, respondents felt that country men generally do not relate to the highly-polished, inner-big-city look of most gay imagery. Many are painfully aware (or implicitly understand) that their life choices haven't landed them in inner-city Brisbane or Sydney having endless male sex but living a straight life in a remote location.

A second reason why respondents felt that men don't relate to young, pretty, inner-city images is because 'put simply, most gay men aren't under 25 and pretty':

> 'Flogging pretty young boy imagery to older men doesn't work. These boys are usually unattainable by older men and aren't their choice of sex partner anyway, and their response can be anywhere from disinterest to resentment. If this imagery reminds them of a time when this type was attainable, and thus reminds them of their ageing and reduced desirability, it can be counterproductive.'

> "Most of the (gay-directed) material wouldn't appeal to the local jackeroo or hospitality worker; it's a big turn-off. The images are all of gorgeous, young, virile guys, and most blokes aren't like that.

Even young MSMs living in the country may not identify with the young, pretty, inner-city images:

> 'Drag queens, leather queens and screaming queens are the last people a nice young macho boy wants to be involved with. A farm boy might want to be on with a plumber or a builder, but certainly not with a manicurist'.

> 'Even my son, who is gay, won't read some of the stuff that's really gay. He thinks that it's trying to stereotype him as a particular type of gay man, and he finds that demeaning.'

So, given that MSMs wouldn't relate to 'gay' images, what would they relate to? Respondents were pretty clear with their ideas.

First, they might well relate to handsome men, even mild body imagery, so long at it is a straight, country setting. This might involve the outdoors, opening the possibility to some mild beat imagery. As respondents said,

> 'Out here' it's miners, ringers and football players. Stuff has to relate to the country life – the wide open spaces, cars, dogs. (Country MSMs) don't identify with the lifestyle in a lot of the material: if they do, they've already up and left.'

> 'For the "hidden" men, I think that beat imagery works, and body imagery, but not cute twink, muscle mary or camp body imagery.'

> 'They would presumably like the handsome men images. These men are experts in furtive behaviour, at looking at things that their wives won't notice. They might work.'

> 'Most of these men don't see themselves as gay, it needs cowboy images.'

These themes come together neatly in materials that respondents liked:

> 'One of the best posters I've seen was done in Vancouver and had two guys riding a horse together, in the style of the Marlborough man.'

> 'I really like the picture on the poster of two guys and a girl on a park bench, and the guys are holding hands behind the girl's back. The caption is, "'How many people are really in your relationship"? It says it all.'

> 'You need to have a man and a woman in an embrace with each other, and a man in the background, which is how most of them think about their male sex, if they think about it at all.'

One respondent suggested that the contact with their everyday straight life could involve storytelling, with plenty of opportunities to humourously address the ironies of MSMs' lives:

> 'The country people don't identify with the pretty gay boys They need to be more identifiable to mainstream people, with no beautiful models with fake sores. You need more mainstream people, telling real stories. It needs to be humanistic, and to address the denial . There can be a role for humour, too.'

In the country, a macho identity is assumed or enforced since early childhood and provides an accepted, secure place in a family and in society. While many country men we spoke to choose for these reasons to retain some or all of a macho identity, they have their work cut out reconciling that identity with their sexual and emotion interest in other men. Images and messages that imply 'gay equals drag queens, leather boys, cute young twinks kissing and hugging' leave them nowhere to go: they know they're not gay like that, and they know they're not macho either, so they're stuck in the middle, without role models or images of an identity to which they can relate.

RECOMMENDATION

5. That material intended for regional, remote and isolated MSMs avoid 'gay imagery' in favour of straight, country imagery.

GRAPHIC IMAGES OF SYMPTOMS, AND THE FEAR FACTOR, MUST BE USED CAREFULLY

The second and third of factors that made survey respondents uncomfortable were graphic images of STIs, and information about the consequences of infections.

The response may well be, 'that's what they're supposed to do', and in fact several respondents who found them disturbing acknowledged that was probably the intended effect. Yet one of the most enduring debates in health education is about the ethics and usefulness of fear as a tactic. If anything can be concluded from this debate, it is:

- fear is most effective as a short, sharp, powerful shock, preferably backed by heavy media support, to initially draw attention to the topic
- the fear needs to be credible to be effective (that is, a credible message that you will suffer the consequences from the undesired behaviour)
- the fear factor wears off with time
- there is a legitimate distinction between setting out to scare people into accepting them, and more dispassionately presenting them with the consequences of a behaviour and the means to avoid them
- care must be taken not to traumatise those who have already suffered as a result of the behaviour.

The Grim Reaper campaign, for example, was perceived to have succeeded on the first three and failed on the last two.

Interviewees reported that fear plays two important roles. The first is that the fear they may have caught something drives MSMs to be tested. As respondents said,

> 'Typically, someone has told them something … something has happened to make them think they might have caught something. Perhaps they've gone into a panic, or their female partner has gone into a spin. Then they want a test, they'll test till the cows come home.

The second, as we saw in Table 49 above, is that telling them the consequences of unsafe sex makes them fearful. As respondents said,

> 'The short talk I give guys who ask about STIs is a really scary eye-opener for them. I think it's enough to scare some of them back into the closet. They're scared of the consequences of taking any of that back to the wife.'

> 'The hottest topic recently has been the 30% increase in new HIV diagnoses. People wanted to talk about it: I believe it made them think and changed behaviours. But I'm not sure how long the effect lasted. Figures like these should be promoted more broadly.'

Several respondents reinforced this notion that presenting people with information about the risks and possible consequences of unsafe sex was important. As they said,

> 'There's been a lack of communication in not keeping people up with the infection numbers. I haven't heard of the infection rates for a long time. The infection rates for both gays and straights should be publicised. People need to be made aware that it's on the increase.

> 'It's important to have safe sex material that spells out the ramifications for partners and friends if they don't practice safe sex. What's going to happen to your wife and children. Even though they might think that "it's not going to happen to me", or they don't think about it, when you get them to think about the impact it might have on the family and children, it has a lot more impact and effect. But it's important that you do it in a way that feeds more into their sense of guilt and anxiety about having sex with men, and don't use scare tactics.'

MESSAGES MUST AVOID SHAME , STIGMA, EMBARASSMENT

We have seen throughout this report the personal, interpersonal and environmental pressures that MSMs face in regional, remote and isolated Queensland: the credo that, as one respondent said, 'Poofter equals stigma, shame, denial, secrecy and being scared'. It is very important to recognise that this sense of shame lies very close to the surface, and can be easily uncovered. As one respondent said,

> 'For many men, to even discuss STIs or safe sex violates their desire to put their homosexual sexual activity in a box and close the lid tightly; it makes them face the fact that their behaviour is homosexual. Unless, it's put in a way that does not imply homosexuality, they won't access it, because they'll have to face the fact that their behaviour is homosexual.'

Sex is a difficult topic for most people, and we have seen how there is a general reluctance especially among older country men, to talking about sex. As one respondent said,

> 'Even going to the chemist can be quite daunting. I know of a guy who went to a chemist for a pubic lice treatment, but because he was so embarrassed, he didn't understand the instructions, didn't dilute it as required and gave himself nasty burns.'

MESSAGES SHOULD NOT CAUSE OFFENCE

A general feeling expressed by respondents is that many people find explicit images and language offensive. While bad language is now a virtually-accepted part of city culture, this does not appear to be the case in regional and remote Queensland, where the attitude is 'it might be all right in the pub at the workshop, but it's not OK in front of ladies and children'.

Plenty of people object to bad language. As one respondent said,

> 'The language that gay material uses is completely inappropriate for straights. The language needs to be modified, to take out the f… and c… words. I took some home to show my husband and he thought it was really rough, really rich. He said, "That sort of talk is OK if you're in a group of mates at the pub, but not in a brochure that anyone can pick up".'

'Surely the subject matter can be covered without any of the swearing and bad language. The general public are put off by filth.'

'Recently I was speaking to a mother of a boy who has just come out as gay, and I couldn't find anything satisfactory to give her. If I'd shown her some of the explicit gay stuff, I would have upset her even more than she was already upset.'

'Much (of the available information is explicit, and explicit language might be "too much".'

As well as causing offence, such approaches feed perceptions that these are 'only gay issues', which both marginalises them and denies a wider public important information. As respondents said,

'Material for the general population would have to be toned down a lot on what is available through gay newspapers. A lot of hetero people would consider the material in gay papers as distasteful and trashy. And a lot of parents would be concerned about the information corrupting their kids. Some safe sex literature is explicit, describing genitalia and sex acts; you couldn't possibly put it into mainstream publications.'

'Many doctors won't put out my gay men's material at their reception. It too explicit: they don't want young people who come in to be exposed to it. Doctors usually have it, but people who are seeing a doctor for something aren't going to take it from a doctor, either.'

'The only place that we can put up posters of gay boys are in the director's office!'

'I was putting up a display today in a public area and they took me aside and asked me if there was any explicit information that would offend. Because I'm from sexual health, they made an assumption that there would be bad language in the display material.'

'The more explicit posters, particularly the two boys having sex one, can't be used anywhere except specific gay venues, which we don't have here. In any other setting, most people would be offended by these images, and would complain.'

RECOMMENDATION

6. **That materials avoid the use of colloquial language for sex terms, and recognise the offence that 'bad language' gives to many people.**

MESSAGES SHOULD BE 'TAKE HOME'

All of these concerns with available information can be summed by simply by saying that they can't take most material home with them. Shame, fear of disclosure, embarrassment and possible offence all combine to make much information except for private viewing. As respondents said,

'They would be terrified of taking home the material that's available here, such as postcards with boys sucking each other off.'

'Good material wouldn't use labels, so that there's no stigma to reading it. It has to be something that they don't feel guilty reading. It would be a general safe sex message that could be read by anyone.'

'There should be ordinary images, including images of older men, and family images.'

'There needs to be a much broader, community-wide safe sex message. If it is seen as a gay community thing, then it's not going to work with these men.'

At first sight, this situation might look impossible:

'The ones who go to Brisbane get the gay newspapers there. They smuggle them home, read them, then get rid of them. It's tricky for them to take any information home, however bland, in case they get asked "Why would you need this?".'

However, as another respondent said, it should be possible to address the 'why would you need this' question, and the possible reaction from children. As two respondents said,

'The real test would be whether they could take it home: it's a big ask, given that there's a risk that someone might find the material, and that these men are already concerned that someone might find out their secret. The question is, 'What sort of materials and campaign might these men design for themselves? It would probably be more covert, much less "in your face" type of stuff.'

'Some guys won't take home material because of concern about what their kids will think. But kids these days need to know as much as anyone else. There should be advertising in mainstream, local community papers. There's probably be some reaction from conservatives to kids being exposed to sex material, but how else do you get it out to everybody? '

9.4 Avenues for the delivery of messages

Table 50 shows where respondents have gained information about safe sex and STIs in the past year.

TABLE 50: WHERE RESPONDENTS HAVE GAINED INFORMATION ABOUT SAFE SEX AND STIS IN THE PAST YEAR

Source	No	%
Brochure / leaflet	120	56%
Local doctor / SHS in own town	81	38%
Internet	73	34%
Friend / word of mouth	52	24%
QuAC	47	22%
Newspaper / magazine	42	20%
Sex partner	41	19%
Local paper	31	14%
Radio/TV	31	14%
Phone service	25	12%
No-one	25	12%
Doctor / SHS farther away	23	11%
GLWA	14	7%
Not interested	9	4%
Workmate	7	3%
No answer	70	

Table 51 shows what respondents think would be good ways to get information and advice about safe sex and STIs.

TABLE 51: WHAT RESPONDENTS THINK WOULD BE GOOD WAYS TO GET INFORMATION AND ADVICE ABOUT SAFE SEX

Medium	No.	%	Typical comments
By Internet	27	17 %	Easily accessible sites on the net ... gaydar.com … a website that doesn't beat around the bush with technical meanings and words … on Internet porn sites

Through doctors / health clinics / hospitals / health education workers	21	13 %	I have a female doctor and I can talk to her about anything and I feel comfortable … educate doctors and get them to talk … greater exposure of the sexual health clinic would also help. A lot of guys may not know they exist or their location or that the service is free …
By phone	11	7%	Over the phone, because it's more confidential … possibly a number that you could ring up if you feel unsure about if you have contracted a disease and get good advice and information and a referral of where to go to … in the first instance, I found over the telephone to be the most satisfactory: It's immediate, it's fairly anonymous and no one questions what comes in the mail ...
TV advertising	6	4%	Late night TV advertising …
Radio advertising	6	4%	
By mail	6	4%	By post, in an unmarked envelope
By emails	6	4%	An email newsletter
At gay venues	6	4%	
On radio	4	3%	
Through schools	3	2%	More information should be provided to high school students from a younger age than grade 11 …
At QuAC offices	3	2%	
Newspaper ads	2	1%	
At adult bookshops	2	1%	
In public toilets	2	1%	
In men's magazines	2	1%	
With condoms	1	1%	Information in condom packs, free condoms handed out in clubs, unis …
At shopping centres	1	1%	
Through community groups	1	1%	
With gay magazines	1	1%	Explicit brochures should be included with the freebies …
In Yellow Pages	1	1%	
At council libraries	1	1%	
Format	**No.**	**%**	**Comments**
TV programs	17	11 %	Documentaries …
Brochures / booklets	16	10 %	Booklet form, being able to have all types of STIs in an easily read booklet form with pics and facts signs and symptoms, easily read and easily viewed …
Newspaper articles	9	6%	
Posters	4	3%	
QuAC outreach activities	4	3%	Peer education, beat outreach … QUAC having more of a presence at venues, beats (Beat Outreach) … QUAC man to man weekend was brilliant
Gay press articles	2	1%	
Pocket cards	1	1%	
Street signs	1	1%	
Other			
Don't know	6	4%	
Continue as now	2	1%	Continue doing what you are doing …
Somewhere to go	2	1%	A drop-in centre for all groups (gay, straight, drug users, etc) that has info for all on as much as can be given … actually having somewhere in the town that I live in to go to! …

9.4.1 Sexual health clinics

The two tables show that among survey respondents, brochures and general discussion – through sexual health services and GPs - are by far the most popular ways of getting information about STIs and safe sex.

Interviewee respondents, while supporting these avenues, doubted how many MSMs use sexual health clinics. Two typical comments were:

> 'Most of these men would be too scared to go into the SHC.'

> 'There is a very low uptake of testing offers. Men feel the risk of being outed, and being identified as a MSM, if the go into the clinic.'

This research did not seek to evaluate clinics or their services. Generally, the impression was gained that a wide range of respondents considered them to be a useful and valuable service. It was, for example, noted that clinics generally are the biggest distributors of condoms in regional and remote areas. However, certain issues were raised.

Stigma and embarrassment to come together when contemplating a visit to some sexual health clinics. As one respondents aid,

> 'Some sexual health clinics put 'sexual health clinic' in big letters over the front door. I'm not sure why: it's pretty clear that that's a major disincentive for many men in country towns to go to the clinic.'

Such labelling forces men to identify to themselves, as well as to others, that they need sexual health services. Even if an unsigned or differently-signed clinic is widely known to be a sexual health clinic, the degree of ambiguity and uncertainty (Perhaps people will think I'm lost? Perhaps I'm looking for general health services?) that is possible with an unsigned clinic lowers the barrier to MSMs seeking services.

PHYSICAL ACCESSIBILITY OF MATERIALS

We observed one waiting room where clients could browse and take material without being overlooked, but in others they could not. As one respondent said,

> 'There are brochures in waiting rooms, but people won't access them if there's a room full of people, or if there's a perception that someone might be looking or watching them. If there are other people in view, it's almost guaranteed that people won't take the material.'

In one health centre mentioned, material is available, but not accessible:

> 'The safe sex pamphlets get hidden away in the health centre, among the ones about pot smoking, drinking, eczema and so on. You'll never find them. It doesn't need to be rammed down people's throats, but it needs to be more visible.'

PRESENCE OF GAY OFFICERS

Most clinics we visited employ openly-gay men, and it was respondent's impression that this enables them to establish more effective rapport not only with gay-identifying MSMs but with other MSMs as well. However, their 'gayness' is an implicit, rather than an explicit, requirement for the job. In regional and remote locations, they appear to be informal community-health liaison officers, often undertaking considerable duties and large workloads on activities that could be argued are important to promoting health but are not recognised as such. These informal arrangements can be contrasted to, for example, the formal arrangements for LGBT police liaison officers. Such formalising of arrangements facilitates the more formal placing of gay and lesbian issues on departmental agendas, and the resourcing of responses to issues. As one respondent noted,

> 'There should be dedicated (gay) officers in Queensland Health. There are for women and Indigenous people. There is no position where being gay is an explicit requirement, although there are quite a few positions in sexual health where it's an implicit requirement.'

PROMOTIONS

Generally, a visit to the sexual health clinic is a gloomy prospect: a trip to the 'pox shop' is hardly something to look forward to. While the facilities we visited looked modern, with friendly staff, their image remains problematic. There would appear to be opportunities for greater promotion of the benefits. Respondents identified these as:

- increased focus on health, rather than disease
- the service as ''fast, confidential and free … no Medicare card and no money needed'.
- the availability of free condoms
- help to improve sexual performance and overcome sexual dysfunction.

It also appeared that promotion of the sexual health services tends to be low-budget, occasional and to rely on the good efforts of staff, rather than of marketing or communications professionals. As one respondent said,

> 'Health centre outreach into the community suffers from spasmodic and occasional efforts and is not easy to sustain over the long term, particularly with staff changes. Often a community health centre will be staffed by agency nurses. Projects come and go, for political and administrative reasons.'

EVALUATION

There would appear to be a need for general community and client research into the sexual health clinics.

We are not aware of any community research done about the service. Such research would answer questions about community knowledge of, and attitudes toward, the services. We are aware of some evaluation activities, but these appear to be informal, occasional and to be conducted by staff. There appears to be no statewide policy or action on evaluation.

ADDRESSING PROVIDER ISSUES

Respondents also felt that a number of internal issues affecting the relationships of clinics and other agencies needed to be addressed.

First was the need for better service coordination. As one respondent said,

> 'There needs to be much better coordination between services, with workers in different services in collaborative partnerships. We have to bring service managements together, then bring together teams of educators and treatment people.'

> 'We need a combination of strategies across services. We need the face-to-face contact through beat outreach. We need a sexual health presence in local health centres in remote places, like a male nurse from the SHC who goes there for a week at regular intervals and who is advertised as an out-of-town, confidential service.'

Second, as was mentioned before, respondents felt that clinics needed to work more closely with mental health staff, so that they could improve their diagnoses of MSMs and refer them more effectively to sexual health clinics, and to counsellors where they are available. As one respondent said,

'I had a transsexual referred to me because she had tried to commit suicide. She's been ostracised by both men and women. And yet she was referred to me in my capacity as a volunteer . The mental health unit don't understand sexuality issues and don't assess properly. And because they have a very high staff turnover, the clients get sick of telling different people the same story, so trust breaks down, too. The mental health service used to be much better.'

Third is the need to increase awareness among Queensland Health staff of issues affecting MSMs, and to increase support for their own employees. As two respondents said,

'I think Queensland Health should work through existing health staff to increase education and awareness of the issue. All our staff are married, straight locals who would be as shocked as the families of these men to know that straight, married men have sex with other men. They would understand married men having sex with women, but with other men would be too wild to think about.'

'I'm a Queensland Health employee, and I think they should do more to support their gay, bi, lesbian employees. I don't think they do enough. We've got working parties looking at all sorts of issues, but no working party looking at the needs of gay & lesbian employees.'

RECOMMENDATIONS

7. **To improve accessibility and the sense of confidentiality, that Queensland Health sexual health clinics do not prominently identify their premises as sexual health clinics.**
8. **That clinics provide areas where materials can be confidentially viewed and the means to confidentially take materials away.**
9. **That Queensland Health formally recognise the importance of gay-identifying staff at clinics.**
10. **That clinics, in promotions, focus more on the benefits they offer the public.**
11. **That there be statewide policy and action on evaluating the operations of clinics.**
12. **That Queensland Health establish formal links between mental health and sexual health clinics, to better coordinate the services provided to clients.**
13. **That Queensland Health provide education and training for relevant staff about issues affecting MSMs.**

9.4.2 General practitioners

Tables 50 and 51 above also show GPs as being a primary source of information. Respondents felt they would be more important than sexual health clinics, which would stand to reason, given their far greater geographical spread.

Although it can be an extremely fine line for MSMs, there is a difference between getting information about STIs and safe sex and talking to a doctor about having sex with men. Table 52 shows how respondents feel about talking to a health professional about having sex with men. While almost two thirds feel they can, one third feel they can't – or are unsure.

TABLE 52: AGREEMENT WITH PROPOSITION THAT 'I FEEL I CAN TALK TO A HEALTH PROFESSIONAL ABOUT HAVING SEX WITH MEN'

Agreement	No.	%
Strongly agree	90	41%
Agree	52	24%
Not sure	26	12%

Disagree	25	11%
Strongly disagree	25	11%
No answer	66	
Total	284	

Interview respondents reported similar mixed feelings: that while they personally felt comfortable with health workers, they doubted that most MSMs would. As respondents said,

> 'Most men I deal with would go to their GP, and would have disclosed to their GP. They don't have a problem with that: the response appears to be usually favourable.'
>
> 'I don't think many of these guys are talking to their GPs; it would be a very small percentage.'
>
> 'These men are isolated and, depending on the location, vulnerable. They are unlikely to access services when they have to reveal themselves (such as in a one-doctor town). However, some doctors are good, and are tuned into sexual health issues and issues for MSMs.'

On the positive side, GPs, sexual health workers and general health workers were felt to be obvious points of contact for information, indeed the only sources in many places. But whether MSMs use them would in part depend on whether the safe sex and STI transmission material could be obtained without revealing the homosexual behaviour. Given that most MSMs would have no idea of how the conversation with the health worker would unfold, the answer is probably not.

The issue is not so much whether they expect the GP to be hostile or not, as that the conversation is outside their comfort zone. As two respondents said,

> 'I don't think these men would tell the GPs in town. It's not that they'd be hostile, but it would be way outside their comfort zone. With the GPs in Cairns being 'gay friendly', I think they would probably go to Cairns.'
>
> They would find it humiliating to tell their doctor. The thinking would be, 'He knows my wife and family. I see him in church. Now I'm bleeding from the bum and I think I have AIDS. My whole world is falling apart. I'll have to leave town or kill myself.'

Their comfort zone is enlarged if they have an expectation they can trust the doctor, and that he or she will be supportive. Respondents were divided as to whether MSMs would receive such a reception. Some respondents thought they would:

> 'They might talk to a doctor, a nurse or a friend who's a social worker or in one of those types of jobs. If the trust is there between the man and the other person, they are more likely to open up … and even more so if they think they will get some support.'
>
> 'IIt's important for GPS to be seen as MSM-friendly, non-judgmental and with lots of knowledge, worth talking to. Queensland doctors used to have a little sign on their desk saying, "You can talk to me about sexual health". That was a good idea.'

Other respondents thought they wouldn't:

> 'We had a medical superintendent here some time ago who told two gay guys that "We don't want your type around here … get out of town". That sort of homophobia just drives guys underground, they just don't want to mention it.
>
> 'I'll give you an example not from Queensland but from Western Australia in the early 1990s. I was in (a mining town of several thousand people). I was unsure about my sexuality and the only person I could think of approaching was the local GP, there being no counselling services. He sat stony-faced listening to me, and finally said, "I can't help you. We have a paediatric specialist who comes up here once a month

who might be able to advise you". That person basically didn't know anything, but told me, "It's something that you're going to have to work out by yourself.". I get a sense that country towns are still like that, unless the town has a sexual health clinic.'

As the last quote indicates, there's also the question of whether or not the doctor is trained, experienced and empathetic enough to provide anything other than basic services to MSMs. Respondents had many concerns about counsellors who weren't up to the job, and pointed to some of the problems that face counsellors dealing with MSMs.

'I suspect that most GPs have little understanding of the lives of their homosexually-attracted clients and don't understand the more complex issues such as the mental health issues. I've heard of responses from GPs like, "If you're gay, you must be depressed. Here's some valium. You'll need to take them for the rest of your life".'

'There was a guy who was diagnosed as HIV+ and throughout the diagnosis and treatment, no-one asked him how he thought he got it. They assumed that he was gay, but they never asked him. They weren't comfortable with it. They can do a great medical and surgical history, but they can't do a sexual health history.'

'Many (straight) professionals think they're qualified to counsel gay men because they've known a gay man as a friend or a family member. But they usually presume the heterosexual paradigm: find the right person, fall in love and have 2.5 pets. For most young men, that's setting them up to fail, it's bad counselling.'

'Gay men have great difficulty getting practical relationship advice from counsellors. First, there's the need to address the quite unrealistic desire of many men to have sex, and a relationship, with 'the perfect man'. Second, gay men need to be counselled about the importance of having a close group of people, their family, with whom they can share the joys and sorrows of life, because this will be the reality of many gay men's lives, rather than a long-term, permanent partner. And also, we need to talk to gay men about the myth of monogamy. Most gay relationships are not monogamous. By pretending that they are, partners tell lies, which breaks trust, which is usually far more damaging for a relationship than the infidelity.'

One counsellor, who is a volunteer, talked about the challenges he faces:

'The quality of the counselling depends on the individual. There is no training, no course, no handbook. And some of the challenges are quite hard. I had one recently two guys in their late 20s, early 30s had been drinking heavily, watched some porn, wrestled and the guy who phoned me was raped by the other one. The guy thought he was homosexual because he got aroused and orgasmed. He though he'd have to kill himself if he was gay.'

RECOMMENDATION

14. That Queensland Health work with professional associations to better understand GP attitudes and levels of information about regional, remote and isolated MSMs, with a view to improving the capability of GPs to provide services to these men.

9.4.3 Sexual health clinics, GPs and confidentiality

Given their fear of being discovered, confidentiality is a key issue for many MSMs.

First, there is the risk that they might be recognised visiting a sexual health centre or a GP. As respondents said,

'Most men are afraid to go into the sexual health clinic at the local hospital, because someone might recognise them. They're very concerned about anonymity.'

'Confidentiality is the major concern. They talk very little: they just want the treatment for their symptoms and to get the hell out. Usually they want to see a male doctor.'

'Hets are much less inclined to have a sexual health screening. It's highly unlikely that they will go to (the local clinic), because of the fear of being identified and outed.'

'This is a very closed little community. They're afraid of someone at the clinic seeing you there and "thinking that you are obviously up to no good" … they all want to tell tales on each other.

It appears that some clinics are prominently labelled 'sexual health clinic'. This would hardly encourage a MSM to visit. Others have taken a more discreet approach:

'The clinic in town goes by the name of Q Clinic. It's inside the hospital, and up the lifts, so its easy for guys concerned about confidentiality to access it.'

Second is the confidentiality of what happens in the clinic. Table 53 shows survey respondents beliefs about how confidential their discussions with doctors, nurses or sexual health counsellors will be. While three-quarters believed they would be confidential, one-quarter did not, or were unsure.

TABLE 53: AGREEMENT WITH PROPOSITION THAT 'ANYTHING I SAY TO A DOCTOR OR NURSE OR SEXUAL HEALTH COUNSELLOR ABOUT MY SEX LIFE WILL BE TOTALLY CONFIDENTIAL, AND WILL NOT BE PASSED ON BY THEM'

Agreement	No.	%
Strongly agree	129	58%
Agree	38	17%
Not sure	24	11%
Disagree	23	10%
Strongly disagree	8	4%
No answer	62	
Total	284	

It appears that many clinics recognise and address the need for confidentiality, and that this is paying off. As respondents said,

'It's a reputation that has to be earned. There are more guys coming in the door now. Hopefully guys will get confidential services and education and spread the word.'

'With STIs, people – whether gay or straight - are very concerned about confidentiality. If I write notes, I read back to them what I've written, or show it to them on-screen. They always ask how confidential it is, and whether anyone will find out.'

'The SHC offers a good service – all the tests are coded to ensure confidentiality.'

'The commonly-asked questions are "Will you tell anyone?", "Will this be confidential?". They ask for advice about what to do if someone recognises them here.'

On the other hand, many respondents raised concerns about confidentiality. One interviewee who was extremely concerned about being found out would not use the local sexual health centre because of confidentiality concerns. He understood the clinics policies and respects most of the people who work there, but felt that one or two might not be as careful as the rest. As he said,

'With due respect to clinic staff, it's only human to gossip, and it's only human to be a bit careless with other people's lives. I could be ruined very easily.'

It is useful to compare the confidentiality that is part of the beat culture with clinic confidentiality (such as, for example, not recognising people on the street). Several

respondents suggested that beat culture confidentiality is higher than professional confidentiality, because participants have a greater awareness of the consequences of breaches. This would suggest that training is needed for clinic staff in the overwhelming important ace of confidentiality.

Some other responses were:

> 'It has to be completely confidential. They won't get an HIV test from their GP, because of confidentiality. I can almost guarantee that a HIV test result from a GP wouldn't be confidential.'
>
> 'It's confidential but not confidential! Doctors still chat to other doctors, nurses and students.'
>
> 'I'm a Queensland Health employee - there's no hope of confidentiality!'
>
> 'In small towns, one feels uncomfortable talking about this stuff because one is afraid of being recognised by reception staff.'
>
> 'Living in a small town and being fairly well-known makes it hard, especially when friends and friends of friends work in the health care sector.'

Another way of addressing both confidentiality and increasing the comfort zone is to travel to another town to see a doctor, which several respondents reported doing. As one said,

> ' I know people who have had NSU and gone to Brisbane to have it checked up on. They wouldn't go to the family doctor about it. They tend to wait till the acute discharge stage before they do something about it.'

Finally, one respondent cautioned against too-great an emphasis on confidentiality, saying:

> 'There's a segment on the local FM radio station with a person from the sexual health clinic. It's very good, but I think there's too much emphasis on confidentiality. It's repeated over and over again, there's such a heavy emphasis. They need to show they're on the case, but not obsessed by it. If you keep going on about it, you can create fears rather than ease them.'

RECOMMENDATIONS

15. **That a statewide confidentiality policy be developed for all clinics, and that rigorous steps be taken to enforce it.**

16. **That clinic staff be trained in the importance of confidentiality, particularly with regard to casual or social lapses.**

9.4.4 Internet

As tables 50 and 51 show, the Internet is a popular and desired way of accessing information. Its privacy, confidentiality and easy accessibility were mentioned as benefits by several respondents, but challenged by others. As respondents said,

> 'A website is a better type of interaction for these men. Reading that you're a MSM is a completely different psychological space to talking about it with someone, however anonymous. A website is just interfacing with a machine: you don't have to declare yourself.'
>
> 'I don't feel there's a lot of Internet use. Guys in hetero households don't want to look up sex stuff on the Internet. There's a fear of who might be looking over their shoulder, or that someone might find out they've been looking at sex sites.'

'A web page would be the best way to communicate with men broadly. But there's a problem with the sex being spontaneous: I go down to the pub of a Friday and see the drunk straight men and think, "these guys would be up for anything". '

RECOMMENDATION

17. That Queensland Health establish a website to provide safe sex and STI information to regional, remote and isolated MSMs.

Our use of the Internet as a research tool was significantly hindered by the refusal of the two main 'gay' websites to enter into discussions about contacting men through their sites. Other health researchers also noted similar refusals, which are a significant barrier to using these information channels for health education purposes. As a result, researchers are required to use roundabout and opaque means to alert potential respondents of the existence of their studies. As the Internet becomes more important for communications with regional, remote and isolated MSMs, the refusal of these websites to cooperate in public health research activity will become of increasing concern.

RECOMMENDATION

18. That Queensland Health communicate with gaydar.com.au and gay.com to ascertain their policy toward the use of these websites for health education purposes, including health education research.

9.4.5 Someone to talk to

As Table 50 shows, one quarter of survey respondents got safe sex information through friends or word of mouth. They are perhaps lucky to have such opportunities: as we have seen, many MSMs don't feel able, or have the opportunity, to talk about safe sex.

Table 54 shows survey respondents agreement with the proposition that they want to talk to someone about the risks of having sex with men. This question can be (and presumably was) interpreted either as getting safe sex / STI information, or talking about sexual identity, or both; and that respondents had not had such an opportunity. About a third wanted to talk to someone, and one half either wanted to talk to someone or weren't sure.

TABLE 54: AGREEMENT WITH PROPOSITION 'I WANT TO TALK TO SOMEONE ABOUT THE RISKS OF HAVING SEX WITH MEN'

Agreement	No.	%
Strongly agree	44	20%
Agree	37	17%
Not sure	36	16%
Disagree	42	19%
Strongly disagree	64	29%
No answer	61	
Total	284	

Table 55 shows the reasons why respondents didn't talk to someone about safe sex, or about identifying or treating a STI, in the last year. Although this is a presumably an easier topic than their homosexuality for respondents to talk about, their answers and some typical

comments show fear of exposure and concern, shame and embarrassment as the reasons why they didn't talk to someone (apart from not feeling the need to).

TABLE 55: IF RESPONDENTS DID NOT TALK TO SOMEONE, WHY NOT

Reason	No	Typical comments
Don't feel the need to	23	Don't feel it's so much of a problem that we have to dwell on it …
Concern / embarrassment / shame	15	Concern about the effect on my position in the small community (e.g. ostracism) … I just want to remain private … I'm just not comfortable talking about man-to-man sex … it took courage and time to make the first phone call, but after that progression to a personal visit was easier ... some stuff was too private and also turned me on too much so I didn't discuss it (like docking) ... too nervous to talk to someone. would like to be able to do it discretely ...
Fear of exposure	9	I live in a small country town and it may not be totally confidential: If I did I'd go to another town … umm, talk to someone who'll blab?: are you kidding?
No-one to talk to	8	I didn't know who to talk to; besides, local sexual health clinic doctor is difficult to see as well as a difficult person to get the information I was wanting out of … I don't think there is a health professional in my local town that deals with sexual health matters ... it is difficult to find normal social workers in this area to talk about safe sex ... it never came up when I wanted to talk about it with a doctor, and I wouldn't make a special appointment with the doctor just for this, as it's too hard to get to see a doctor in regional Queensland ... not sure who to ask ...
Afraid to	7	Not game, no confidence …
Other information sources	4	

Fears and concerns about talking to someone should be acknowledged by counsellors and educators. As one respondents said,

> 'Face-to-face contact is fraught with difficulties unless sought by the man, or conducted by someone with experience or training in reducing the anxiety likely to be felt by the man (such as a beats outreach worker). Strategically, it should be avoided unless the type or goals of the intervention make it necessary.'

'There's no-one to talk to' was a point often made by interviewees, too. As two respondents said,

> 'The most important topics in a consultation are their sense of social isolation, questions about their identity, their loneliness and their desire to share the knowledge of a love object, because it occupies a large amount of their emotional space. They want to know, is it real? Are they crazy? Should they take this further?'

> 'We need to have somewhere for men to talk to other men. 'There comes a time when you have to get it all out of your system … you need to have somewhere confidential that people can pour their heart out.'

9.4.6 Phone services

As tables 50 and 51 show, telephone services are also popular and desired. As two respondents said,

> 'Phone services are well-accessed and utilised. They are discreet, anonymous and provide the opportunity to access information and get support. It also gives them an opportunity to talk.'

> 'The best, and possibly the only, way to get information to these men is through better telephone services. It is completely anonymous, it enables the person to ask questions and to focus on what interests them: it enables them to control the discussion.'

The telephone survey for this research used wording similar to that used to advertise the Queensland AIDS Council 1800 line: the advertising said only that, if you had sex with men, 'we would like to talk to you if you want to talk about it.'

Many men interpreted this as a line where they could find sex. Others had major difficulties continuing with the call after our researcher answered (as we saw earlier this report). As one researcher said in a project debrief,

> 'It was almost impossible to get some men to talk. No matter how engaged or encouraging I tried to sound, I'd often only get grunts or yes or know answers. Callers would hang up early in the interview, or the line would just drop out, or they'd say that they'd call back later.'

While phone lines might be a useful service for those with the confidence to use it, many MSMs do not appear to have such confidence. As one respondent said,

> 'It needs to go beyond the anonymous telephone counselling. A telephone conversation is problematic, because people don't want to speak the word, they don't want to verbalise what they're doing. Verbalising about it takes them into a new space that they're not comfortable with.'

Several respondents talked about the RRAP project line conducted some years ago. It was remembered as a valuable and useful service, particularly to coalesce local people into active groups. Problems with the line were also remembered. As respondents said,

> 'Originally, this was set up as a local service. Although there were some problems with the local services, at least you had a group of men who got together locally, which got something going here. Now there's nothing for the locals to do.'

> 'There was a perception that it was used as a pickup line, rather than a support and counselling service. That was a problem with using volunteers.'

Although the current QuAC line was mentioned (and indeed had been used by a quarter of survey respondents), it appeared to have a low profile among interviewees and some had mixed feelings about the service. As one respondent said,

> 'The AIDS Council 1800 number is good. People can discreetly phone it and get information. But the problem is that the people in the QuAC office often don't know the answers to questions. They offer to get back to callers, but that doesn't work. People need to talk about issues and to get answers on the spot, when they call. They don't want to be called back. And they don't want to wait till a group is formed in the area to talk about something – and they usually won't attend groups, anyway. It's often a frustrating service.'

RECOMMENDATION

19. That the QuAC 1800 line be evaluated, and that such evaluation include a comparison with the local lines offered previously.

We did not interview Lifeline counsellors so did not form a view about that service. However, it appeared that links between gay groups and sexual health services were limited, and several respondents raised concerns about the service. As one respondent said,

> 'I understand that they don't include HIV in their training programs which means that if the attitudes of their counsellors reflect general community attitudes, this would have implications for the counselling.'

9.4.7 Beat & other outreach

We saw in Table 50 that a quarter of respondents had received information from the QuAC. As well as the telephone service, this would also cover their beat (and other) outreach programs.

These programs were generally well-received as 'taking the message to where they feel safe and non-threatened.' However, it was also observed that beat workers can alienate MSMs on

the beat, who they see as 'killing the beats by scaring men off'. Significant problems were also raised in the voluntary nature of some of this work:

> 'Outreach, although with its benefits, also has its difficulties. It's hard to get volunteers, it's one of the least areas of interest, mainly because of the security issues and because volunteers don't like to get the reputation of doing the beats.'
>
> 'It's after hours, in the dark, risky work. If we're serious about it, we shouldn't be leaving it to volunteers, we should be paying people to do it.'

9.4.8 Mainstream media

Tables 50 and 51 show that mainstream media are well-used and desired sources of information.

Respondents wanted to see more information and advertising on TV and radio about safe sex and STI services available, particularly more mainstreamed information aimed at 'middle-of-the-road' men. And there should be an emphasis on men's magazines. As respondents said,

> 'The information has to be mainstreamed. There should be more condom use in straight videos. There should be more coverage in men's mags – footy, car, bike and fishing mags.
>
> Ads and articles should be in men's magazines … editors should cover that stuff. But it shouldn't focus on STIs, but on health issues that men are more comfortable with.

Respondents from sexual health clinics reported good rates of response from local radio advertising.

9.4.9 Schools

Several respondents were concerned about the apparent lack of sex education in general, and sexuality education in particular. As two respondents said,

> 'I understand that schools do address the AIDS issue, but it's a tiny part of sex education and being gay/bi/lesbian is never mentioned. And they can't talk privately, confidentially or supportively with teachers. Even in progressive schools, they say that it's not wrong, but they don't say that it's right. So there's nowhere at school where they feel comfortable going. There's a teacher that is very popular and that the gay students suspect is gay, but they can't approach him to talk about it.'
>
> 'I do some education in schools, and I'm surprised about the attitude of high school kids. They seem to think that people choose their sexuality when they get older; that they choose to be gay; and that you make yourself gay by conscious choice.'

9.4.10 Through local government

During interviews, local government was repeatedly mentioned in relation to MSMs: as custodians of public toilets and other beats, as providers of local health services and as potential sources of education (such as through public libraries).

Respondents were almost universally uncomplimentary about local government. As one respondent said,

> 'Local government should provide more services. Besides from a bit of work in immunisation and paediatrics, their efforts are pretty abysmal … non-existent. Their community development people could run workshops and face-to-face meetings with their staff, to improve their ability to address these issues. Local government needs to be convinced about the relevance of the issue, to get material more widely distributed.'

While many local government authorities are deeply concerned about the drift of people (often young people, and often the 'best and brightest') to the big city, respondents felt that they were painfully ignorant that their lack of respect for, and validation of, diversity was a major contributor to the drift. Isolated cities and towns may lack the facilities and diversions of the big city, but what they lack even more is the active and public support for diversity that would make people who are 'different' feel welcome to stay.

RECOMMENDATION

20. That Queensland Health work with local government organisations to determine how local government policies and services could be more supportive of regional, remote and isolated MSMs.

9.4.11 Other delivery mechanisms

A number of other delivery mechanisms were mentioned by respondents as also being desirable. They include:

- adult bookshops
- career information days (which have been used by one clinic)
- fridge magnets
- drink coasters (which have been used by one clinic, with one respondent feeling that they are 'great at getting the message out to regular, ordinary guys who drink in pubs'
- personal ads in the local paper
- pornography (which should carry safe sex messages)
- postcards with safe sex and local clinic information
- sponsorship of sporting events
- toilet door advertising