Rural, remote and socially-isolated gay, bisexual and other homosexually active men who have sex with men research project

Project report

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Smart Strategic Services Pty Ltd
http://www.smartss.com.au

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1. At a glance

Because of excessive download times, this section is not included in this report. It contains the site navigation images that can be accessed separately from the website.

2. Strategic findings

This report paints as comprehensive as possible a picture, given their desire for secret lives, of who regional, remote and isolated men who have sex with men in Queensland are; what they do; the pressures they are under; how they respond to those pressures; what they know about safe sex and STIs; what they want to know; and what the issues are getting information to them.

The twin purposes of this research were to better understand the situation of these men; and to lay the basis for more effective communication with them in future.

2.1 The social marketing model

The first broad conclusion of the research is that the social marketing model is an effective framework for future communications. It reminds us that simple information provision is not enough. The hard work of communicating is to address personal, interpersonal and environmental barriers to change in a ways that are physically and culturally accessible. The research findings, which are organised along social marketing lines, should help educators better understand the breadth of the task in front of them.

RECOMMENDATION

1. **That the social marketing framework should be used to plan and deliver safe sex interventions for MSMs.**

2.2 An emphasis on men's health

While a great deal is said about 'strategy' in communications planning, it comes down to a simple proposition: there should be clear, commonsense and believable reasons as to why communications will work with people.

The research shows that the approach taken by much safe sex and STI material - to be 'gay-friendly' and explicit about involving other men in sex – may be a strategic mistake for communications with regional, remote and isolated MSMs. It is certainly a mistake to be upfront in communications about being gay (whether conveyed by words or clichéd graphics) and it may even be a mistake to allude to what MSMs take pleasure in doing.

The research suggests that the best way to address the many barriers to communicating safe sex and STI information to MSMs – to provide information that men can 'take home' - is to put it in the broader context of men's health. As two respondents who are connected with sexual health clinics said,

> 'These are men who need to talk about a range of deep personal issues, not only about sexuality, and who don't have the opportunity.'

> 'We get a very low percentage of the general population, for a range of reasons, but mostly because of the difficulties of addressing and raising the profile of men's health. We have to normalise men's sexual health and get it up there on the agenda with smoking, alcohol and other drugs, cancer and heart health. We're fighting 50 years of the "pox clinic" mentality.'

Respondents generally felt effective STI communication required raising the profile of men's health. While it is part of a gay man's mindset to keep an eye on his health (including his sexual health), this is not so for straight-identifying MSMs. As three respondents said,

> 'A guy in the locker room chatting to a friend will admit he's having trouble pissing, but he'll hold off going to a doctor. They'd rather risk dying of prostate cancer than get it checked. Men are wimps!'

> 'Generally, men's health is a very difficult area. Ill-health doesn't fit the macho image, and it's well-known that men don't think much about their health.'

> 'It should be put more in the context of men's health, under a broader men's health banner. There's been so much focus on women's health, but men's health is really lacking. Men don't access health services: they'll wait till there's a crisis till they do something.'

Some respondents had a clear picture of what the ideal material would be. As two said,

> 'It would be focused on men's health in general and mainstream, with sexual health dealt with in a minor way (or by implication). It would be the sort of stuff that could be taken home without stigma. As well as STIs, it would deal with exercise, diet, tobacco, alcohol and other drugs, communication, how weight affects health, easing the burden on your heart and liver, testicular health and prostate cancer.'

> 'Diabetes, hypertension, obesity, cardiac risk factors should be included in broader messages'.

It is important to note that respondents were not arguing for STIs to be subsumed or made subservient to other health messages, but that 'men's health' should be the strategic approach. It is not hard to imagine campaigns where 'men's health' was a Trojan horse for messages primarily about sexual health. Such an approach would also allow for coalitions across Queensland Health sectors to provide a more integrated approach to the different areas of men's health campaigning and information.

To restate this point, safe sex and STI prevention should have a greater profile with MSMs at present, and the best way to do this would be as part of a broader campaign about men's health. For STIs and safe sex to be a significant and recognisable component, such a campaign would have to be a major Queensland Health initiative.

We envisage a coordinated social marketing strategy, of which safe sex and STI prevention is a specific, high-profile and identifiable component. This campaign would have a strong community profile, good community uptake and adequate resourcing.

RECOMMENDATION

2. **That Queensland Health address safe sex and STI as a specific and identifiable component of a broader social marketing campaign about men's health.**

2.3 Testing as a key point of intervention

The central messages of the research are:

- the desire by most MSMs to keep their behaviour secret
- the lack of awareness of MSMs that their homosexual behaviour carries sexual health risks
- the various (accurate or inaccurate, explicit or implicit) risk assessments that MSMs do to conclude that they are at low risk
- the lack of engagement by MSMs with sexual health networks (clinics, GPs and gay community organisations)
- fear they have caught an infection is what mainly drives engagement with sexual health networks.

In sum, these messages indicate that regional, remote and isolated MSMs are very difficult to identify and intervene with until they decide to attend a sexual health service for an STI test. This makes these services very much more important to intervening with regional, remote and isolated MSMS than with gay men, for whom there are many more points of intervention. Indeed, a sexual health service may well be the only point of intervention with many of these men.

Strategically, the research suggests that testing would be the most effective point of intervention with these men. 'Testing' effectively means 'visit a sexual health service'. In the same way as sex-on-premises venues were kept open during the height of the HIV/AIDS epidemic because men would visit them and become accessible for safe sex interventions, doctors and sexual health services appear to be the only network regional, remote and isolated MSMs are likely to contact (except, of course, for sex-on-premises venues, where the logic of our argument also applies).

Thus, just as city MSMs are engaged by their desire for sex, regional, remote and isolated MSMs can be engaged by their desire to alleviate their fears of infection.

While this might not be an ideal strategy, it may well be the only practical one for these men.

There is, of course, nothing new in this concept: sexual health services already use this strategy. The research recognises this, and the success of the concept. Our proposal is to recognise this, focus on it and resource it adequately.

Implementation of this strategy would have to be carefully considered. The positioning of the strategy within a broader men's health approach, the right communications approach, the adequacy of existing services to conduct minimal interventions with clients and convincing practitioners of the importance of them, and the requirement for confidentiality and physical accessibility, would all need to be carefully considered.

RECOMMENDATIONS

3. **That Queensland Health recognise that the desire for testing by MSMs is the main strategic (as distinct from operational or tactical) point of intervention in ensuring safe sex and STI prevention among MSMs.**

4. **That Queensland Health further investigate the service delivery implications of promoting testing as the main strategic point of intervention, with the intention of making it so.**

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3. Summary of findings and recommendations

Methodology

1. This study is a social inquiry into the situation of rural, remote and socially-isolated gay, bisexual and other homosexually active men who have sex with men (MSM) in Queensland, not including those in Brisbane, the Gold Coast or parts of the Sunshine Coast.

2. These men are by and large secretive with regards to their sexual behaviour and unwilling to talk to researchers. We believe, inevitably, that we recruited a disproportionately high percentage of MSMs who identify as gay, and a disproportionately low percentage of MSMs who don't. The methodology seeks to allow for this. We caution though that all statistics in the report are only broadly indicative because of this sampling bias.

Who are men who have sex with men?

3. Male / male sex is reported as occurring at unknown (but probably very low) levels among prisoners, miners and ringers (who are isolated for long periods from women); and among some men from Papua New Guinea who are in Queensland temporarily.

4. A typical progression is for an early teenage man to recognise a sexual attraction for another male; to act or not act on it. Post-school, they may leave their remote location for the city, or stay. If they stay, they are most likely to marry and have kids; but they may also stay single, often living with parents. Married MSMs often divorce after the kids grow up and head for Brisbane, Cairns or other cities. A small number come out (commonly in their teens or twenties) and are known to varying degrees as gay.

5. It was not possible to estimate the total number of MSMs in the study area, including those who identify as gay. What data and information were collected, combined with respondent's intuition, suggested they may number some 6 000.

6. The Internet, outdoor cruising areas and friends and past sex partners were the most common ways of meeting other men for sex.

7. Some 40% of survey respondents reported always or most times travelling away from home for sex. They will do so to avoid being found out, or to find men to have sex with; or they might be travelling for business or other reasons and take the opportunity to have sex. Men travel away from regional, remote and isolated areas for sex, but men don't travel to it: eight out of ten survey respondents who last had sex locally had it with a local or with a man from nearby.

Identity and factors that influence it

8. There is a crucial difference between homosexuality (a behaviour) and being gay (an identity). MSMs commonly see themselves as 'straight'. Although they engage in homosexual acts, they do not see themselves as gay, or identify with a gay culture. That is, they have homosexual behaviours and a straight identity.

9. They might call themselves 'gay' to some people (potential sex partners, close friends) but this appears to mean that they have sex with men (i.e. to describe behaviour), rather than that they identify with a gay culture (i.e. to describe identity). MSM's attitudes to gay

culture (as they understand it to be) tend to be negative. 'Bisexual' also tends to be used to describe behaviour, rather than identity.

10. This pro-straight, anti-gay labelling by MSMs is a result of personal, interpersonal and environmental pressures in regional, remote and isolated Queensland.

11. The environmental pressures are:

    - machismo, the product of the harsh environment and tough, male-dominated jobs, which is learnt young and passed from father to son and is about 'getting married and having kids, being a brawler, drinking beer, playing sports …

    - its everyday and acceptable face of 'being straight', usually meaning getting married and having children

    - homophobia, discrimination and the cultural norm of anti-gay sentiment

    - religious fundamentalism, and their strong to fanatical disapproval of homosexuality

    - small town values, which can be either negative for MSMs (gossip, little respect for diversity) to neutral / positive (a live and let live mentality)

    - an often-negative perception of country gay life among MSMs.

12. The interpersonal factors are:

    - physical violence (although the general opinion was that there is not much of it)

    - harassment, intimidation and ostracism

    - rejection by family, and by friends, which was reported as the most powerful of all factors

13. The personal factors are:

    - an inability, or unwillingness, to talk about having sex with other men (and often about sex in general)

    - the decision-making skills and self-efficacy skills required to withstand environmental and interpersonal pressure.

14. While LGBT police liaison officers appeared to be a valuable and increasingly-recognised resource, it was felt that the liaison program was weakening in some areas, and not effective in others. Concerns were also expressed either about police impersonators or police acting beyond their powers, about the briefs of liaison officers, and about the ability of MSMs to report crimes to police.

RECOMMENDATION

5. Given the valuable role of the Police Liaison to the LGBT Communities Program, that this program be evaluated with a view to addressing deficiencies and defining possible linkages with health education.

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15. Rejection by friends and family is a key factor in restricting the ability of MSMs to make life choices, particularly young men. This can lead to a range of mental health issues (discussed later). There is a role for Queensland Health, as both a sexual and mental health matter, to help create a 'space' where young MSMS and their parents can talk about the issues. Such efforts would also be expected to create a more supportive environment within the families of older MSMs.

RECOMMENDATION

6. That Queensland Health undertake promotion and information activities to advise parents that some children are attracted to the same sex, the social and health importance of supportive responses and suggested supportive responses.

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16. Given that concern about legal penalties is a powerful motivation for change in small and medium enterprises, and an apparent opposition to discrimination by large employers, it might be relatively easy to encourage employers to reject if not vilification of MSMs then at least employment discrimination, with the right information and approaches.

RECOMMENDATION

7. That Queensland Health work with other government agencies and industry representative bodies to raise the profile of anti-discrimination legislation as it affects MSMs, and employer responsibilities under the legislation.

How MSM respond to identity pressures

17. The most common way that regional, remote and isolated MSM respond to the pressures on them is to identify as 'totally straight, not at all gay'. They overcome the obvious contradiction between their straight identity and their homosexual behaviour by seeing the sex with other men as a purely physical act with absolutely no other consequence; by simply not thinking about it; or by acknowledging it but not seeing it as a challenge to their straight identity.

18. This accommodation between the straight identity and homosexual behaviour appears to be a stable and acceptable situation for many men, and does not appear to be problematic for them. The intuition of many respondents was that perhaps half of MSMs reach this stable, non-problematic accommodation. But for others, it raises various problems.

19. Some MSMs appear to have anti-gay attitudes stronger than would be expected from the environmental or interpersonal factors they face. It has been suggested that these attitudes reflect an increasing level of discomfort between what the man does, and who he sees himself as being; and that the strong anti-gay attitudes are a form of self-hatred.

20. Other men respond to the contradiction between their straight identity and their homosexual behaviour by becoming increasingly confused about their identity, or by not having sex.

21. Some men respond by seeking refuge in religion which, in line with 19 above, can increase anti-homosexual attitudes within these churches; that is, that men whose reconciliation of their straight identity and homosexual behaviour is problematic are using churches to promote discrimination.

22. Mental illness can become a significant issue for men who are unable to resolve their conflict between identity and behaviour. It appears that a majority of MSMs live in fear of

friends, relatives and workmates finding out they have sex with men. This leads them to close themselves off, to isolate their feelings from others. They are unwilling or unable to talk about this part of their lives, and may deceive their partners. Low self-esteem is both a reason for and a consequence of being unable to resolve the questioning and confusion about their sexuality. These men are also subject to loneliness, depression, anxiety and stress. There is evidence that this can lead to alcohol and other drug misuse and to suicide.

23. MSM who are moving toward resolving the conflict between their identity and behaviour may identify as bisexual (primarily in sex-seeking situations, but more broadly as they move closer to resolution).

24. Their female partner might also know of the homosexual behaviour. This may cause the female partner major distress and (or) stress on the relationship; or they may reach some accommodation.

25. Those MSMs who do come out report mixed experiences: from general tolerance and acceptance through to continuing harassment, violence, discrimination and ostracism.

Social marketing, safe sex and STIs

26. Although use of condoms for anal sex appears widespread, so does non-use.

27. The threat of HIV/AIDS, and the importance of safe sex, appears to have a low profile in the general community and consequently among regional, remote and isolated MSMs.

28. There appears to be widespread understanding among MSMs that wearing a condom prevents spreading HIV during anal intercourse. However, this understanding is not universal and is still challenged (by, for example, the Vatican). However, MSMs do not appear to be as aware of the benefits condoms offer for preventing other STIs.

RECOMMENDATION

8. 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.

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29. Ambiguity about whether HIV is spread through oral sex, and about whether the safe sex message is to wear a condom (or a dental dam) for oral sex, are the main distortions of the safe sex message. Two-thirds of survey respondents believe that HIV is not transmitted through oral sex.

RECOMMENDATION

9. 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.

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30. MSMs feel that the main health risk they face from having sex with men are STIs generally, and HIV/AIDS specifically. They are concerned about catching an STI, but think their risk is little to none.

31. Among men who recognise the need to use condoms to prevent STIs, the main reason for not using condoms is dislike of doing so.

32. Among men who recognise the need to use condoms to prevent STIs, the second main reason for not using condoms is trust that their partner doesn't have an STI. Different strategies of varying effectiveness are used to determine whether the partner has an STI or not. These include a monogamous partner, knowing a casual 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.

33. These 'clean partner' strategies are commonly combined with using a condom, to provide two lines of defence.

34. Eight in ten survey respondents don't have problems getting condoms confidentially.

35. Among men who recognise the need to use condoms to prevent STIs, other significant reasons for not using condoms are:

    - they don't have one on hand at the moment of having sex
    - they are simply forgotten or overlooked in the heat of the moment
    - the other sex partner may not mention them, or may not want to use them, or the MSMS may not be prepared to ask the other partner to use them
    - the MSM might be under the influence of alcohol or other drugs.

36. There appears to be a very low recognition among straight men of the need to use condoms to prevent STIs; and that when condoms are thought of, it is usually in the context of preventing pregnancies. Straight-identifying MSMs appear to have similar low recognition and many appear not to think, or to worry, about the risk they might catch an STI.

37. Their low concern about the risk of catching an STI is partly a belief that 'it won't happen to me', because:

    - HIV/AIDS is a 'city poofter' thing that doesn't affect them because they're not gay and don't live in the city
    - they have not caught an STI to date, so are not likely to in future
    - they don't have much sex
    - their partner appears to be healthy
    - they will hear as gossip if anyone in their town has an STI
    - they are young and believe themselves to be invincible
    - they only engage in masturbation and oral sex, which they consider safe.

38. The environmental factors that lead to low concern by MSMs about the risk of catching an STI and disinterest in safe sex are:

    - the invisibility of HIV/AIDS within their communities or among their peers

- with gay-identifying MSMs, the rise of 'barebacking' and the consequent mixed messages about the necessity of safe sex, every time

- that condom use is not part of the macho image

- the longstanding culture that if one catches an STI, the doctor will fix them up, which may be reasserting itself with the arrival of more effective treatments, including PEP.

39. There is evidence that providing information and motivational messages about safe sex improves attitudes towards it and makes MSMs more likely to have safe sex. It also gives them peace of mind and increases their confidence.

40. There appears to be significant unmet demand for information about STI transmission and prevention, how to recognise symptoms, how to access services confidentially and the safety of oral sex.

41. A significant percentage of MSMs, when seeking information about safe sex and STIs, also sought information about dealing with their sexuality. 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.

42. While most survey respondents knew where to go to get information about safe sex and recognising and treating an STI, and received all or most of what they wanted, interview respondents felt that information services were difficult to access; and that in many places there was 'next to nothing' available. What information is available is in gay meeting places, or in sexual health clinics, not in the mainstream.

43. A small number of MSMs reported feeling uncomfortable with 'gay' images (explicit images of male-male sex or stereotypical gay men), graphic images of symptoms and (closely related to the second), information about the consequences of infection. A much larger number of MSMS appear to feel not so much discomforted as disconnected by materials with these images and information.

44. Gay images do not appeal to most men who identify as straight. They do not identify with the underlying message of these materials: that it's happy, healthy and desirable to be gay. They do not relate to 'city-gay' imagery. They are afraid of being identified as gay, and are more likely to respond to straight imagery in a country setting.

RECOMMENDATION

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

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45. There would appear to be a role for graphic images of symptoms, in the context of conveying information about the possible consequences of behaviour rather than trying to shock MSMS into changing behaviour.

46. Many people find colloquial language about sex offensive and are off-put by 'bad language'; and the knowledge or perception that safe sex and STI information contains offensive material is a barrier to providing or accessing it.

RECOMMENDATION

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

47. Brochures and general discussion through sexual health services and GPs the most popular ways of getting information about STIs and safe sex. However, it is felt that many MSMs do not use sexual health clinics.

RECOMMENDATIONS

12. To improve accessibility and the sense of confidentiality, that Queensland Health sexual health clinics do not prominently identify their premises as sexual health clinics.

13. That clinics provide areas where materials can be confidentially viewed and the means to confidentially take materials away.

14. That Queensland Health formally recognise the importance of gay-identifying staff at clinics.

15. That clinics, in promotions, focus more on the benefits they offer the public.

16. That there be statewide policy and action on evaluating the operations of clinics.

17. That Queensland Health establish formal links between mental health and sexual health clinics, to better coordinate the services provided to clients.

18. That Queensland Health provide education and training for relevant staff about issues affecting MSMs.

48. General practitioners are a key source of advice about STIs and safe sex. However, their usefulness is reduced in the minds of MSMs if they feel they cannot talk to their GP about their homosexual behaviour. MSMs would like to be able to talk to their GP about their homosexual behaviour, but are concerned about confidentiality and rejection, however mild. While it appears that many GPs are well-thought-of, others lack the training and empathy for the task.

RECOMMENDATION

19. 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.

49. Confidentiality is a key issue for MSMs. While sexual health clinics recognise and address the need for confidentiality, MSMs are still concerned about lack of confidentiality.

RECOMMENDATIONS

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

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

50. The Internet is a popular and desired way of accessing information about safe sex and STIs. Quite apart from the introduction services offered by several commercial sites,

51. It also has potential as a way of enabling men to explore their sexuality

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RECOMMENDATIONS

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

23. 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.

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52. Telephone services (the main one being the QuAC 1800 line) are a popular and desired way of gaining safe sex and STI information, as well as support. Several issues were raised with the QuAC line, which were often compared with previous times when local lines were run.

RECOMMENDATION

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

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53. Beat outreach programs were generally well-received.

54. There was a desire for more information and advertising on TV and radio about safe sex and STI services available, particularly more mainstreamed information including information in men's magazines.

55. Local government generally does not appear to respect MSMs, or in many cases to respect diversity.

RECOMMENDATION

25. 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.

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4. Methodology

4.1 *Introduction*

In May 2003, Smart Strategic Services was engaged by Queensland Health to undertake a research project into rural, remote and socially-isolated gay, bisexual and other homosexually active men who have sex with men (MSM).

The study arose from the perception by Queensland Health that, although the situation of gay-identifying men in major metropolitan cities was well-understood and the needs of these men catered for, there was another group of men engaging in homosexual behaviour throughout the State. Their needs were not understood, and services did not currently provide for them.

The propose of the study was therefore to engage in social inquiry of key respondents, supported by a quantitative survey, to provide insights into the situation and needs of this group, leading to recommendations about how sexual health messages could be delivered more appropriately to them.

4.2 *Locations*

Although it was recognised that socially-isolated MSMs might be found in inner-Brisbane, Queensland Health initially intended to focus the project on areas other than Brisbane and the Gold and Sunshine Coasts. After further discussion, it was decided to include the hinterland behind the Gold Coast, and the Sunshine Coast other than the Noosa – Perugian – Coolum corridor. Locations subsequently visited for interviews were Toowoomba, Nambour, Maryborough, Gladstone, Bundaberg, Rockhampton, Cairns and Mt Isa (and their surrounds)

4.3 *Recruiting strategy*

It was realised at the outset that this would be a very difficult group to reach. We expected that many MSMs wouldn't want to talk to the researchers: if we were in their position, we probably wouldn't want to talk to the researchers, either.

Incentives were ruled out: to claim (let alone use) an incentive, MSMs would have had to identify themselves (as in, "Honey, guess what, I won a trip for two interstate for talking about how I have sex with men").

One other survey has used mailouts in adult bookshop mailings. This appeared to us likely to reach a particularly skewed sample: open about their sexuality (if not their homosexuality), mail order clients and actively engaged in sex.

The recruiting strategy instead was twofold:

- interview key informants who know about regional, remote and isolated MSMs from personal and professional contacts, and ask them to speak on behalf on these men

- recruit as many regional, remote and isolated MSMs as possible through newspaper advertising, cards and posters placed at beats, word of mouth, through local contacts and through websites used by regional, remote and isolated MSMs.

4.4 *Key informant interviews*

34 people were interviewed as key informants, including:

- men and women
- Indigenous men
- sexual health workers
- men married with children
- well-connected gay men
- a proprietor of a sex on premises venue
- a policeman
- volunteers in community services.

Interviews were conducted in person in ten locations throughout regional, remote and isolated Queensland, with further interviews conducted by phone.

The material gained, while valuable, is anecdotal, because it comes from asking people to comment on the position of other people. While we acknowledge the difficulties and issues with this approach, it was considered valid in this case because:

- a number of those interviewed were regional, remote and isolated MSMs who don't identify as gay
- a number of others had only recently begun to identify as gay, or would identify to us as gay but had only done so to a small number of people
- the remainder had ongoing and close dealings with the target group.

4.5 *The survey*

The second tool was a survey questionnaire which could be completed via the project website, by calling a toll-free number, or by completing a printed copy. The first two opportunities were widely advertised in the personals sections of regional newspapers, and through a wide range of other means. Printed copies of the questionnaire were made available to sexual health coordinators, sexual health workers and others, and through them to interested parties.

4.5.1 Numbers completed

341 surveys were completed, or part-completed with useful information. One from outback NSW, one from ACT and one from Victoria were not included, nor were surveys from the Gold Coast and Brisbane areas. 284 surveys were included in the final analysis.

Based on the experience of the telephone interviewers, we believe that a significant number of people had two or more goes at doing the survey by phone; and the same might be expected for the Internet. Therefore, the 284 responses do not represent 284 individuals, but a smaller number. We have no way of saying how many individuals they represent, because we did not seek any identifying information from respondents.

TABLE 1: REASONS FOR TERMINATING INTERVIEW AFTER INITIAL EXPLANATION

Reasons for surveys terminating after initial explanation	No.
Wanted to speak to someone/counsellor, but not do survey	12
No reason / not interested	9
Decided to call later	8
On a landline (4)	
Wanted to call later, no reason (1)	
When he had the time (3)	
Cut-off, line dropped out during survey	7
Terminated before completing, no reason	6
Caller wanted sex discussion / thought it was a sex line / line to meet men	5
Out of area	3
Was originally not sure what the newspaper ad was about / did not realise it was a survey	3
Wrong number	3
Would not do survey with a woman	1

4.5.2 Limitations of the survey data

The survey was designed with the clear understanding that it would be difficult if at all possible to gain a representative sample of men who have sex with men, but who do not necessarily identify as gay.

Firstly, this is because:

- many keep their sexual behaviour a secret, and will not identify as MSMs to others unless they are likely to get sex from it
- many, as the report explains, live in states of denial about their behaviour and identity
- many are simply not motivated to talk to researchers.

We were aware throughout the research that men from the target group knew of the study, but didn't want to talk. As one local contact said:

> I've had a couple of guys who have called here, and I've asked them to do your questionnaire, and their response has been, "Sorry, not interested".

Secondly, the sample size is too small to project the figures onto the general regional, remote and isolated MSM population with confidence.

Thirdly, the whole notion of who identifies as gay / homosexual is complex and involved (as this report shows) and, for example, excluding men who identify as gay from the sample begs many of the question this report tries to answer.

Fourthly, it is a conclusion of this and other reports that MSMs 'are everywhere', and are indistinguishable by demographic or physical characteristics from men generally. A representative sample approach would therefore involve choosing a male general population sample, and reducing it to men who have sex with men by preliminary questioning, in the process overcoming all the barriers men might have to self-disclosure. This approach would require a budget many times what was available for this project.

Accordingly, while numbers have been published in the tables, they cannot be said to be definitive for regional, remote and isolated MSMs. Rather, readers should look at them qualitatively rather than quantitatively: they support hypotheses and suggest directions, rather than accurately quantify proportions of people.

4.5.3 Interpretation of the data tables

Table 5 below shows the Indigenous status of respondents. As with all tables, a number of respondents did not answer the question. With some questions, the non-response rate is quite significant. Accordingly, the percentage figure is only a percentage of the total responses, not the total survey respondents. This was felt to provide the most accurate snapshot of the proportions of the sample choosing each option.

TABLE 5: IF RESPONDENT IS OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN

ATSI	No.	%
Yes	9	3%
No	267	97%
No answer	8	
Total	284	

The table below is an extract from Table 10. Since respondents usually nominated a number of locations, the percentage is for the total number of respondents, but there is no total provided for the 'No.' column, as this would be meaningless.

EXTRACT FROM TABLE 10: WHERE RESPONDENTS MET OTHER MEN FOR SEX IN THE PAST YEAR

Where met?	No.	%
Internet	89	31%
Outdoor cruising area	87	31%
Friends / past sex partners	84	30%
Gay bar / club / pub	69	24%
Private party	69	24%
Non-gay bar / club / pub	57	20%
Sauna for men's sex	53	19%
Adult bookshop or sex club	42	15%

4.5.4 Characteristics of survey respondents

Table 1 shows the age of respondents. They tended to be fairly evenly-distributed from 18 to 50.

FIGURE 1: AGE OF RESPONDENTS

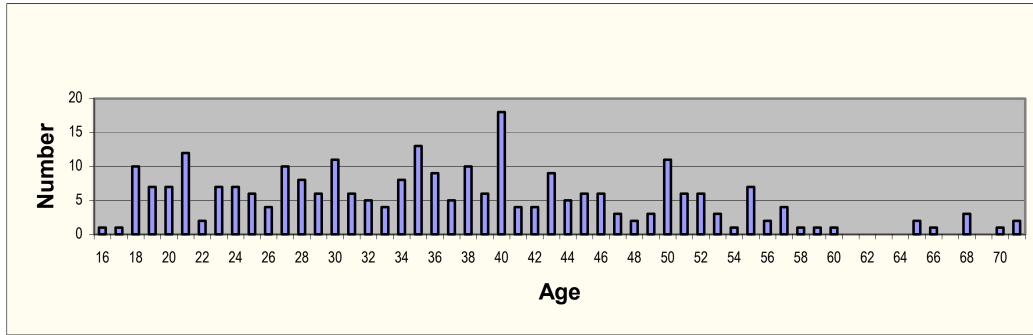

Table 2 shows the postcodes of respondents. They tended to be concentrated around the major cities

TABLE 2: POSTCODE OF RESPONDENTS

Postcode	Location	No.
4275	LAMINGTON NATIONAL PARK	1
4285	BEAUDESERT	1
4300	BELLBIRD PARK	1
4305	BASIN POCKET	3
4306	AMBERLEY	1
4311	BUARABA SOUTH	1
4341	KENSINGTON GROVE	3
4345	GATTON COLLEGE	1
4347	GRANTHAM	1
4350	TOOWOOMBA	28
4352	AMIENS	1
4360	NOBBY	1
4370	WARWICK	3
4410	JANDOWAE	1
4455	ROMA	1
4487	ST GEORGE	1
4500	BRENDALE	1
4510	CABOOLTURE	2
4512	WAMURAN	2
4551	CALOUNDRA	1
4557	MOOLOOLABA	1
4559	WOOMBYE	1
4560	NAMBOUR	2
4562	EUMUNDI	1
4563	COOROY	1
4567	NOOSA HEADS	2
4568	POMONA	3
4570	GYMPIE	3
4573	COOLUM BEACH	1
4575	BUDDINA	1
4580	TIN CAN BAY	1
4612	HIVESVILLE	1

Postcode	Location	No.
4670	BUNDABERG	5
4680	GLADSTONE	11
4700	ROCKHAMPTON	9
4701	ROCKHAMPTON	13
4702	KEPPEL SANDS	1
4703	YEPPOON	1
4710	ZILZIE	1
4720	EMERALD	1
4721	CLERMONT	1
4737	ARMSTRONG BEACH	1
4740	MACKAY	5
4741	WHITSUNDAYS	1
4744	MORANBAH	1
4745	DYSART	1
4754	BENHOLME	1
4800	PROSERPINE	2
4802	AIRLIE BEACH	1
4807	AYR	1
4808	BRANDON	1
4810	TOWNSVILLE	16
4811	JAMES COOK UNIVERSITY	1
4812	HERMIT PARK	5
4814	AITKENVALE	5
4816	GREENVALE	3
4817	ALICE RIVER	3
4825	MOUNT ISA	14
4869	EDMONTON	1
4870	CAIRNS	28
4871	ALMADEN	4
4872	BARRINE	2
4873	DAINTREE	2
4878	BARRON	2

4625	GAYNDAH	1
4650	MARYBOROUGH	8
4655	HERVEY BAY	14
4660	CHILDERS	1

4879	CLIFTON BEACH	3
4880	MAREEBA	2
4883	ATHERTON	1
Unknown		37
Total		284

Table 3 shows the highest education level of survey respondents. The highest level of sex in ten respondents was Year 11 or 12.

TABLE 3: RESPONDENT'S LEVEL OF EDUCATION COMPLETED

Education	No.	%
Primary	4	1%
Years 7-10	65	23%
Years 11-12	99	36%
Apprenticeship or traineeship	32	12%
Diploma, degree or higher	78	28%
No answer	6	
Total	284	

Table 4 shows the work or study situation of respondents in the week before doing the survey.

TABLE 4: RESPONDENT'S WORK OR STUDY SITUATION LAST WEEK

Work	No.	%
Student	21	8%
Unemployed	34	12%
Employed full-time	134	48%
Employed part-time	39	14%
Self-employed	22	8%
Medically retired	13	5%
Other retired	14	5%
None	7	
Total	284	

Table 5 shows the Indigenous status of respondents, with 3% identifying as Indigenous.

TABLE 5: IF RESPONDENT IS OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN

ATSI	No	%
Yes	9	3%
No	267	97%
No answer	8	
Total	284	

Table 6 shows who the respondent has had sex with the past year. Half had only had sex with a man, and almost half with a woman or a man dressed as a woman.

TABLE 6: WHO RESPONDENTS HAD SEX WITH IN LAST YEAR

In last year, who?	No	%
Men	137	51%
More men than women	45	17%
More women than men	53	20%
Women	14	5%
Cross dresser	10	4%
No sex	11	4%
No answer	14	
Total	284	

Table 7 shows who respondents are having regular sex with. Four in ten have only homosexual sex. One in ten only had heterosexual sex. Almost a quarter regularly have sex with men and women. Almost a third don’t have regular sex.

TABLE 7: WHO RESPONDENTS ARE HAVING REGULAR SEX WITH

Regular sex with …	No.	%
Man only	108	39%
Woman only	25	9%
Man and woman	61	22%
Not regularly having sex	86	31%
No answer	4	
Total	284	

4.6 Other

Some claims, in particular about rates of HIV infection from oral sex, are included in this report as reported by respondents. The researchers do not endorse any claim made by any respondent, or vouch for its accuracy or authenticity. Quotations by respondents are included to illustrate or dramatise a point, not to provide valid facts.

5. Who are men who have sex with men?

5.1 Introduction

When we asked interview respondents, 'How do you picture men who have sex with other men', some thought first of stereotypes: the teenager lying alone in his bedroom, wondering about his feelings; the men, alone at public toilets late at night as the wind whistles through the trees and raises clouds of dusts, pierced by the headlights of men in cars out for a similar purpose; the city councillor, afraid of being discovered; the truckie, looking for quick release to break the monotony of life on an endless road; two mates off together on a fishing expedition.

Others summarised this diversity with the simple observation that MSM couldn't be pictured or labelled or categorised: that no types came to mind; that they were of all ages, all occupations and all walks of life; that there are no indicators; that there is no way to describe a stereotypical man who has sex with men.

While we believe that to be a true description of reality, it seemed that we would sell ourselves a little short, and not give report readers some images and practical examples that they could carry with them into the body of the report, if we did not attempt some categorisation of men who have sex with men. So this is what we have tried to do.

5.2 Situational sex with men

In very general terms, the picture of MSMs that we will paint in this report is one of men who have a lifelong, underlying interest in male/male sex and who do (or don't do) something about it given particular factors (which we will look at) .

There does however appear to be another group with no (or very little) interest in male/male sex, but who will have it if they find themselves without the company of women for extended periods. Because they are something of an exception to the report's general rule, we will deal with them first.

We did not speak to such men, and research protocols prevented us asking the occupation of survey respondents; but interview respondents believed these men to exist.

5.2.1 Prisoners

Several respondents referred to some male / male sex occurring within prisons and youth detention centres. As one said,

> 'male-to-male sex happens almost always only when they are incarcerated, especially for the young ones'.

5.2.2 Miners

Some respondents believed male / male sex to be occurring on isolated mine sites, but felt, with the increasing 'fly-in-fly-out' working arrangements, that there is probably less of this happening than in the past. It was also noted that the idea of the single man alone in the mining town is pretty much a myth, with most men living in mining towns doing so with their families.

Late night, end-of-shift showers were thought to offer opportunities for sex. As one respondent said,

> 'Underground mining is one of the hardest and most dangerous industries there is. It's got a very macho image, it's a man's industry, it's certainly not hairdressing or hospitality. I get the feeling that there's a bit going on, but it's unspoken. It's a hush-hush world, and you wouldn't be able to identify who are the men who have sex with men among them.'

5.2.3 Ringers / cowboys

Several respondents spoke of sex among the ringers who work on stations mustering cattle and who only see town a couple of times a year.

5.2.4 Men from Papua New Guinea

Up around the Gulf and the Cape, mention was made of the steady stream of men from Papua New Guinea who come through. While their situation (not the least their immigration situation) was not clear, it did appear that some of these men have sex with men. As one respondent said,

> 'Qunite a few PNG guys come down here looking for partners. They seem to be comfortable with whatever label – het, bi or gay – and maybe their cultural background is not quite so restrictive as ours. They're looking for sponsorship for Australian citizenship, and for a gay relationship with a European (sic).'

5.3 Young and sexually active

The first main group of MSMs are young men who are having sex, often with both men and women. We did not interview men under 18, but several respondents were in their late teens or early 20s; and other respondents knew of the teenage situation as friends, informal counsellors and relatives. As one said,

> 'Boys of 12-13 are starting to discover their sexuality, and are having feelings for other males. They're thinking about doing it. They mightn't know the meaning of these feelings, and may not want to identify them if they do. Through the teens they may become more aware of these feelings, but they usually don't want to – and can't – admit the feelings.'

There is a great deal of anecdotal evidence to suggest that teenage boys are having sex with their peers and with other men, and it would be naive to think otherwise.

In the teenage years, the male hormones run even greater riot than they do at other times in life and, combined with youthful naivety, experimentation and freedom from society's expectations and the burden of responsibility, a much broader range of behaviour appears to be tolerated by peers than in later life. Young respondents in several inland towns and cities painted a fairly liberal picture of 'young queer boys mixing closely with their straight peers'; of tolerance toward young lesbians, and,

> 'a lot more young ones having sex with guys … it's a bit more the norm these days, they feel more relaxed having sex with guys, so long as they cover it up. From talking to them, I feel these kids will probably marry and have kids, but they'll keep on having sex with men.'

Equally,

> 'There are lots of young, sexually active men who haven't come to terms with their sexuality, or explored it much. They are living as straight, and having sex with women, with the occasional sexual dalliances with men.'

> '(Sex with men) can start mid- to late-teens. They might have a regular girlfriend, but have regular sex with a sistagirl. Some move on to having a wife and kids; others might keep having casual encounters on the side.'

These pictures of an increasingly liberal environment must, however, be set against the very considerable pressures to identify as 'straight', which we will return to in the next chapter.

5.4 Come out and leave town (or vice versa)

Many MSMs realise their sexuality early and leave regional, remote and isolated Queensland for the bright lights of Brisbane, Sydney, Melbourne and further afield. As one respondent said,

> 'Young gay people usually won't stay in town. As soon as they've finished school and can get a job, they clear off. Younger kids these days have a better sense of themselves, they know who they are, they come out much earlier.'

The research excluded respondents from Brisbane, and was therefore unable to speak to these men. However, most respondents knew and referred to these men when discussing life for MSMs in the country. This story by one respondent was similar to several we heard:

> One guy I know in his middle 20s lived remotely. He knew he was gay but was terrified of his parents finding out. It virtually pushed him to suicide. He couldn't tell his parents. Eventually, he moved to Brisbane.'

5.4.1 The question of numbers

The 'Come out and leave town (or vice versa)' group were also important in examining another question of interest to the research: how many MSMs are there in regional and remote Queensland, and how can we explain the apparent discrepancy between what surveys show, and what respondents feel to be the numbers.

The Australian Study of Health and Relationships1 (the 'Australian Sex Survey') noted that 1.9% of men in the survey had a same sex experience in the past year, and that 5.6% of men has ever had a same sex experience (5.6%).

With an estimated 646,963 people living in Queensland outside the Brisbane and Moreton statistical divisions[2], then the total number of men who have had sex with men may be anywhere between 6,100 and 18,100.

If these figures were projected to one typical central Queensland coastal city of some 60,000 people, then 570 male residents had sex with a man in the last year, and 1680 residents have ever had sex with another man.

In this city, however, these figures are universally scoffed at. After looking at gaydar.com and gay.com registrations, doubling them to allow for those not on the Internet, making an estimate of the local scene, beat usage, mailing lists, the likelihood that men travel away from (as well as into) the city, and respondent's intuition, a sense emerges that the number is perhaps half that.

5.5 Get married and have kids

When we asked respondents how they pictured men who have sex with other men, far and away the most common and emphatic response was that they are married or in another type

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[1] Smith, A., Rissel, C., Richters, J., Grulich, A., de Visser, R. Australian Study of Health and Relationships in Australian and New Zealand Journal of Public Health, Volume 27, Number 2, April 2003

[2] Australian Bureau of Statistics 2001 Census, Internet

of relationship with a woman, with or without children. These opinions based on observation and talking with MSMs on the Internet, at outdoor cruising areas (which we will see later are the two most common ways of meeting) and after sex .

The comments of one interviewee paint a neat picture of beat users, which was generally repeated:

> 'The most common profile of a beat user here is a man who is married or in a heterosexual relationship and very straight-acting: the hairy chested, ute-owning, dog in the back type. This type works in a male-dominated industry and is typically 20 to 45.
>
> 'The second common profile is the paraprofessional or sales rep in the hired or company car, with a suit and tie, nice shoes, parked at the beat pretending to work or talking on the mobile. He might be anywhere between 30 and 50.
>
> 'Then there's a group of local men between the two groups. Born and bred Queensland men from here or the nearby country, working in blue collar, service, hospitality industries or self-employed.
>
> 'None of these types of guys are "out". They're carefully trying to live the straight lifestyle. They all tend to be "heterosexual" and married, based on what I've seen at the beat, and the conversations I've had with them.'

After marriage, respondents most commonly noticed the children in the MSM's background:

> 'I was at the beat one day and I saw this guy go into a toilet and have sex with a guy, then he walked out and across the park and back to his wife and kids.'
>
> 'The younger married guys will come in here and get sucked and fucked, then they'll go home to play with the kids in the backyard.'
>
> 'I think of the guy who turned up at the beat with a kid in the baby seat, who stayed locked in the car while the guy went into the beat and got a blow job.'

Otherwise, these MSM appear to be of all ages (from the early 20s on), all occupations, all socioeconomic levels and have nothing to identify them as MSMs: 'everyday working guys', as one respondent said.

5.6 Stay single

Another group frequently nominated was those men who never marry, but who identify as straight. They may live by themselves, or with parents. They were generally nominated as being mid-20s (being the age when 'single' has some meaning, their peers having moved off into relationships) and their 50s (which, as we shall see next, is when many straight MSMs have their life change).

One respondent nominated that these men are 'usually born and bred in the area' and 'are often connected with an evangelical faith community'.

5.7 Empty nesters

Many respondents noted the number of older men – men in their middle 40s to 60s – who were now openly identifying as gay but who had been previously married, and who had had children. While these stories were predominantly of men who had moved to Brisbane, a number of interview respondents fitted this profile, and still lived in their home towns.

The situation of these men is perhaps best understood by looking what respondents said when describing young MSMs:

> '(There's a lot of) younger men who are not married, but who will probably get married and have offspring, at great cost to themselves and often to their families.'

> 'There are so many men doing the beats with kids and wearing a wedding ring … They don't identify their sexual desires to society. They've decided that the best thing to do is to hide away and to marry and have kids.'

> 'A great number of 'gay guys' have had previous heterosexual lives, and have been married with kids. They were brought up in an era when their duty was to get married and have a family. It's when the family grow up and move out that they finally decide to do their own thing.'

This was an oft-repeated theme: that the man, who has always either been interested in sex with other men, or has been having it, decides once the children have left home, to pursue the lifestyle. As one respondent said, drawing also on his own experiences and those of a network of men of whom he is organiser:

> 'Men in that age group had to get married. Now the family is grown up, and the kids are gone, and they're empty nesters. He's thought about it a lot, and had some experiences, and he decides to do something about it. Sometimes it ends it divorce, other times in an accommodation.'

Another respondent also noted,

> 'It amazes me how many gay men were married, and are dads and granddads. One day they say, "I can't stand it any more" and get divorced.

5.8 Live as openly gay

Then there are the MSMs who live as openly gay, either singly or in a relationship.

In many locations (particularly more remote locations), these tended to be 'born and breds' who had both decided to stay in their home town, and to come out. Their degree of 'outness' ranged from wholly out and acknowledged as gay by the town; to 'thought to be out and not particularly hiding, but not publicising it, either', to 'out to a small groups of friends and confidants.

There are also the gay men (and gay couples) who choose to move to country towns and cities from the capitals or from other country towns and cities. They may do so for work reasons, because accommodation and living is cheaper, to support aging family, or for a better lifestyle.

While these men may be out, in most cases they also take steps to preserve their privacy. Gay men in long-term relationships (with some exceptions) appeared to keep low public profiles, and were not known as beat users. It also appeared that many gay couples choose to live on the fringes of towns or on farms a short distance from town, even small distances providing a degree of anonymity. As one respondent said:

> 'You can be fairly isolated among the gum trees. You don't have to have anything to do with the neighbours.'

One respondent reported that:

> 'There's a whole scene north of Cooktown right up to the Cape, out in the bush: Vietnam vets, ferals, backpackers. I know of at least 20 or 30 gay couples living openly as gay, in a variety of occupations, operating businesses, right up to the top.'

Lastly, there are two other groups of 'gay-identifying' MSMs.

The first of theses is sistagirls, Indigenous men who have sex with men. While it was not part of this research to survey this group in depth, some information was gained. 'Sistagirls' is a broad definition, covering Indigenous men who have sex with men and who choose to identify as sistagirls. While some feel that 'sistagirls' implies effeminate characteristics, others do not agree, seeing the identity as including masculine characteristics. Sistagirls, it was said, usually don't have sex with each other, but with men who identify as straight.

While there were some suggestions that the sistagirl identity may have its antecedents in an older Indigenous culture when effeminate men played motherly, caring, supportive roles (helping with the children and housework, and trusted by the women), opinions differed on how supportive communities now are of sistagirls. Some communities were reported as generally fairly tolerant and understanding, others not so, in part (according to one respondent) to the degree of past church / mission involvement and control.

In practical terms, they can't be too supportive: as one respondent noted:

> 'Because sistagirls can't have relationships in their own communities, they tend to move away.'

Secondly, there are backpackers. A backpackers 'scene', based on public open spaces and beats, was reported in a number of towns along the coast. We did not speak to backpackers, or people involved in these scenes, so were not able to verify these claims or to determine whether these were travelling gay backpackers or straight-identifying backpackers using their freedom and anonymity in a foreign country to explore their desires. The opinion was gained, however, that the claims were true and both types of backpackers were likely involved.

5.9 What the survey said

Table 8 shows survey respondents' marriage situation and sexuality[3].

The 'never married, homosexual / gay' group were the largest group of survey respondents. This is consistent with our belief that 'out' gay men were the most enthusiastic to be heard through the survey.

The two second-biggest groups were 'Never married, bi', and 'married, bi'. This is consistent with the belief that married MSMs and single men who don't identify as gay are major segments of all MSMs; and the married component is also supported by the 'Married, heterosexual / straight) and 'In a defacto relationship, bi' groups.

The significant 'Divorced or separated and bi, gay and straight' groups lend weight to the 'empty-nester' scenario.

TABLE 8: RESPONDENTS' MARRIAGE SITUATION & SEXUALITY

Marriage situation, sexuality	No.	%
Never married, homosexual/gay	99	36%
Never married, bi	34	12%
Married, bi	34	12%
Divorced or separated, bi	16	6%
Married, heterosexual / straight	13	5%
In a defacto relationship, bi	12	4%
Never married, don't think about my sexuality	11	4%

[3] Comments about the survey (i.e. non-interview responses) findings should be read in light of the general comments about survey limitations in the methodology early in this report).

Divorced or separated, homosexual/gay	11	4%
In a defacto relationship, homosexual / gay	11	4%
Never married, no sexuality nominated	7	3%
Divorced or separated, don't think about my sexuality	4	1%
Never married, heterosexual	3	1%
Divorced or separated, heterosexual/straight	3	1%
Divorced or separated, no sexuality nominated	3	1%
In a defacto relationship, don't think about my sexuality	3	1%
Married, homosexual / gay	3	1%
In a defacto relationship, heterosexual / straight	2	1%
Married, don't think about my sexuality	2	1%
Married, no sexuality nominated	2	1%
In a defacto relationship, no sexuality nominated	1	0%
No answer	10	
Total	284	

Table 9 shows the marriage situation of survey respondents. While just over half have never married (which combines straight, bisexual and gay men), a third are (or were) married, and 10% more in defacto relationships.

TABLE 9: RESPONDENTS' MARRIAGE SITUATION

Marriage situation	No	%
Never married	154	56%
Married	54	20%
Divorced / separated	37	14%
Defacto relationship	28	10%
No answer	11	
Total	284	

5.10 How and where men have sex with other men

5.10.1 Where men meet for sex

An objective of the research was to better understand how MSMs meet and where they have sex, because better knowledge about these physical locations might prove useful for distributing health messages.

Table 10 shows where MSMs met other men for sex in the past year. The Internet and outdoor cruising areas were both equally popular with friends and past sex partners

TABLE 10: WHERE RESPONDENTS MET OTHER MEN FOR SEX IN THE PAST YEAR

Where met?	No	%
Internet	89	31%
Outdoor cruising area	87	31%
Friends / past sex partners	84	30%
Gay bar / club / pub	69	24%

Private party	69	24%
Non-gay bar / club / pub	57	20%
Sauna for men's sex	53	19%
Adult bookshop or sex club	42	15%
Sport or recreation activities	42	15%
Phone chat line / other phone service	41	14%
Shopping centre washroom	32	11%
Through work	32	11%
Commercial sex service	28	10%
Personal press ad for sex	28	10%
Sex magazine	22	8%
At TAFE or university	18	6%
Other	16	6%
Through family	13	5%
Through a neighbour	13	5%
Through a non-personal ad or notice	5	2%

INTERNET

As one respondent said, 'the Internet is fast taking over from the beat as a way to meet guys. Gaydar or gay.com have opened up a lot of possibilities to meet men for sex. For the regional, remote and isolated MSM, it has everything: the ability to communicate privately and instantly across large distances.

BEATS

Outdoor cruising areas include public toilets (municipal, shopping centre, truck stops, highway rest areas), parks, beaches, and anywhere else that men are known to look for other men for sex. And some that aren't: men met other men for sex at the tip, on both sides of the supermarket checkout, on a cruise ship, on a courtesy bus; and has sex with their tradesmen and masseurs. One claimed his 'wife brings home teachers from the school she works at or friends'. As one respondent said,

> 'I can't think of one truck stop along the Bruce Highway where it's not happening. Lots of the toilets in petrol stations now have condom vending machines, so they must know what's happening.

It appears that the broadest cross section of MSMs use beats: from teenagers to:

> 'old guys whose peers are probably playing golf or fishing. They're hanging out in the bushes hoping to get some action.'

While gay men have traditionally used beats or not, it was felt by several that the beats were increasingly drawing – and were now mainly populated by – straight men. As three respondents said,

> 'It's a paradox. Gay men have largely left the beats in favour of relationships, clubs and the Internet, and the beats now seem mainly to be populated by straight men.'

> 'There are men that appear only on the beats. It is a complex networks of secret, likeminded men. The beats go day and night here. I rarely meet people who are gay on the beats, or who are happy and proud about having sex with men.'

> 'I'd say that only 10% of the gay guys in town use the beat. The rest are straight / bi / in denial.'

Beat users are quick to point out the 'culture' of beats – the right and wrong ways of behaving - and that many straight men have yet to learn this culture. As two respondents said,

> '(The straight beat users) have an incapacity to engage with local gay men and don't know the norms and mannerisms of cruising beats. When they enter into a "gay space", they seem not to know the ways of it.'

> 'There are codes of conduct for beat use – about being discreet and not publicly visible - and lots of straight men abuse that code. (our service organisation) is always getting reports of men exposing themselves in public.'

The beats aren't just for sex: in locations with so few opportunities to meet other men, they can be social gathering points as well, particularly if they are well-out of town and shielded from passers-by. Some beats appear to be known more for social interaction than for picking up.

FRIENDS / PAST SEX PARTNERS

It stands to reason that many men would have had sex in the past year with past sex partners. However, this category (as well as 'through a neighbour') may also include those men who do not use the Internet, or beats, or other opportunities to find new men, because they only have sex with one or two people.

While this means that they are virtually invisible to research such as this, one of our telephone interviewers noted,

> 'One guy called who said he'd only ever given a blow job to his mate … he was very nervous and rapid with his answers.'

One respondent said that a small number of people who turn up at their service fit this profile, and another respondent noted that:

> 'In terms of very isolated guys, you just don't know, but you hear stories. There's one guy I know in his late 30s, he's been having sex with a neighbour since he was 14. He doesn't have sex with anyone else.'

The 'mythology' that 'best mates do each other on fishing and camping trips' was contested. On the one hand, one respondent opined:

> 'Sometimes it's kept within a small number of families, where men are having sex with each other. It's always done under the cover of weekends away, camping, fishing, hobbies and such, which provide both legitimate and effective cover.'

One the other hand, another respondent argued:

> 'I think the stories of men having sex on fishing trips is mythology. I think that sistership in gay circles operates the same as mateship: you just don't have sex with sisters. I don't think straight guys have sex with their best mates, either. There's a strong taboo against it in mateship.'

PUBS / CLUBS / BARS

The interview respondents also confirmed that pubs, clubs and bars were good places to meet men, and that 'lots of cruising happens at pubs'. AS one said,

> 'A lot of (male-male sex) is related to drinking sessions. There'll be a drinking session, and then people will creep around in the night.'

Many towns only have one night club, and it's all in together: as one respondent said,

> 'On the nightclub scene, gay boys will mingle in with straight boys … there's a bit of a "live and let live" attitude in the country.

TRAVELLING RENT BOYS

One significant source of sex is the travelling rent boy. As one respondent reported,

> 'There's a small number of guys who come out from (a major coastal city) stopping at the small towns along the way. They advertise in the personals, and get clients by word of mouth, too. They each do regular circuits.'

WORKPLACE

Despite the low percentages of survey respondents who identify as gay at work, it nonetheless appears to be a significant source of sex partners. As one respondent reported,

> 'After Friday night work drinks or boys nights out. This sex is opportunistic and infrequent, and will never be mentioned again. But this sex usually requires one of the partners to initiate it, and they are likely to want to repeat it. So you might see them again at beats, or at sex on premises venues.'

FLATMATES

Both survey and interview respondents also mentioned flatmates or housemates, one citing a number of instances where young gay men have joined straight households and have been sexually assaulted. As another said,

> 'Where you've got households of single people – students, shift workers –sex will happen.'

Table 1 shows where respondents actually had sex in the past year. It would appear that most men who meet men for sex at an outdoor area, at a sauna for men's sex or at a shopping centre washroom, also have sex there; and that Internet sex results in sex at one or other man's house. Most sex with men met at private parties or adult bookshops takes place on the premises, but some are taken home.

TABLE 11: WHERE RESPONDENTS HAD SEX WITH MEN

Location	No	%
At his home	152	54%
At my home	148	52%
At a park or toilet or beach or other outdoor area	95	33%
At a sauna for men's sex	55	19%
At a private party	42	15%
At an adult bookshop or sex club	33	12%
At a shopping centre washroom	28	10%
At a hotel / motel / caravan park	16	6%
At a brothel or massage parlour	13	5%
At work	13	5%
In a car / coach	3	1%
At a gay bar	2	1%

5.10.2 Do they meet and have sex with men locally or away?

The research sought to get a sense of whether men have sex locally and with locals, or whether they go away.

Sexual health workers believe that MSMs have a degree of protection against STIs by dint of living in (sexually) closed communities; and, as we shall see later, MSMs justify unsafe sex with this belief. However, travel does happen, sexual health workers are worried about it, and the situation needs to be monitored closely. As two respondents said,

> 'There a number of big mines in the district, some of which operate on a "fly in, fly out" basis. The three major mines have a workforce of 10,000 serviced like this. Many of these guys live in Townsville and Brisbane. There's obviously the danger of these guys bringing infections into town.'

> 'Trips to the south-east corner of the state are a real risk. They are much more likely to engage in unsafe sex than when at home. They're going on a great adventure, and they're likely to get lost in it.'

Table 12 shows how men travel for sex. It shows that the largest group (34%) always have sex in town or close by, but that 40% almost never, or never, do. These men travel for sex. In a third of cases, sex is always or sometimes the purpose of the travel.

TABLE 12: TRAVEL INVOLVED IN MEETING MEN FOR SEX

How often?	No	%
I meet a man or men for sex in my town, or close by		
Always	68	34%
Sometimes	56	28%
Almost never	37	19%
Never	38	19%
No answer	85	
Total	284	
To meet a man or men for sex, I travel to another town		
Always	24	10%
Sometimes	70	30%
Almost never	32	14%
Never	107	46%
No answer	51	
Total	284	
If I travel to another town to meet a man or men for sex, that is my main reason for the travel		
Always	27	13%
Sometimes	45	21%
Almost never	30	14%
Never	114	53%
No answer	68	
Total	284	

Some respondents felt people travelled because they were scared of being found out having sex with someone in their own town. As two noted:

> ' The most frightened of being outed will drive miles … a lot of men are too scared to have sex with someone locally … how far they will go depends on how scared they are.'

> 'People from smaller towns could drive 300-400km to somewhere where they aren't known.'

However, others noted that it's simply too far for many people to travel, especially from the inland, and preferred the simpler explanation favoured by both interview and survey

respondents that men travelled to where other men are: mostly, Brisbane, Cairns and Townsville. While respondents were not asked where they went, only two nominated Sydney and one Melbourne.

Remote people (including men from the Indigenous communities) come to get supplies and have sex. Businessmen take opportunities to go to the cities and hang out in bars, catch up with friends, use rent boys, meet Internet contacts, do the beats, pick up men in straight venues. Travellers (including tourists and sales reps) will take the (many) opportunities their journeys presents them with.

The other way of looking at if men travel for sex is to look at who travelled to them for sex, when respondents had it locally. As Table 13 shows, eight out of ten times it was with someone local or nearby, and only a relatively small number of people were passing through.

TABLE 13: WHEN RESPONDENTS LAST HAD SEX LOCALLY, WHERE THEIR SEX PARTNERS CAME FROM

Where he came from	No.	%
Local	158	73%
From a nearby area	20	9%
Travelling through	28	13%
Working short-term here or nearby	9	4%
Working long-term here or nearby	1	0%
Don't know	33	
No answer	35	
Total	284	

Table 14 shows how many sex partners respondents had in the past year. The largest single group had one partner, but significant number also had over 50. We had expected that there might be some correlation between travel and a higher number of sex partners, but further data analysis revealed none: many with low numbers of partners travelled for sex, and many with higher numbers reported having most or all of their sex close by or in town.

TABLE 14: HOW MANY SEX PARTNERS RESPONDENTS HAD IN THE PAST YEAR

How many?	No	%
1	40	18%
2	19	9%
3	16	7%
4	13	6%
5	11	5%
6-10	33	15%
11-15	19	9%
16-20	17	8%
21-30	5	2%
31-40	15	7%
41-50	5	2%
>50	29	13%
No answer	62	
Total	284	

6. Identity and factors that influence it

6.1 *Homosexual … or gay?*

In the last chapter, we started this report by looking at the main segments within the whole population of regional, remote and isolated Queensland men who have sex with men.

We did this by focusing on demographic factors as much as possible (age, marital status) but could not, even at this early stage, ignore psychographic characteristics (attitudes, beliefs and values).

The most striking of all demographic characteristics is identity, or 'the attitude and values-based labels that one attaches to oneself. For example, there is a world of difference between 'I drink Coke' and 'I'm a Coke drinker'. 'I drink Coke' is a statement of behaviour and thus a demographic characteristic. It might apply to anyone from 10 to 100 who acts, without thinking, to slake their thirst. 'I'm a Coke drinker', on the other hand, is a statement that a person identifies with the values so strongly associated with Coca Cola through it's advertising: young, hip, cool, sporty, fashionable, even risk-taking.

The relevance of this analogy is understanding a very important distinction between 'homosexual', and 'gay', and equally between 'heterosexual' and 'straight'

6.1.1 What's the difference between 'homosexual' and 'gay'?

Not much, according to the Oxford English Dictionary. The dictionary defines 'homosexual' as 'sexually attracted to people of one's own sex'; and 'gay' as 'homosexual; of or pertaining to homosexuals; intended for or frequented by homosexuals'.

Yet if you look carefully, you see a fine distinction between the two. One is about the sex act itself, and the attraction behind it. The other is a somewhat broader picture: unnamed things that 'pertain' to homosexuals, or are 'intended for' them.

Trawl through references to 'gay' and 'homosexual' on the Internet and this fine distinction becomes clearer. References to homosexuality are clinical, abstract and mainly deal with physical or psychological matters. References to 'gay' are sociological and cultural: they talk of communities, of art, literature and politics, and of how people choose to define themselves. This is perhaps best put by the OED's footnote of 'gay pride' as 'a sense of strong self-esteem associated with a person's public acknowledgement of his or her homosexuality'.

So there is, after all, a difference between 'homosexual' and 'gay'. It is a difference between behaviour and identity: between what a person does for sex, and how they see themselves and the culture they identify with. A person may well engage in homosexual acts but not see themselves as gay, or identify with a gay culture.

In fact, as this report will argue, regional, remote and isolated men who have sex with men in Queensland commonly see themselves as straight.

Another way of looking at the distinction between behaviour and identity is the ongoing 'nature versus nurture' debate. According to QUT's *Inside Out*[4]:

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[4] INSIDE QUT, October 7-20, 1997, Page 3

> 'QUT senior lecturer Dr Michael Dunne and Dr Michael Bailey, a visiting researcher from Northwestern University in the USA, said preliminary findings from their six-year research project had shown that sexual orientation in men was primarily determined by genetics, but expressing that sexuality depended on environment.
>
> 'It's pretty clear that the expression of something like sexuality really depends upon the time in which you live,' Dr Dunne said. 'It's much easier in the 1990s to express some genetic predisposition to being homosexual, to being sexually adventurous, than it was in the 1950s or 1930s.'

6.1.2 How respondents see themselves

The distinction between engaging in homosexual sex, and being (or seeing yourself as) gay, is a key distinction, and a good example of how clear language can help progress dialogue and understanding about important issues. Yet in everyday life, the two concepts are often confused, or used interchangeably.

We asked survey respondents what the words 'homosexual or gay' meant to them, if that was their chosen identity. The largest number did not differentiate between the two: it all meant 'men who had sex, or a desire for sex, with other men'.

Some implied a difference between the two when they were quite emphatic about homosexuality only being about sex acts or sex attraction, and not about the bigger issue of how one lives one's life (or, as one said, 'homosexuality is only a small part of the whole persona'.)

Another group did not differentiate, but saw the behaviour and identity elements. Generally the differentiation was either simplistic or confused:

> 'A person who falls in love with and/or finds the same sex sexually appealing.'
>
> 'Being attracted emotionally and physically to other men'
>
> 'Gay = sleep with men and am happy about it and well-adjusted'.

Equally, there were those who did differentiate between gay and homosexual, but also had either simplistic or confused definitions:

> 'Gay means more inside ... Homosexual- more legal, human rights situation'
>
> 'The difference between a gay man and a man who has sex with men is a gay man can love another man'
>
> 'I'm a man who has sex with men, is sexually attracted only to men and wants to identify as not heterosexual.'

Lastly, there was a small group for whom the distinction between gay and homosexual was a distinction between identity and lifestyle:

> 'Gay = identification both sexually and culturally with a sub-culture of the mainstream.'
>
> 'Homosexual = person who has sex with members of the same sex, normally used for guys. Gay = more open/natural/relaxed about his/her sexual preferences.'
>
> 'They mean I am gay out and proud.'
>
> 'Gay means that I speak fluent fag, party and love Monday nites on free-to-air TV'

> 'To me, the terms homosexual, bisexual and heterosexual refer to the physical/sexual/emotional attraction a person feels, whereas gay and straight refer to lifestyle the person chooses to live. For example, it sounds contradictory, but I believe a person can be homosexual, but not 'gay' (live the gay lifestyle).

This distinction was made in several cases to point out while they had sex with men, it was not their identity, such as in:

> 'Being gay (sic) is my sexual preference, not my lifestyle.'

One survey respondent identified as queer: 'which has political connotations'

Most of the (small number of) people who identified as heterosexual or straight saw these as describing their sexual attraction to women, which fitted them best. They described their attraction to men either as a curiosity (implying they were either pre-action or early experimenters); or very occasional or rare encounters; or into transsexuals.

One went straight to the heart of the identity issue when he said,

> 'Straight means that I'm a man.'

6.2 *So where does that leave bisexuals?*

Our analysis of the difference between identity and behaviour raises the important question of whether 'bisexual' best describes one or the other.

It clearly describes behaviour. A much larger number than identified as heterosexual identified as bisexual, and most of those who identified as bisexual were clearly describing it as a desire to have sex with both men and women. As one respondent said,

> 'A bisexual is a person who has no firm preference on the gender of their sexual partner. They enjoy sex with either.'

While a few expressed a leaning toward a preference for either men or women, almost all did not. Several expressed a main attraction to their girlfriend or wife, and pointed out how much they enjoyed sex with them, but wanted (oral or anal sex with a man).

The men who didn't think about their identity had mixed reasons for doing so, mostly because they rejected labelling of what they felt was a fluid, unclassifiable aspect of their lives.

Interview and survey responses did not help us answer the question of whether 'bisexual' can describe identity as well as behaviour. We had initially expected that such an identity might be something libertine, sexually progressive, with a 'best of both worlds' flavour; that it might be something like a 'swinger'; and positively held at least by people engaging in bisexual behaviour. Despite our inquiries, we did not get a sense that people adopt that identity in regional, remote and isolated Queensland.

6.2.1 What the survey said

Table 15 shows how respondents see themselves sexually. Half identify as homosexual or gay, just over a third as bisexual and a small percentage as heterosexual or straight. This did confirm an impression gained from the interviews that men might refer to themselves as heterosexual / straight to the broader world, but to the interviewers preferred either bisexual or homosexual / gay. As noted above, the interviews would suggest that 'bisexual' is used to describe their sexual behaviour, rather than their identity.

TABLE 15: HOW RESPONDENTS SEE THEMSELVES SEXUALLY

Sexuality	No	%
Homosexual / gay	125	48%
Bisexual	95	37%
Heterosexual / straight	21	8%
Don't think about it	19	7%
No answer	22	
Total	**282**	

6.3 Factors that influence identity

We previously quoted QUT senior lecturer Dr Michael Dunne as say that expressing one's sexuality depended on one's environment. While this is true, it doesn't tell the whole story. Social marketers (such as those who design anti-smoking and drug use interventions) categorise factors that influence behaviour and identity into three groups:

- **personal factors** (the life skills and abilities that one uses to influence and control events in one's life, including one's perception of oneself)

- **interpersonal factors** (the influence of people close to oneself and one's reactions to those influences)

- **environmental factors** (the cues and pressures about what is acceptable / desirable or not to one's broader community).

We agree with the hypothesis advanced by Dr Dunne (and by many, many others) that desire to have sex with other men is essentially genetic, or at the least not something that a man has a choice about. Their choice is whether they act on their desire or not.

The story told by interviewees is fairly consistent with this hypotheses: that, fairly early on in life, they identified a sexual interest in other men; they consciously or subconsciously made assessments of the degree to which this behaviour would be supported by others; and then undertook behaviours and adopted identities based on the personal skills they had to reconcile the conflict between what they wanted to do, and what they saw as socially acceptable.

For a few, this appears to be a conscious process; for , it's intuitive and rather 'the way that things work out'.

This means that to understand what 'causes' identity, we must understand the personal, interpersonal and environmental factors that determine it.

6.4 Environmental factors

We cover environmental factors first because from the interviews and surveys, respondents identified these factors as by far the most important in influencing their identity.

6.4.1 The all-pervading creed of machismo

Defined (loosely) by the OED as 'a show of male virility and masculine pride', machismo was identified by many respondents as being alive and well and a strong influence on life in regional, remote and isolated Queensland.

As one said,

> 'This is a harsh environment and traditionally male-dominated. There's all the hardship associated with living on the land, and the sacrifices of the pioneer life. It's about mining and cattle. It's very heterosexual and macho.'

These attitudes have a practical and enduring effect on the way young men are raised, and the expectations on them. As two respondents said,

> 'The macho things starts very young. Kids are raised by their dads to fight and drink and be tough. I suspect there's as much of that as there always was. The fact that there are more gay guys visible would help some of them, but there are still a lot of today's kids who are going to have a shit life.'

> 'The thinking is, "If you're a man, you have to get married and have kids, be a brawler, drink beer, play sports … there's a great deal of pressure in that direction. How much pressure depends on their friends and family.'

Definitely, sex with other men is not part of any interpretation of machismo:

> 'The attitude is that it's OK to get pissed and to beat up the wife and kids, but any feelings for other men are completely taboo.'

> 'Obvious displays of heterosexuality (pig shooting, rodeos, trucks and bikes) are the norm.'

However, it's worth reminding ourselves that machismo is an environmental, cultural factor. This means that its influence will vary from community to community, as was pointed out by several respondents. As two noted:

> '(How people feel about homosexuality) depends on how 'macho' the local culture is. I've lived in various parts of Western Australia and Queensland and it varies markedly. In some outback mining towns, there is total denial of any gay or bisexual activity.'

> '(This town) is very much a melting pot, a lot of people from different Indigenous communities come in from outlying areas to do their shopping and to access services. Sex with men is pretty much taboo in most (Indigenous) communities, even more so in those where the young men still go through initiation ceremonies.'

Equally, the influence of machismo on individuals within communities varies: as three respondents noted,

> 'The young ones are under a lot of pressure to identify as macho, and so identify as straight or as 'new vogue bisexual'. They'll stand around telling you how much they want pussy, then they'll disappear out the back and have sex with a guy.'

> 'There's a distinction between group and individual behaviours. There is such a strong macho culture, an all-pervading heterosexual environment, and it's not just that it's really easy to fit into it, it's a requirement for a quiet life out here. Standing at the urinal or at the bar for a beer, you'll hear them talking on about how they're out for the night to 'get a bit of pussy'. But in private, their views are different, much more tame.'

> 'Those people who go off and be nasty to gays I think are afraid of their own desires and thoughts, afraid of maybe being attracted to men themselves. But separately, they also want to be seen as super-macho. It's a childhood belief that's drummed into their heads that "you don't have sex with other men … it's a no no no … it's a sin".'

6.4.2 'Everyone is straight here'

Fortunately, Australian culture being what it is, 'machismo' is generally regarded at the extreme end of the spectrum of thought about male/female roles. Queensland communities tend not to ostentatiously, openly (and, importantly, legally) display macho values in the same ways as, say, the Latin American cultures from which the term derives.

Instead, the acceptable face of machismo is 'being straight'. This is universally held to be getting married and having children – and definitely not looking sideways at your peers in the shower block.

The advantages of 'being straight' are evident and considerable, and young country men face intense pressure to marry and have kids. They live in the community, they understand the expectations on them, and they meet those expectations. In the country, no-one is brought up to be gay.As two respondents said,

> 'Family life offers men an identity, stability and most of the things that are held by society to be desirable. It's an extremely attractive package.'

> 'In country towns, everyone who knows you and has grown up with you has the expectation that you'll get married and have kids. That's enormous pressure.'

Although it was seldom verbalised by respondents, it became clear that the default condition of a straight identity was to avoid any hint or rumour of sexual interest in other men, rather than marry and have kids. Single men are accepted as straight so long as they are rumour-free. However, marriage and kids is an effective talisman against rumours: the presumption that 'he can't be gay, he's married and has kids' still apparently widespread.

6.4.3 Homophobia and discrimination

Equally, the disadvantages of not being straight are very evident and very considerable in regional, remote and isolated Queensland. While life might appear to be fun and even 'trendy' (superficially at least) for small numbers of gay men close to the centre of Brisbane, the ability to live unmolested even a private gay life is fast evaporating by the time one reaches the outer suburbs and survives against significant odds only in small pockets throughout Queensland. Most respondents reported anti-gay sentiment as very much the cultural norm.

At the extreme, there is homophobia, defined by the OED as 'a fear or hatred of homosexuals'. One respondent told us,

> 'In this district, in the past two years, men have been murdered, bashed, lost jobs, been discriminated against at work, ruined, treated very badly by health services, and have had their house burned down – because they were gay or perceived to be gay. And that doesn't count the men who committed suicide or who left town.'

Commentators have suggested a number of reasons for homophobia. One was that mentioned several times by respondents was the equation, 'gay = paedophile = threat to my kids'. This (while basically a malicious, ignorant slander) has the apparent virtue of protecting the family unit and thus is an acceptable 'straight' position.

Others talked of the fear of 'being hit on': as two respondent said,

> ' You have people who think "poofter, faggot, you stay away from me" … but now that I've been around some gay men who don't try to pick me up, I'm much more relaxed about it than I used to be. Lots of straight guys don't have problems with lesbians, but they have big problems with two guys together.'

> 'It seems to be easier for lesbians. There are quite a few around, and it doesn't seem to be an issue. I guess lesbians are every straight guy's fantasy, whereas straight men tend to think of "the act" when they think of gay sex. They think of anal sex which they see as dirty and unnatural, as in, "I don't want any poofter bastard trying that on me".

Next down from homophobia is a more generalised discrimination. As one respondent noted,

> 'People still feel that homosexuality is legitimate grounds for discrimination, unlike disability or Aboriginality. They still tell poofter jokes in bars and in the pubs, and they still tell derogatory jokes about gays in the workplace. There's a general feeling now that you shouldn't tell these types of jokes about Aboriginals or people with disabilities, but you can still tell them about gays.'

6.4.4 Religious fundamentalism

In most Queensland towns, religious organisations play an important part in social and cultural life, through the influence of their leaders and followers. The research indicated some minor acceptance by mainstream churches for being gay, it was felt that none of the fundamentalist sects view homosexuality positively, with disapproval ranging from strong to fanatical (as in the OED's use of the term as meaning 'their fanatic sense of righteousness, their absolute certainty that … they alone had God's ear').

While there is an extensive literature on the problems young Catholics have had exploring their sexuality (and one quote is included below to remind us of the flavour of it), most concern was reserved for the fundamentalist sects. As respondents noted:

> 'The Anglicans encourage the participation of men and woman who are not practising homosexuals. With the Catholics, you have to renounce it completely. With the fundamentalists, you are damned no matter what. Nothing you can do will make God love you more or less than he does already, so there's nothing you can do.'

> 'The fundamentalists are those that take a literal interpretation of scripture to condemn gays. The major churches acknowledge gays and have made some sort of space for them, whether formally or informally. But with the fundamentalists, it's vilification and hatred from the pulpit. They feel quite free to play on the hatreds and fears of people.'

> 'These churches are dangerous: they're like cults. We look kindly on things called churches because we have an expectation that they are loving, caring communities. But they're not; they're breeding grounds for intolerance, prejudice and bigotry, full of people with personal problems. These churches suppress the desire and imagination in people. It's not healthy.'

> ' I became a fundamentalist Christian when I was 19. They were a very conservative, racist, homophobic group of people. They had an expectation that you were heterosexual; anything else was considered extremely abnormal.'

> 'I'm a Catholic myself, and that's one of the things that made me hate myself so much, and made me feel so guilty about my sexuality … but when there's no alternative (to being gay), its me, it's the way I am, then you just have to fight through your sense of guilt.'

Several respondents puzzled over why the sects were so vehement in condemning homosexuality, given that there are many behaviours in the bible that are condemned. One respondent extrapolated from his own experience that it might be because sect followers are running away from their feelings of homosexual desire. We will look at this in the next chapter, under Taking up religion.

Others see more worldly (mercantilist and populist) reasons behind the fundamentalists' position:

> 'It's popular. It's motherhood. It gets support from everyone. The few people who don't agree are too scared to contest it. It's a hook by which to make the cult more popular. It gets bums on seats, and that means extra income.'

> 'There are lots of Christian outreach churches here and lots of churchgoers. They play unashamedly to family values. People like it here, they come here because they see it as being a 'family town': no drugs, no kidnappers, no drive-by shootings, no paedophiles.'

As one Indigenous respondent noted, the churches historical role in communities is also important:

> 'All the communities have sistagirls, but some are more accepting than others. The influence of the church and the histories of communities as missions is a big factor that affects how accepting communities are, especially in Cape York and the Torres Strait. In some communities, they're fairly open and sistagirls have been elected to local government. In others, it's the opposite'

While respondents were almost uniformly negative of the role of churches, one did note that:

> 'There are some clergy who are supportive, but I don't know how many men look to the clergy for support.'

6.4.5 Small town values

While small towns are often portrayed as bigoted, small-minded places where everyone knows everyone else's business, some respondents felt this image to be unfair. While gossip about one's private life is obviously of great concern to MSMs, this needs to be offset against a 'live and let live mentality' that is often, too, found in the country. As two respondents said,

> 'People out here tend to be open-minded and friendly. I feel in some ways that smaller communities are more accepting. People get on with their lives … people don't care … gay guys are everywhere.'

> 'In the country, the feeling is that unless you go out and make yourself offensive, there's a collective realisation that everyone has to live together. In everyday terms, it boils down to demeanour and dress *(as well, of course, as not being caught in the act)*. There's a threshold of what is acceptable, as long as you don't exceed that, you're OK. Most people are happy to leave it at, "Well, he could be or he couldn't be".'

The latter comment may go some way toward explaining the varying attitudes encountered by out gay men. Our general impression from interviews was that the straighter the out men acted, the more acceptable they were. Or, as one respondent noted,

> 'The ones that tend to have the easier time of it are the ones who aren't effeminate, or who are less effeminate.'

This would tend to suggest that abandonment of the straight identity might be as much an offence against values as the actual sex act itself, fundamentalists notwithstanding. While some might interpret this as a somewhat tolerant attitude, its effect is to encourage MSMs to look straighter than straight men themselves, and thus reinforces the hegemony of the straight identity.

The above notwithstanding, another respondent had a different explanation for how the small-town dynamic worked, saying.

> ' In small towns, men having sex with men is seen as freaky and unacceptable. And people are perhaps more open in their views about these things than they are in the big cities. This makes men afraid of being identified, because they will be a target of rumour and harassment, sometimes even violent. It restricts your social life, because it's hard to go to nightclubs and not get harassed, for example.

It is also worth noting that 'small town values' vary widely between locations. While some respondents found their localities to be reasonably accepting places, others did not. As one respondent said,

> 'This is the most insular city on the whole east coast. It's provoked by difference: difference creates attention. It's a matter of xenophobia as much as homophobia. If anybody's 'different', the response is, 'Well, he's not from here, he's just passing through. (Homosexuality is not talked about in (this town). Everyone's too scared to talk about it. I think that other towns are more accepting. This town has a very low tolerance for diversity. They've been steadily been knocking down public toilets for years, which has driven it into the shopping malls and out of town.'

As noted before, the other main environmental factor about small town living is the relative lack of anonymity. As three respondents said,

> 'Everyone knows everyone else's business. If you don't know what you did last night, you've only got to ask your neighbour. Because of the gossip factor, it has to be very closed door. You've even got to put the cat out, or else the cat will have something to say!'

> ' You don't have the anonymity in a small town. For example, I had people calling up my friends and asking them if I was gay … and I didn't even know these people!'

> 'A lot of the small towns are real busybody places where you can't do anything without the rest of the town knowing about it. It's very hard for men who have sex with other men, not so much from the macho pressure as from trying to make sure that the neighbours don't find out. It's not denial, it's just the reality of their life. Out of town they'll open up, but not at home.'

6.4.6 Negative perceptions of being gay

The other main environmental factor affecting the lives of MSMs is what 'gay' means in the country.

On the one hand, TV is felt to have a positive effect in showing gay lifestyles: in fact, it is the only environmental factor that supports gay identity. Shows like *Queer as Folk*, *Queer Eye*, *Big Brother* and *Australian Idol* with their gay characters show being gay as acceptable. As one respondent noted,

> 'People watch these shows and talk about them. If it keeps going, it will make life a lot easier. It makes it easier for guys to make a decision about it.'

On the other hand, positive role models are few and far between on the ground. One respondent felt'

> 'If you acknowledge your feelings for other men, you believe you're going to have a life of creeping around in the bushes looking for sex, or joining the church to molest little boys.'

Another respondent from a fairly gay-friendly city noted.

> '(MSMs) almost never come into contact with any gay men who feel good about it. We ran a group once to introduce them to other men, but the problem was that although this was meant to be a positive, reinforcing experience, there was no-one in the group who felt positive about it. Most had never had any social contact with a man who identified as being gay.'

The norm in the country is that 'gay' is not seen in positive terms. As one respondent said,

> 'Most people identify "gay" in pathological terms … it's a problem. It's a negative label, so gay men think, "I wish I wasn't … it's my bad luck in life …. If I was born again, I'd have it differently … now, I've got to do the best I can". Poofter equals stigma, shame, denial, secrecy, being scared.'

One respondent even identified gay community attachment as a health and social risk:

> '(What are the risks?) Heavy drinking in gay bars and getting involved with people I wouldn't normally … isolation due to friendship just not forming cause they want your cock only'

6.5 Interpersonal factors

Interpersonal factors are those to do with the relationships between a person and those close to them: mainly family, workmates and people they mix with socially. This also includes people (such as those who physically or psychologically harass the person, or anonymous sex partners) who carry messages about sexuality from the person's general environment into their immediate space.

6.5.1 Physical violence

At the most extreme end of these factors is the threat of physical violence from being known to, or suspected of, having sex with men.

Opinions varied on the extent of violence. Table 16 shows survey respondents level of concern about violence, discrimination and trouble with police, through looking for and having sex with men. While a majority were concerned, almost a third were not, and one in ten weren't sure.

TABLE 16: AGREEMENT WITH PROPOSITION THAT 'I AM CONCERNED ABOUT VIOLENCE, DISCRIMINATION AND TROUBLE WITH POLICE, THROUGH LOOKING FOR AND HAVING SEX WITH MEN'

Agreement	No.	%
Strongly agree	73	33%
Agree	58	26%
Not sure	24	11%
Disagree	26	12%
Strongly disagree	43	19%
No answer	60	
Total	284	

Many interview respondents felt that there was little or no violence in their locality. Others, when talking about violence, were talking about episodes between six months and several years ago. On the other hand, many respondents did report instances of bashings on beats (generally as an occasional phenomena) and did rate it highly as a safety concern. As one said,

> 'There's the occasional basher, and you can certainly be in the wrong place at the wrong time.'

There was also the well-publicised bombing of the Townsville AIDS Council, which is well-remembered throughout Queensland.

Several respondents mentioned violence, and particularly self-harm and violence within same sex relationships, that is so often connected to alcohol misuse.

Although violence did not appear to be a major issue, violence or the threat of it can have a profound and lasting effect. One respondent summed up what are probably common experiences for many MSMs:

> 'People swearing at you because you're a gay man … people walking up to you and punching you in the face. If they know they can get away with it, they'll do it … Being at a beat and straight guys come in and catch you doing something … having people put you down and want to fight you ... getting beat-up at gay beats. Coming across some aggressive or angry/confused gay/bi/straight guys who are looking for sex at beats ... some people swear at me, some physically hit me ... idiots driving by in cars yelling faggot, people calling me a faggot at work …'

THE POLICE

Table 17 shows the survey respondents level of interest in reporting violence or discrimination against men who have sex with men to the police, and have action taken. While almost half wanted to, a third did not, and one fifth were undecided. This would suggest that it is not an important issue with significant number of MSMs (the 'not sures')

and that many others (the 'disagrees') perhaps have significant barriers (like fear of disclosure) to doing so.

TABLE 17: AGREEMENT WITH PROPOSITION THAT 'I WANT TO REPORT VIOLENCE OR DISCRIMINATION AGAINST MEN WHO HAVE SEX WITH MEN TO THE POLICE, AND HAVE ACTION TAKEN'

Agreement	No.	%
Strongly agree	63	28%
Agree	36	16%
Not sure	42	19%
Disagree	17	8%
Strongly disagree	65	29%
No answer	61	
Total	284	

The general tone of interview responses was that the police were much more accepting of homosexuality than in the past, no doubt due to the Police Liaison to the LGBT Communities Program, and related training. It was suggested by several that the perceived reduction in violence may be due to it having filtered through to potential bashers that the police were now not the natural allies they might once have appeared to be. While police appeared to be an increasingly-recognised resource, it was felt that the program was weakening in some areas, and not effective in others.

Being picked up and harassed by police was also rated as a concern by several respondents. Indigenous respondents expressed the greatest concern. As one said,

> 'I get worried when I get questioned by the police. A lot of people die in jails. The inquest might say that I'd killed myself, but I'm not the type with any inclination to kill myself … although I'd say that the 'bully men' aren't as bad as they used to be.'

Another respondent had been stopped by someone claiming to be a police officer and harassed, although it was not clear whether the harasser was in fact an officer or not. There were also reports of beat workers being harassed by plainclothes and uniformed police for 'loitering' and for suspicion of being gay (with one person being told that homosexuality is a criminal offence in Queensland). However, the possibility exists that some so-called plainclothes police are in fact impersonators, since men are generally too intimidated to ask for identification.

There also appeared to be some confusion on-the-ground about whether the brief of liaison officers extended to straight-identifying MSMs, or whether its boundary was the gay community.

We were not able to gauge the way in which the work of liaison officers promotes health education. While it is appreciated that health education is not necessarily the work of liaison officers, their work has significant sexual health consequences (and within that mental health consequences) and these should be better understood and communicated to liaison officers.

RECOMMENDATION

5. **Given the valuable role of the Police Liaison to the LGBT Communities Program, that this program be evaluated with a view to addressing deficiencies and defining possible linkages with health education.**

6.5.2 Harassment, intimidation and ostracism

Next on from physical violence is the more general harassment and intimidation that men face, or expect they would face, if their sexual behaviour was widely known.

Openly-gay respondents reported being called a fag in public places, sneered at and taunted in shopping centres, abused (and in one instance hit) in pubs and night clubs and otherwise made to feel distressed. Openly-gay have had 'fag' scrawled in paint across their cars, and had abusive letters left in their mailboxes.

Harassment was also reported in slightly less subtle form of mischief-making. As one respondent reported,

> 'A gay guy I knew had as neighbours a group of young people from religious backgrounds who would play loud music and make lots of noise and play anti-gay religious propaganda till the early hours in the morning. He talked to them about it, and they made it clear in a roundabout way that they thought he was a 'faggot with AIDS'. That he was, in fact, HIV+, only made it more distressing for him.'

For some, the possibilities of ostracism are comprehensive and potentially devastating:

> 'I'd be banished if anyone found out ... I'd have to go packing … loss of friends and family … contempt; ridicule … being excluded from "couple"-dominated social events … homophobia from some people … I dread to think!!! … If friends found out they wouldn't talk to me, I wouldn't get a job on the farms and couldn't drink in the pubs ... being treated badly by members of my sports team. I also coach a kid's sports team and wonder whether children would be withdrawn from the team because parents probably link homosexuality with paedophilia ... public humiliation ... burned at the stake! … people don't like that sort of stuff, there would be problems …'

6.5.3 Rejection by family & friends

The most powerful of factors of all types reported by respondents was fear of rejection by family, and by friends. As two respondents said,

> 'How tough it is for guys to come out depends very much on the reaction, or the expected reaction, of the family, on whether you think they're going to love you or hate you.'

> 'The biggest factor of all is whether they feel they can talk to their family. The biggest thing these guys of all ages want is acceptance.'

In the first instance, this severely affects young people exploring their sexual identity, as two respondents reported.

> 'One young guy I know, when he came out to his family, they burned all his clothes, and tore up all the family photos with him in them. They saw themselves as the good Christians and him as the black sheep of the family. They've come to regret what they did, and have tried to mend the bridges, but he's giving them back now what they gave him.'

> 'All the time the kids are hearing "fucking faggots this, fucking faggots that". There's a huge amount of pressure, especially if you've got a redneck parent. The daughter who's pregnant, or the son who's gay, will simply be kicked out of home. This is what ends up in youth suicide. If the kids have these tendencies, where do they go? The services aren't well-publicised, and often don't exist in the country.'

When we wondered at the sort of mentality that would cause such strong reactions from parents, respondents were more than happy to enlighten us – while at the same time indicating that in many cases the hurt heals with time. As three respondents said,

> 'Every parent wants the best possible for their child, and they think that gay men grow up to be lonely old men who don't give them grandchildren, and they don't want that. They want them to grow up to be model

heterosexuals. There's also the thinking that gays are all paedophiles, so they pose a real threat to their children.'

'My dad doesn't accept it, but he understands. A dad's pride is a dad's pride. I think he's disappointed. I've got a half-brother, but I'm the only real son he's got. I'm the only male that carries dad's name. He used to go on about it, with things like, "If you're a fag, then all those generations of history will stop". He was an arsehole about it at first … but he's better about it now.'

'I've seen kids who've been thrown out on the street by the father (not usually by the mother). It's almost like they feel that they've created a deformed child who they can't love. Fathers have such high expectations for their sons. Having a gay son is a major shock. It can break up the whole family. Often, the son moves away.'

'Many people see gays and lesbians as a threat to family values, and somehow our "choice of lifestyle" is an attack on families. It's like they see us as somehow opposed to them, even enemies of them. Of course, it takes an enormous amount of self-centeredness to see someone else's choice as an insult to you, but this is the way they seem to think.'

The situation is no less difficult for men with established families, with little to mitigate the gloomy picture for men considering their options. Many towns have strong communities based on religious or ethnic affiliation (Catholics, Muslims, Italians, Yugoslavians, Albanians, Middle Eastern nations were just some of the groupings reported), which in a rural, foreign country context only emphasises strong family bonds. As one respondent said,

'These men are often brought up in big, extended families – married, with two or three kids, granny in a flat on the property – and they have substantial holdings, cane, fruit, avocados, whatever. They are cemented into their situation, and it would be extremely hard for them to extract themselves.'

The way that social life revolves around sport and get-togethers opens up the possibility of group harassment. Wives will be shamed; children will be harassed at school and their fathers humiliated in front of their peers. Most of all, they might lose everything they have, their whole lives. As one respondent said,

'They perceive they will lose jobs, friends, wives, girlfriends, families; they'll be beaten up by their mates; they won't be able to have a beer at the pub; they won't be able to live the life they want to live. They don't want to live a gay life: they want to live a straight life, but they need to have sex with men. They fear their possible losses greatly.'

This fear of loss is perhaps the strongest factor of all. These men fear losing their wives, their children, their in-laws, their friends, their careers, their businesses and their homes. And they routinely believe it to be either a strong possibility or an inevitability: of losing everything, of being cast out, of having 'nowhere to go', of having no support. As three respondents said,

'Usually, when relationships of whatever type break up, one or both of the partners have to leave town. So you lose your family and your kids.'

'I've seen some men who have decided to come out. Some have had to leave their partners, children and jobs. Only over time have they managed to win back some of the things that they've lost.'

'It's harder here than other places. If it goes wrong, they expect that they'd have to leave town. By going wrong, I mean that wives, families and friends don't accept it, so they don't have any support or anywhere to go.'

It is therefore not surprising that most MSMs don't want to be identified or associated with the gay community, because of the possible ramifications.

While one respondent simply stated that 'family disclosure would be devastation', it is worth noting that this is not always an accurate perception. As we shall see in the next chapter, sex with men often occurs with some wife or girlfriend involvement or permission. The larger

towns (Cairns in particular) do offer looser family connections and a greater degree of anonymity). Also, as Table 18 shows, many survey respondents have people that do know about their situation and life presumably goes on for them. Respondents who had come out described the process as often difficult, but something they managed. As one respondent said,

> 'Of course, (rejection and family devastation) can, and does, happen, but you can get through it if you're brave enough and don't care what people think. When they finally tell people that they like sex with men, the reaction is often, "I've always known that". If you really trust a person, it will be OK.

TABLE 18: WHO KNOWS THAT RESPONDENTS HAVE SEX WITH MEN

Who knows?	No	%
Male partner	146	51%
Close friends	92	32%
No-one	78	27%
Most people	67	24%
Close family	65	23%
Close workmates	41	14%
Female partner	22	8%

Therefore, it would appear that fear of losing friends and family is a primary concern of MSM, and a particular concern for young MSMs. This may significantly affect their ability to make life choices and may, as we shall see later, lead to a range of mental health issues. There is a role for Queensland Health, as both a sexual and mental health matter, to raise with parents that their children may be different, and to create a 'space' where both young MSMS and their parents can talk about the issues. Such promotional efforts would also be expected to create a more supportive environment within the families of older MSMs.

RECOMMENDATION

6. **That Queensland Health undertake promotion and information activities to advise parents that some children are attracted to the same sex, the social and health importance of supportive responses and suggested supportive responses.**

6.5.4 Lack of support

'Lack of support' is the flip side of the same coin as 'rejection by friends and family'. The anticipated hostile reaction of friends and family man that they have no-one important in their lives to talk to. As three respondents said,

> 'In my town, if a guy came out, he would have to move out. I can't imagine his previous social milieu continuing. There would be no social support. He'd be divorcing and moving out, because suddenly he'd have no-one to talk to.'

> 'What young men need most is support from their own kind – friends, family, trusted people. The social structure just isn't here. These issues are kept quiet. They feel that if they seek help, they'll get kicked in the teeth.'

> 'Families aren't comfortable talking about sexuality. So lots of guys won't talk about it because they're afraid of the reception that they'll get.'

They often can't talk to their families of friends, don't talk to the men they have occasional sex with and don't know any other MSMs that they can talk to. There is no support and, even worse, there are no role models. In many towns, there seems to be simply no-one to talk to – or no-one whose confidence and motives can be trusted. As two respondent said,

> 'There's simply no-one here in town to talk to. When I was coming out, I needed someone to talk to. There were only dirty old men, who wanted sex with me but they didn't want to talk to me about it. A (particular sexual health worker) is there now, and he's great, but most people don't know about him, and how he can help them … and he's just one person, he mightn't work there for ever.'

> 'Even though I'm 'out', people think that I'm far too butch to be gay. When they finally believe it, they often hassle me for too much information about sexuality issues and what I do sexually. And none of it is supportive … you get the feeling that they're looking for gossip that they can use against you in the future.'

There is little doubt that many MSMs are looking for someone to talk to in a meaningful way; opportunities to reflect, input, talk. They want to know how other men in their situation are dealing with the issues. As four respondents said,

> 'What do they ask me? Am I unique? Am I the only person the planet like this? Are there others like me? How does my experience compare with others? And where can I go to talk about this?'

> 'There are a few guys who phone me for advice, and to talk about it. It's not really a friendship, and it's not for sex. They just want to talk to someone. The more they talk, the more comfortable they are. They just don't have anyone else to talk to.'

> 'People come here stressed, drunk or high and want someone to talk to … they just want to talk … how it started, when they first discovered they were like that, their degree of comfort with it, whether they're happy with it, whether their children know, whether they accept it … and also their terror at being outed.'

Despite our previous observation that MSMs want no public contact with gay men (or the gay community where it exists), it stands to reason that a visible gay community would be of some benefit to MSMs. Unfortunately, gay contact does not seem to have been a wholly-positive experience for some respondents. As four respondents said,

> 'There are a few cliquey groups in town, but because it's such a small (gay) community, everyone bitches about everyone else, and they stick to their own circles.'

> 'I know this 21 year old guy who had a lot of trouble coming to terms with his sexuality, because the only thing he knew about being gay was what he saw on TV about the Mardi Gras. He wondered how he could be gay, because he knew that *he wasn't like that*. It caused him a lot of trouble.'

> 'There are very few opportunities to meet people for meaningful exchanges. There might be other gay people, but they're not necessarily the sort of people who you'd choose as friends. And it's an incestuous environment; everyone knows each other's business. There are few people to turn to for advice.'

> 'This town is bible belt, Pauline Hanson territory. The gay community is not visible, it's very much a ghetto mentality, you either fit in, or you don't. It's black and white, there's no in-betweens.'

6.5.5 Discrimination at work

Discrimination at work, ranging from loss of job through to the 'cold shoulder' was reported as a reality by several out gay men and as a fear of many who were not.

Several respondents reported losing their job, or not getting a job. As one said,

> 'I've been knocked back for being gay or more precisely for "being too open" about my sexuality … where I was working some people found out I was gay, they didn't want me back on the premises despite having been congratulated before on my work. Other workers wanted to tell the public, which created a problem for me. When I'd walk into the panel shop they'd say "fucking fag, don't come in here, don't let me catch

you talking to my mates”. They used to pick on me all the time. One day I answered back to some other workers in front of my boss and he didn't stand by me, he told me not to stand up for myself. Two of the other were picking on me. They might have been gay themselves, they were in their late 40s and didn't have wives or girlfriends. If someone liked you and couldn't get you they'd pick on you ...’

A very similar story was told by another respondent,

> ‘A bisexual guy knew about me, and the news went from him to this other “heterosexual” guy who outed me. This “het” guy was in fact having sex with guys, and he had put the word on me for sex, but I had rejected him. Then he outed me by telling other workmates that he thought I was queer.’

Although it has no doubt happened to more than one or two men, we did not get the impression that being sacked for being gay was a routine occurrence. The fear was more of being discriminated against, through ostracism, lack of promotion or general harassment. As three respondents said,

> ‘It often wouldn’t be formal (like being sacked), but rather sideways looks and glances and the ostracism from social networks.’

> ‘Especially in the public service, such as in local government or a public organisation in the bush, anyone who is looking for a career would have to be very careful about how they were identified. Being gay is not an advantage. Politics works in very indirect ways, and it’s easy for your career to stall , for you to be left out in the cold, and for you to find yourself looking for something else. I think in other industries it’s possibly more relaxed, so long as you do your job well.’

> ‘I was harassed by other workers. There was verbal abuse, and I was sent to Coventry. I was shunned and ignored, and the company tried to make sure that our customers – the people I dealt with - didn’t find out I am gay.’

This picture is consistent with the findings of a December 1999 study titled *The Pink Ceiling Is Too Low*[5] which examined the work experiences of more than 900 homosexuals in Victoria, NSW and the ACT. It found that almost 60% had been subjected to either assault, verbal harassment and abuse, destruction of property, ridicule and homophobic jokes.

Maintaining a macho image, not revealing anything about one’s sexuality, and keeping a barrier between the personal and professional lives, seemed to be the order of the day for respondents. As one respondent, a confident young ‘straight-acting’ men who is out to a wide range of people, said,

> ‘My boss doesn't know, but he doesn't need to know. It's not the sort of thing you put on your resume. If you have a good relationship with people at work, you might tell them, but I don't know my boss well enough to say anything.’

Negative attitudes and behaviours by managers were also reported by several respondents employed by local and State government agencies (actually, in the latter instance, by Queensland Health).

Table 18 above shows who knows that survey respondents have sex with men. Given that the number of female partners who know (many respondents not having them) is naturally very small, then ‘workmates’ constitute the group who know the least.

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[5] At http://www.ilga.org/Information/legal_survey/asia_pacific/supporting%20files/australia_lesbians_and_gays_ridi.htm

While Australia does not have federal law outlawing discrimination on the ground of sexual orientation, the HREOC can investigate complaints of discrimination in employment and occupation due to sexual preference, and resolve complaints by conciliation.

The Queensland Anti-Discrimination Act 1991 protects lesbians and gay men from discrimination on the grounds of lawful sexual activity (with some exemptions). It has anti-vilification provisions.

Many studies have established that legal compliance (or rather fear of legal penalties) is a powerful motivation for change in small and medium enterprises. Further, many large enterprises oppose discrimination as a matter of policy. One respondent of a major organisation, while reporting ostracism, also mentioned that he had been approached by a senior manager, told that the organisation did not tolerate discrimination and that the senior manager would personally intervene to stop it if the respondent ever wanted to report it to him.

This suggests that it might be relatively easy to encourage employers to reject if not vilification then at least employment discrimination, given the right information and approaches. As one respondent said,

> 'I think that more could be done in workplaces. I'm sure there are lots of managers and bosses who know about it, but who don't do anything about it, either way. It's a pity that there's not information available for bosses who would like to be a bit more supportive, at least to tell them about anti-discrimination provisions and what their responsibilities are. There might be a way of tackling it through employers and giving them the knowledge and the tools to help out.'

RECOMMENDATION

7. **That Queensland Health work with other government agencies and industry representative bodies to raise the profile of anti-discrimination legislation as it affects MSMs, and employer responsibilities under the legislation.**

6.6 Personal factors

Personal factors have also been called 'self-efficacy' factors: the belief in one's competency to take action, and the knowledge, skills and ability to take action.

6.6.1 Inability, unwillingness to talk

The main personal factors identified by respondents was the ability to talk about their situation, and therefore move toward resolving their situation through discussion hearing themselves speak, and by listening to the views and experiences of others.

While MSMs might lack the opportunity to talk, it appears equally true that they are often unwilling, or unable, to talk about having sex with other men when the opportunity arises. In the next chapter, we will suggest some reasons for this: fear, a habit of hiding away, a habit of denying that the sex is actually occurring.

Whatever the reasons, the inability to express oneself if the chance does arrive robs people of powerful opportunities to explore and understand their world. As one sage once said, 'I never knew what I thought about love until I heard myself say it'.

It is often observed that most men, not just MSMs, appear to have difficulty verbalising their feelings and there are some reasons to believe – machismo, isolation, the hard life, the need to

get on with life without complaint, the few opportunities to open up – that regional, remote and isolated men have a harder time of it than city men. As two respondents said,

> 'These guys find it very difficult to talk about what they're feeling. My questions about how guys are feeling go straight over their heads. Men generally don't know what they're feeling. When they do open up, they say things like 'my wife doesn't know … no-one at work knows … I don't want to be known as a poof … I don't want to lose my family'.

> 'Their circumstances don't allow for discussion, especially when they're frightened, ashamed and embarrassed. They don't talk much, and they're hoping that it won't be mentioned to other people.'

As our respondents reported (in relation to beat conversations), they'll talk about 'fishing, footy and beer' but seldom about themselves,

> 'They'll talk about how busy or how quiet the beat is. They'll ask me what I'm doing, talk about the weather, have chitchat, nothing of any personal consequence.'

> 'Straight men don't ask questions, unless it's about fishing, footy and beer. I have an interest in motorcycles, so that's often an effective icebreaker.'

> 'They certainly don't talk about their wives or girlfriends.'

Given this inability or unwillingness to discuss personal matters, especially with strangers, it's hardly surprising that they don't want to talk. People are generally uncomfortable talking about sex. As two respondents reported,

> 'Kids are scared about sexuality – they don't want to ask questions. Neither do the older guys who are living a double life.'

> 'I'll only go in to the health clinic if there's (a specified person who he trusts) there. I went to the health clinic recently, but I wouldn't go in because (the particular person) wasn't there that day. I didn't know if I could talk about (STIs) to anyone else. I think my carry-over guilt stops me from talking about some sex things. Sex is still a taboo subject. Parents don't talk about it. People make dirty jokes about it, but you never actually discuss it.

If it's hard enough to talk about sex in general, then it's even harder to talk about this secret part of their lives can further involve fear, shame, guilt and denial. As three respondents reported:

> 'As a beat outreach worker, I often get the impression that when I engage guys on the beat it's the first time they've ever talked about it with anyone. Their attitude is, "I just do it. I don't want to talk about it. I don't need to share it". They don't ask about anything. They just sit there in a sexually provocative pose and I have to make them feel comfortable and safe. They don't ask anything, they don't talk about anything, it may take an hour of wandering around and small talk to get them to open up.'

> 'Usually they don't say anything or ask questions. It's part of the denial, the avoiding being identified.'

> 'Most of the men I have casual sex with don't want to talk, don't want to ask questions, or show emotion. It's just a release of lust thing. They want you to suck them, or fuck them, but they won't kiss you or connect emotionally.'

Our telephone interviewers fielded quite a few calls from men who had almost nothing at all to say after their initial 'hello'. While the interviewers were very adept at getting callers to open up, it was often difficult to get even a simple 'yes' or 'no' response to the most straightforward question, and callers frequently hung up shortly into the interview. One interview respondent explained this behaviour as:

> 'They simply don't know how to talk about it. They've probably never spoken to anyone about it in their whole life. They might have been thinking about making that call for years, possibly even decades, but

> when they finally get the courage to do it, and when someone picks up the phone on the other end, they just don't know how to go through with it.'

The inability to talk about personal, and sexual matters, would appear to have a number of consequences. It reduces or prevents the person's ability to negotiate sex matters, such as safe sex, which is key to preventing the spread of STIs. Combined with the interpersonal and environmental factors previously covered, it reduces or prevents the establishment of formal or informal peer networks that can influence people to engage in safe sex. It also sets up a prison for men: as far as sex matters go, they are effectively in solitary confinement, trapped with no escape from their fears and concerns.

6.6.2 Other personal factors

There are also a whole group of personal factors that relate to a MSM's ability to deny, handle and ultimately resolve the severe environmental and interpersonal pressure put on him to be straight. These include communications skills, decision-making skills, ability to withstand peer and environmental pressure, ability to negotiate outcomes, levels of self-esteem, sense of control over situations, and the influence of feelings of shame and guilt.

Although it was not part of this study, we could confidently predict from general observation of human nature that men with positive attitudes and skills would find it easier to handle and act on their feelings toward other men. However, we could also predict that the skills and abilities of many MSMs in regional, remote and isolated Queensland would be severely tested in the process of responding to interpersonal and environmental pressures; and that they would fail the test; and that such failures would result in a comprehensive catalogue of personal problems. This is in fact what we found, and is the subject of the next chapter.

7. How MSM respond to identity pressures

In the last chapter, we saw the personal, interpersonal and environmental factors that act on a MSM in regional, remote and isolated Queensland, as they struggle to create a viable identity while also engaging in the taboo activity of having sex with other men.

Basically, to do this, they must attempt to sidestep or minimise the negative factors, and maximise the positive factors, so as to create a stable and workable identity within their (overwhelmingly straight) communities.

This is often wholly successful: a straight identity can be maintained indefinitely, while the man continues to have regular or irregular sex with other men. Often also, it appears to lead to various states of questioning and confusion about their identity, the most notable feature of which are the mental health risks attendant. These survived, many men appear to move on to some form of resolution, whether through a permanent accommodation with the female partner (and the adoption of a bisexual identity), or through some level of coming out as a gay man, or a combination of both.

7.1 'Straight strategies'

7.1.1 We're all totally straight

The first, most obvious and most popular strategy adopted by MSMs is simply to identify as straight: straight to the bootstraps, in most cases. Many respondents were emphatic that these men present themselves as totally straight. As one respondent said,

> 'These guys see themselves as totally straight. I don't think they're going to talk to anyone, including you, about having sex with men. They don't admit it in any context except for picking up … the guys I used to see wouldn't admit being anything other than straight even to me, and I was having regular sex with them! They don't see themselves as different in any way to the macho stereotype.'

Many respondents also noted that 'straight' also means 'definitely not as gay'. As three respondents said,

> 'They do not think of themselves as being gay. They have a rigid, stereotypical view of what a gay man is, which is 'lonely, sad and unsuccessful'. They look at coverage of the Mardi Gras and feel that that sort of flamboyance is clearly not for them. That's what they see gay men as being like, and they don't want any of it. They don't realise that a gay man can be anything he wants to be, because they almost never know an out, proud, happy gay man, and there are no images of them in the media.'
>
> 'They attach a very negative connotation to being gay; and they know that any public disclosure of gayness is risky, dangerous.'
>
> 'They're fathers and husbands, with that identity, and they're living a double life. They don't identify with the gay stereotype because they don't want to have anything to do with 'gay', for fear of being identified.

There is in the 'totally straight, not at all gay' identity the not inconsiderable contradiction that straight men don't have sex with other men. Many MSM sense or acknowledge this contradiction, and adopt strategies to deal with the confusion and anxiety that it creates. These strategies are dealt with in the next section of this chapter.

Many MSMs, however, don't appear to even recognise the contradiction. Their private version of the straight identity cuts them the slack to have sex with other men

The first way of doing this is to see the sex with other men as a purely physical act with absolutely no other consequence: as inconsequential as scratching an itch. As one respondent said,

> 'They don't think of themselves as gay or bi … it's just a matter of getting their rocks off. They don't rationalise about it, it's just "blowing a load", getting sexual release. I suspect that sometimes they don't even acknowledge to themselves that the sex has happened. I've seen one or two who have still been pulling off the condom as they've been walking out, they're in such a hurry to get out of here, and you won't see them for weeks or months.'

This is very similar to another attitude identified, which is to simply put the behaviour in a box and isolate it off from real life. As the respondent above said, moments later it simply didn't happen. As two respondents said,

> 'They don't see themselves as gay, but as heterosexual. I don't think many of them try to stop and reconcile their heterosexual identity with the fact that they have occasional sex with guys. It's within their norm, something that they do occasionally.'

> 'There's a lot of deception and misery involved: the wife and kids are at home, and dad's out on the prowl. Wake up, go to work, check out the beats on the way to work, look for sex in the showers before and after work, on the way home do the beats, have tea, then go for a walk in the park. They may not even be wholly aware of the deception or the sex-seeking: it's just a routine work day, and the sex is just something that happens, it isn't acknowledged or explored.

Taken to the extreme, this type of thinking can lead to a sort of 'I'm here but I'm not here' mindset while seeking and having, a type of total disassociation from reality that to observers seems ridiculous. As a police officer said,

> 'Some guys are very surprised to see us turn up at a beat. They seem to think that they're in an invisible bubble, that because they don't look abnormal, then they won't be seen as abnormal, they'll be perceived as normal. They seem to think that its quite normal for two perfectly average-looking blokes to disappear into the bushes together in a public park. Maybe they feel camouflaged by their normalcy, or maybe they're just lost in the moment.'

Two other respondents made similar comments:

> 'I'm not sure how these guys see things. They will drive over, and park the car outside for everyone to see, but then they'll come inside and ask me to close the blinds and turn off the lights, as if that isn't suspicious enough, after all, the neighbours know all about me. They think with their dicks, not with their heads. They're not thinking clearly, sometimes they're even panicking, they just want to get it over with.'

> 'There's another guy that I'm aware of who has a professional job, but who will sit for hours in the public toilet. I've gone there, gone away and come back hours later and he's still sitting there. I've wondered a bit about him. Like, where does he get the time to do it? Do his employers wonder where he is? Doesn't he get bored? Is he locking himself in a cubicle to get away from his life?'

Perhaps the answer simply is, as one respondent said, 'they're thinking with their dicks, they just want sex.'

A little on from this position is the man who acknowledges that he has occasional (or even regular) sex with men, but is quite confident and secure within his straight identity and the sex with men does not threaten that security or confidence. As three respondents said,

> 'Many of the married ones think of themselves as straight. They would be shocked if other people thought of them as bi or homo. Their occasional dalliances have nothing to do with their sexuality, or their identity … they see it as 'not really sex'.

> 'They don't see themselves as gay – homo – queer, but as straight men who just happen to like sex with men on the odd occasion. It's just a physical issue for them, a release, there's nothing emotional about it,

and therefore it's not gay. They're married, they're not gay. 'Gay' is often seen to mean having womanly, female tendencies.

'They see themselves as straight men who have sex with other men occasionally. This might just be when the opportunity presents itself: it is not always sought out. Then there's the straight guy who seeks it out. They might only do it occasionally, but they know where to go. Many are quite content to leave it at that. They don't want friendships or relationships. It's "I have sex, then I go back to my normal life".'

A little further on from this position is the MSM who is publicly straight but in private is somewhat more bent. As one respondent said,

'They're all straight. If you told them anything else, they'd probably punch your lights out. I know six guys like that, only one of which might sometimes identify as bisexual. They're living in a fantasy world. They present the macho image, but they're not really that person. Their image is straight, macho, a fighter, but behind closed doors, they're willing to learn and wanting to try anything … often stuff their wives won't do.'

'Often stuff their wives won't do' was an often-repeated theme. Some men see male-to-male as a counterpoint and supplement to their heterosexual activity, and thus something that doesn't compromise their straight identity. It is nothing more than an 'enjoyable change' from an otherwise settled heterosexual routine. For some, being the passive partner is a release from being the dominant partner. For others, it's just a matter of getting more sex, more variety, and not being too concerned about labels. As three respondents said,

'they're married men who aren't getting enough sex at home, or enough sex variety … the missus won't give me blow jobs, it's a "lights off, nightie on" situation.'

'They see themselves as straight. They're looking for more than they can get from their female partner. They say, "You make love to a woman, but you fuck a man". They appear to be happily straight – they like their wives, families, homes – but they want the enjoyment of male sexuality, too. Even though they appear to be happy, they would like to be more open about their sexuality.'

'I had sex with a guy in his late 20s. He was married with two kids and sexually, he wanted to do everything. As he put it, he "managed to escape" two or three times a year "for a feast" and he would go to a sauna and do everything that he wanted to do. He was from the country. He would identify as heterosexual, because he's in an ongoing heterosexual relationship.'

As the end-point in this particular spectrum, there would appear to be some men who just do what they want to do, without regard for labels. As two respondents said,

'An ex-partner of mine is still a married man. He doesn't identify as gay, but is quite happy going to gay parties and having sex with men, leading what we would understand to be a gay lifestyle.'

'Mostly, they don't see themselves as gay or homosexual. They don't want to be labelled. They might say that there's an element of experimentation in their behaviour. There's a danger that publicity that uses 'gay' will be wide of the mark, that they won't relate to it.'

7.1.2 No (or not many) worries!

The groups we just looked at not only identify as straight, but do not appear to see their homosexual behaviour as an issue or concern. At the risk of stating the obvious, these men are not part of the gay community. They spend their lives in the straight community, and firmly believe themselves to be part of it. And things seem OK for them.

There seems to be a common belief among gay men that there is something wrong with the lives of straight-identifying MSMs (or at the very least something that needs improving); that they are confused and unsatisfied; that they need to come out; and that life would be better for them if they did.

This does not appear to be the case with a substantial number of MSMs. In the same way that ignorance about the diversity of gay lifestyles breeds misperceptions by straights, so too does the lack of identified, happy straight MSMs breed a belief among gay men that this lifestyle is not possible. But many interview respondents, including many who are gay, believed it to be a workable lifestyle choice for many straight MSMs. As three respondents said,

> 'It's not necessarily painful or difficult for them. They get a blowjob on a Friday night and that's it. It poses no great dilemma. I'd venture to suggest that about half of them are quite happy with things that way.'

> 'They are happy with their straight identity, and many of them are comfortable with whatever compromise they have worked out to rationalise the fact that they have sex with men. If they don't think about it too much, this situation can be maintained indefinitely.'

> 'Some don't see the need to come out. They're having a fun time, happily married with a wife and kids and a male fuck on the side. They don't feel the need to go any further, and it can (and does) work for them, so long as he is having regular sexual health checkups and the female partner isn't at risk of STIs. That, however, is where the problem can lie: it's hard to convince them of the need for checkups, and for them to have the confidence to go and get tested.'

One respondent, however, felt that this accommodation might carry costs that were not obvious:

> 'Men who live in a heterosexual relationship, and that also have sex with men, are making a logical and sustainable lifestyle choice for the country. They may have to engage in considerable deceit and deception to maintain that choice, but it is nonetheless a popular lifestyle choice. From the ones that I know, that choice looks pretty attractive to me; although admittedly, I don't see the hidden costs of that choice, in terms of what it does to the man and to his relationship with his wife.'

Some men may be in a stable accommodation, not seeking to change it, but not happy about it either. As one respondent said,

> 'A common story (with married, 30s to 50s men) is that they're dissatisfied with the marriage but they don't feel a need to come out. It's a tortured life, but they appear to be happy to be in it. They are sexually dissatisfied, and the idea of having sex with a woman doesn't stimulate them. These are men who often made their life choices up to 30 years ago when there weren't many options, especially in the bush.'

This was primarily qualitative research, and we were unable to determine how many MSMs reach a stable and acceptable accommodation between their straight identity and their homosexual behaviour, but several respondents thought it to be a significant number: to several, half-and-half came to mind.

7.2 Questioning and confused

While many men might reach a stable accommodation, many do not. The seeds of questioning implant themselves at some stage, and at some level of the mind, and slowly grow, leading, it appears to increasing confusion about identity.

7.2.1 Homosexual and anti-gay

Respondent's comments indicated that there is a group of men who do have sex with men, and who do have anti-gay – and even violent anti-gay – opinions and behaviours.

We put this group within the 'questioning and confused' category rather than the 'straight strategies' group, because something has happened within their minds to evince an anti-gay attitude stronger than would be expected from environmental or interpersonal factors. We don't set ourselves up as psychologists, but several respondents suggested that at least one part of the explanation might be that for someone who is confused and increasingly anxious – let alone a card carrying member of a homophobic culture who feels the benefits and

comforts for him of that culture are increasingly under threat – it is easy for him to feel and act homophobic.

They deny what they do at the beats. They deny that they would prefer male-to-male sex. They deny who they are, and what they want. And yet it doesn't decrease the desire, only increase the discomfort until the two steadily resolve as self-hatred.

Commenting on this type, two respondents noted,

> 'There's the total denial type … not only don't they not see themselves as gay or bi, they are often quite anti-gay. Their attitude is "I just let some faggot suck my dick, that's all it was". Once they cum, they get angry and aggressive. I've heard them blame gays for doing something they don't want to do; they feel they are coerced."

> 'They're often the biggest cursers of gay guys. They act disgusted with them so they won't be identified or associated with them. The straight MSMs don't want to associate with the gay side of it at all. It's too dangerous for them.'

And from a police officer,

> 'The people we talk with down at the beats see themselves as normal people. Other police report that they can take great exception, and can get very agitated, if you suggest they're gay or homo. These are the sorts of people that can bash gays.'

7.2.2 Neither one nor the other

As we would expect, once the questioning process begins in earnest, its effect is to weaken the sense of being straight, rather than reinforce any sense of being gay. As two respondents said,

> 'They often don't know what they are, or what they want … they feel uncomfortable, not knowing if they're one or the other … and they seem to be trying to discover what they want. They're in between closeted and half-out. They say things like, "I'm not gay, I'm here for a social evening". They talk about their family, work. They'll often say if they're married; they often say they're not getting enough sex.'

> 'They have no idea of their self-worth when they step outside a heterosexual identity. There really isn't any well-defined or publicly accepted alternative identity, which is why so many stay with it, and so many have a major struggle creating an alternative identity for themselves.'

It reminds one of those Cold War movies, where the deserter crosses the foggy bridge from the known, stable but ultimately unwanted past to the exciting, unknown and potentially dangerous future. And there's still the danger of being rejected by both sides: of being caught in the middle. As one respondent said,

> 'Part of the struggle is to have a number of identities coexisting. One dual identity is "I'm a successful, well-educated professional" and "I'm a dirty hussy slut who's addicted to being fucked up the arse and filled with cum". There's no in-between, and no way out. One guy I know is married with four kids. He's a well-educated professional. I must have seen him 15 times now, and I've told him the safe sex message every time. Yet he still quite openly talks about getting fucked without a condom, which he still does, even after all this time. I'm starting to think that he doesn't even identify with his sexual behaviour, that the person who gets fucked unsafely is someone else, and that he will never get a STI. But I must admit I don't know what's going through his mind.'

7.2.3 Don't have sex

As Table 19 shows, 12% of respondents had not had sex with a man in the last year (more or less: the survey was conducted in October / November).

TABLE 19: WHEN RESPONDENTS LAST HAD SEX WITH MEN

Last sex	No	%
2003	219	88%
2002	13	5%
2001	7	3%
2000	2	1%
<2000	9	4%
No answer	34	
Total	284	

It appears that one strategy for addressing the questioning and confusion is simply not to have sex with men, while accepting one's homosexual feelings. This might be for lack of opportunity, not knowing how to go about it, or being too scared. Or it might be, as one respondent said, because the homosexual feelings are the basis of an active fantasy life:

> 'Some guys will fall in love with someone they know here in town, like the guy at the service station for example. That person doesn't know and, of course, they don't have sex. He has a fantasy that one day the guy will declare his love, and that they'll go off and live together. This can sustain him for long periods, without them actually doing anything about it. But one day the guy at the service station will start sending out very negative signals, or just disappear, and they will be devastated … then they'll get in touch with our service about grief and loss issues'.

7.2.4 Take up religion

Many respondents, including several who had been members of fundamentalist congregations, thought that one strategy adopted by confused and questioning MSMs was to seek an outlet through the church: as one respondent said, to 'find a cosmic escape hatch to get away from something in our lives':

> 'I have thought long and hard about those years (when I was part of a fundamentalist congregation). I realise now that I was trying to run away from my homosexuality. My church had over 300 people, and I realised later that there were a significant number of gay people there – my guess would be upward of 5%. I've realised subsequently that what we had in common was that we were all trying to run away from something; we all had to find some sort of cosmic escape hatch to get away from something in our lives. So I guess it's not surprising that there were quite a few gay people there.'

Others offered other possible explanations of what these men might be thinking:

> 'Some of the born-again Christians have gay feelings. They're hiding from their own sexuality and their fantasies; they're denying and repressing them.'

> 'The mentality is like, "Homos are men who live in the big cities and don't care what other people think of them. They are big sinners. I'm only a small sinner because I immediately regret what I've done and want forgiveness. I need to believe this about myself in order to keep living this lie. I don't think about what I do, I don't analyse it, it's just something that happens, but it's not who I am".'

> 'Faith communities offer an escape from sickness and sin. I think that many of these men have identified their attraction to men as a moral sickness, a sin that needs to be taken away from them.

As we saw in the last chapter, churches are generally not supportive of homosexuality, and some are strongly opposed to it. Several respondents conjectured that confusion and questioning by MSMs who take up religion may be driving anti-homosexual attitudes within these churches.

> 'When it comes up for discussion, it's discussed with a passion bordering on fanaticism. Maybe there's been an unfortunate instance in their lives, or in the lives of someone close to them.'

> 'I know a divorced man in his 30s who's got major questions about his own sexuality. He's just joined some obscure sect. In a discussion he initiated, he said in his opinion homosexuality is wrong and asked me for a copy of the bible so he could prove it. I think he's either frightened to admit it, or he's done it and he's terrified of thinking about it.'

> 'We had a very anti-gay Lutheran pastor here. He used to march down the street in town with a banner demanding that the Mardi Gras not be televised. I spoke to him about it, but there was no discussion, his mind was totally made up. He wanted the traditional family unit preserved and thought that gays were destroying it. I asked him why he was so obsessed about it, why it was such an important issue to him. He just turned his back and walked away. His reaction and other comments he had made me think, "Methinks thou doest protest too much".'

One respondent went further than conjecture, citing a particular instance,

> ''One man who I know who used to go to the sex clubs in Brisbane and was into heavy sex. As it happened, he was also a leading church identity, who was known to give lectures on the evils of homosexuality.'

While membership of evangelical communities may not necessarily lead MSMs to anti-homosexual attitudes, one respondent suggested that it doesn't lead to positive attitudes, either:

> 'They feel that the discrimination is something to be expected. They think, "It's the way things are, so I won't flaunt it, or be flamboyant". This leads to strong judgements about queeny, flamboyant gay men, like, "they make it hard for all of us by making it so visible".'

Society traditionally supports religious institutions and grants them significant benefits (such as tax-free status and freedom from anti-discrimination legislation) not only because so many people belong to them, but also because they are seen to be loving, charitable institutions and 'wellsprings of goodness'. However, the research suggests there may be a darker side: that men experiencing difficulties with their same-sex attraction are using these institutions to promote discrimination.

7.2.5 Have mental health issues

Questioning and confusion can in many situations be a normal part of resolving life's issues, especially with supportive friends, people to talk to, and expectation of societal support and the personal skills to work through emotional issues. Unfortunately, most MSMs don't have any of these. Worse, they might have spent ten, twenty, thirty years or more, hiding and denying, with no immediate hope of resolution. In many cases, the environmental and interpersonal pressures they face affect them so deeply, over so long, that mental illness becomes a major issue.

LIVING IN FEAR OF BEING FOUND OUT

Table 20 shows respondents level of concern about friends, relatives and workmates finding out they have sex with men. Over half were concerned, and almost half the sample were strongly concerned. Given that survey respondents were a fairly 'out' sample, this suggests how strong is the concern of being found out among men who have sex with men.

TABLE 20: RESPONDENTS CONCERN ABOUT FAMILY, FRIENDS OR WORKMATES FINDING OUT THEY HAVE SEX WITH MEN

Agreement	No.	%
Strong concern	92	41%
Concern	32	14%
Not sure	10	4%

Unconcern	33	15%
Strong unconcern	58	26%
No answer	59	
Total	284	

This concern translates into an abiding sense of fear. 'Terrified, afraid, living in fear and scared' were some of the ways were described as living their lives. The are afraid of the consequences of the environmental and interpersonal pressures described in the last chapter: rejection, homophobia, physical violence. As one respondent said,

> 'I don't want people talking about me. No one would accept me if they knew … I'm afraid of my friends finding out. I play rugby league, and I don't want anyone on the team to find out. My (female) partner doesn't know that I have sex with men, and I'm fearful that she would find out ... I'd hate anyone to find out what I am doing. I Also have two or three girlfriends and they don't know that I am that way either ... there's the humiliation of everyone knowing... I'm also concerned about my business and profile in the community ...

As one respondent noted, these feelings are also shared by openly gay men:

> 'I have one friend in his late 40s who is known by a fairly broad circle as gay, but he's still terrified of being found out. It's very intimidating. Another guy who's fairly 'out' wouldn't sign a petition that was going around about recent changes to the law in Queensland. He was afraid that 'big brother' would go through the forms and 'out' people, he was terrified of a conspiracy.'

Those who identify as straight are afraid of admitting their sexuality to themselves, as well as losing their straight identity and its benefits. They are intimidated and do their utmost to keep their sexual behaviour a secret. Respondents described them as 'furtive, and 'isolated' and said,

> 'They wouldn't share it. They would lose their friends, they'd be disowned. A lot of these straight guys are afraid of losing friends, family, everything.'
>
> 'They are primarily afraid that, as this is a small community, people will find out about them. Their circle of friends would be predominantly or exclusively heterosexual, and they risk being ostracised. . They also fear for the ramifications for their children (such as school-yard taunts); and the effect on their father-child relationships.'
>
> 'They are fearful of being identified. For example a big worry is whether their car will be seen … and with good reason! There's a local Christian here that lives opposite the big park that's a beat. She sits on her veranda, with binoculars, and takes down number plates and reports them to the police. She's put the local police under enormous pressure to '"do something".

The sense of fear leads MSMs to close themselves off, to isolate themselves and their feelings. As one respondent said,

> 'I never let myself get too close to anyone, and I'd never let people get too close to me. People used to say, "You've always got this wall around you, you never open up, there's a big part of you that no-one can get to". It was about not being able to deal with my sexual feelings. It's a defence mechanism. You grow up hiding a part of yourself, never letting people get too close to you.'

Table 18 above showed who knows that survey respondents have sex with men. About one quarter of respondents are known fairly widely to have sex with men (with close friends most likely to know, then most people, then close family, then close workmates). About one quarter of respondents feel that nobody knows.

Given that the survey was likely to attract people who are prepared to disclose their activities, the percentage of MSMs who feel that nobody knows is likely to be substantially higher. This

was borne out by interviewees, who emphasised that 'they keep it discreet'; 'they don't discuss it with anybody'; 'it's the "love that dares not speak its name"; 'they don't talk to anybody, because they're scared that someone might find out'.

UNWILLINGNESS OR INABILITY TO TALK

The consequence of this fear of being found out is that MSMs are unwilling or unable to talk about their sexual behaviour. As we saw with 'straight strategies', this unwillingness to talk may not be an issue if the behaviour itself is not seen as an issue. But when fear becomes an increasingly-important part of life, as it seems to do with many MSMs, then it needs to be resolved. It needs to be talked about – which is just what they don't, or can't do. As respondents noted,

> 'They wouldn't discuss it, they're silent. They are afraid to talk because of fear of being identified. They're hiding their sexuality … they're in hiding mode.'
>
> 'They understand that they want sex with guys, but it totally doesn't fit in with the rest of their life. They don't know how to come to terms with it. Who can they tell? Who can they talk with?
>
> 'Their mentality is 'don't talk about it, don't get caught, don't get sprung or all shit will come down on you'.
>
> 'They won't tell you much about themselves, even if you ask questions.'
>
> 'Perhaps not so much "no-one knows", as "it's never discussed".'

This lack of communication appears to extend in many cases to their sex partners. In general, they don't appear to talk to other men that they pick up on the beat for sex, and even several respondents with longstanding, straight-identifying sex partners knew almost nothing about them. And you never, ever say hello to someone in street that you've had sex with.

DECEITFUL RELATIONSHIPS

Not surprisingly, efforts to avoid being caught lead men to deceive their friends and loved ones. Only having gay friends around 'who look and act straight' and 'complicated excuses to explain their absence from home if required' were two strategies mentioned. There is also the stultifying effect on relationships. As one respondent noted'

> 'The common response is, "it's no-one's business except mine". On one level that's fair enough, but on another level, I think that my family and friends need to know the key aspects of my life, or else there can never be a caring, supporting, trusting relationship between us. Separation and secrecy aren't good for an intimate, trusting relationship.'

This bottling-up of issues, fears and concerns, the hiding, the deceit in relationships, all have their personal toll, as we shall now see.

LOW SELF-ESTEEM

Many respondents noted the low self-esteem that is both a reason for and a consequence of being unable to resolve the questioning and confusion about their sexuality. As they noted,

> 'I felt like the odd one out. All my straight friends go out with partners. I stay at home with my father. I want someone by my side, someone to lean on.'
>
> 'I don't look people in the face because I feel ashamed, I don't know what people will say.'

Low self-esteem afflicts not just the questioning and confused MSM, but the out gay men. The lack of environmental and social support can eat away at one's sense of self, as respondents noted:

> 'Lots of gay guys have low self-esteem, especially when they get to middle age and lose their good looks, and they can tend to let themselves go.'

> 'With the sistagirls, it is near impossible to have a relationship or long-term partner. This raises significant self-esteem and self-worth issues, and probably feeds into alcohol abuse.'

> 'There's this endless sense of not being normal, of not fitting in; even with all I've experienced in life, I start to think that I'd like to be other than gay.'

DEPRESSION

When asked what they saw as the major health risks facing MSM, about one third of interview respondents nominated mental health issues before they nominated sexually-transmitted infections. As two said,

> 'The mental health and sexual health issues are inextricably linked, and I think the mental health issues are more important. Desperation makes you vulnerable.'

> First up are the mental health issues. The secrecy, the stress of keeping it secret can overwhelm them. They get depressed, go to doctors and get onto antidepressants.'

Respondents were mainly referring to depression, anxiety, stress and suicidality. As they said,

> 'Of all the gay men I know, I don't know one who hasn't been on antidepressants at some stage.'

> 'People have to spend a lot of energy hiding and disguising their sexuality. It leads to depression and to worse mental health problems.'

> 'That's why I see it as a mental health issue. You feel beaten up by what you hear said about gays. People talk in the most unpleasant terms, and you're always having to face the fact that they're talking about you.'

> 'Lots of guys turn up (at our sexual health clinic) from (the) mental health (clinic), stressed and depressed, and its often related to sexuality.'

> 'Aboriginals have fewer options than white people in terms of doing something about it, in terms of packing up and moving away. Some Aboriginal men I've known have had sex with men, and not known how to deal with it. That then raises issues like increased drinking, low self-esteem, sex with anything that moves, violence and homelessness issues.'

Two respondents described their own personal experiences.

> 'Emotional well-being and mental health are the important things for me … dealing with the loneliness and isolation and the stigma and the sense of depression that comes with them. You take on a sense of detachment: I've become a lot more insular since I've moved back here (to a country city, from Brisbane).'

> 'I had chronic depression. I'd lock myself in my room for weeks on end. Till you experience it, you don't imagine what it's like … I'd never thought of myself as someone who would get depressed. And it was all sexuality-related.'

As Table 21 shows, this picture of widespread loneliness and depression is borne out by survey respondents: almost four in ten usually felt lonely or depressed because of their desire to have sex with men. Three factors contribute to the impact of this finding: that the proposition says 'usually' rather than 'occasionally'; that almost two in ten strongly agree with it; and that this sample might be expected to be better adjusted to their sexuality than MSMs generally.

TABLE 21: AGREEMENT WITH PROPOSITION THAT 'I USUALLY FEEL LONELY OR DEPRESSED BECAUSE OF MY DESIRE TO HAVE SEX WITH MEN'

Agreement	No.	%
Strongly agree	41	18%
Agree	52	23%
Not sure	16	7%
Disagree	28	12%
Strongly disagree	88	39%
No answer	59	
Total	284	

ALCOHOL AND OTHER DRUG USE

There is an extensive literature on the use of alcohol and other drugs to address emotional issues, and a small but growing literature on its use by gay-community identifying people[6]. As one respondent said,

> 'I know one man who's been married to his childhood sweetheart for over 20 years. He sees himself as straight, but he's always checking out other men, and he has sex with men. He's split up with his wife three times, had problems with alcohol and drugs and violence. It's a miserable situation for him. He doesn't want to let his family and his kids down: he doesn't want to be seen as a disappointment. So he hides behind the myth of "he can't be one of them, he's married".

This picture of seeking escape in drugs was echoed by other respondents:

> 'There's this guy who comes to me when he's drunk. After we have sex, he sometimes talks about his emotions. He often says that he wants to do himself in, being gay. It's the stigma attached to it, most importantly the rejection, being rejected by the people he loves. He rationalises his situation through grog. It's what gives him the energy level and the willingness to go over to someone's house and do it … it's the grog.'

> 'A lot of times the guys that I had sex with were drunk. Lots of the non-identifying guys drink heavily and smoke dope, and have done so from an early age, a lot of which has got to do, I think, with dealing with their sexual feelings. For these guys, having sex when you're sober is a shame thing.'

> 'Some "blame" their behaviour on the alcohol – "I'm pissed, so any hole will do".'

One respondent saw alcohol and drug misuse as a short step from broader self-harm:

> 'Some gay men get into major piercing and tattooing, which is pretty close to self-mutilation. Beyond that is the drug abuse. In (the small town that I come from), there are several gay guys with serious drug issues. So I see it as more of a mental health issue, which can then become a sexual health issue.'

VIOLENCE AND RAPE

While no clear picture emerged, one respondent claimed to:

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[6] One example is Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria (Murnane, A. Centre for Youth Drug Studies, Melbourne, June 2000). The study found that dealing with emotional issues (coming out/establishing sexual identity, low self-esteem, depression, insecurity, sense of oppression, inhibition, family conflict, abuse [physical/sexual/verbal] were the main reasons for drug/alcohol use/misuse.

> 'deal with 10 or so cases a year of gay men who have been raped by so-called straights. There are probably many more.'

One police respondent also noted the occasional case of same sex domestic violence.

SUICIDE

Almost a third of interview respondents mentioned suicide considered by confused and questioning MSMs. 'If anyone found out about me, I'd have two options: leave town or kill myself' was a commonly-repeated sentiment. As one respondent said,

> 'There are big mental issues if you spend your life being frightened. The country mentality is that if you're discovered as a poofter, then suicide is your only option.'

Some told us they had contemplated suicide themselves:

> 'I thought about suicide. The only thing that stopped me was what it would do to my family … but it crossed my mind plenty of times.'

> 'If I didn't have my head screwed on right, I probably would have committed suicide by now. There's nowhere to go to meet people.'

Others knew of situations where sexuality was a key ingredient in a suicide:

> 'There was one young guy I knew who only ever wanted his parent's support, but they banished him from the home and told him they'd never accept him. He killed himself eventually.'

> 'An 18 year old guy had been in and out of the mental health clinic for sexuality-related issues which led to alcohol and drug problems. They released him one Saturday. He borrowed a mate's car, lined up a tree in the main park in town and drove straight into it.'

> 'Several people I know in remote areas have struggled with their sexuality, and have thought about or attempted suicide. They'll all engaged in destructive behaviour.'

Although many respondents did not know of specific instances, many felt or had gained the impression that suicides (particularly by young people) were linked to homosexual feelings. As one respondent said,

> 'I think suicide is worse in smaller towns, but with youth suicide you often never find out what's really behind it. It's not like the father who's son suicides is going to tell everyone that they had a fight that morning about the son being gay, and that he was thrown out of the house. Police try to keep a tight lid on it for privacy reasons, and to discourage copycats. And they don't report suicides in the paper, they like to present an image of a happy family town'.

7.3 Struggling toward resolution

There appears to be a group of MSMs who have pretty much moved beyond the 'questioning and confused' stage but have not yet moved toward resolving their identity. One respondent described them as 'the honest type': they realise and accept their situation, they want to resolve it, but they haven't worked out what to do yet. How it works for some is,

> 'They see themselves as heterosexuals. But when they start getting turned on by men, they start questioning that. Then they fight it till they can't fight it any more. How long it takes depends on family attitude and religion.'

One respondent said of these men,

> 'They will be asking questions and wondering what a gay lifestyle would be like for them. They will be confused and anxious, looking for help but not knowing where to get it. They don't know who they ask, or

> tell, or who they can trust. Their question is how do they get out of the current lifestyle and commitments. They need a safe environment to get information and come to terms with their sexuality at a pace that suits them."

Another respondent described his own situation:

> ' I was married, but I knew that I wanted sex with guys. I was happy with my wife, and monogamous when I was with her. But the more I realised that I wanted sex with guys, the more I realised that I shouldn't be with her. And once you realise you shouldn't do something, you shouldn't do it.'

For some, it becomes a matter of costs and benefits:

> 'The question for a lot of these men is whether the advantages of family outweigh the costs of secrecy and denial that they must maintain, and the costs of being exposed. I think that a lot of them know that their own personal balance is tipped in favour of coming out, but just can't do it. The main question these marrieds struggle with is how to come out to the wives, kids, family and everyone else in a small town. It raises all sorts of uncomfortable issues.'

> 'Then one day they realise their true sexual feelings and they think "oh shit". They want to get out, but they realise that they have to maintain the façade.'

> 'It's more a matter of them stepping out of their comfort zone: the "happy heterosexual couple" is a very easy label to wear. By discarding it, they put themselves at risk.'

7.4 Resolution

Eventually, many MSMs reach a stage where they feel that they need to acknowledge their homosexual feelings, and so make them part of their identity.

7.4.1 'I'm bisexual'

The first and most obvious way to resolve these feelings into an identity is to label yourself as bisexual. This label appears increasingly popular in big cities, and particularly among young people, who like sex with both genders.

'Bisexual' appears to be both an honest description of sexual behaviour as well as a sort of halfway-house identity, that you first try on when reflecting on who you are. If you like the fit, you'll try it out with others. Plenty of people are calling themselves bisexual (especially on the gaydar and gay.com websites where describing themselves as straight would be somewhat absurd) and in bars and among likeminded peers.

Because it means 'straight-identifying' as well as 'available for sex with guys', 'bisexual' appears to be used mostly in sex-seeking situations, and to be a private (or semi-private) rather than a public label. That implies there's a conversation about sexual behaviour going on, which, as we have seen, is not common among MSMs; and it's a harder conversation to have the smaller the community gets. Accordingly, we did not gain the impression that 'bisexual' was a popular or common label among MSMs outside sex-seeking situations. As one respondent said,

> 'A small number will identify as "bi", but even that becomes too complex. If you're identifying as heterosexual, or live in a highly-heterosexual community, to label yourself as anything except heterosexual sets you apart from the community … so they tend not to choose a label.'

A primary attraction of the bisexual label, as one respondent said, is 'it's not as bad as being a homo':

> 'It's not as bad as being a homo (as in "I'm not a poof, I only do this occasionally" (such as when I go to Brisbane, or with a long-time friend). It implies a bit of licence to enjoy a range of behaviours. However, I

> don't come across it as a positive image. There's an extroverted sexual type who projects their bisexuality as part of a libertine lifestyle. But it's usually fairly exploitative, where friends and contacts are consumed as sexual partners and discarded.'

Bisexuality is not only 'not as bad as being gay', but does give MSMs the feeling they still have one foot firmly in the straight camp. As respondents said,

> 'Lots of gays think that bisexuals are "only playing games", but it's not that at all. They need sex with men, like gay men do. But their heterosexual relationship is their safety. After they have sex with a guy, they can always go home to their family.'

> 'People think that if you're married, or if you've ever been married, or even with a woman, that you must be bisexual, that you can't be gay. That takes a hell of a lot of pressure off these guys.'

> 'Most of them, even the ones who are quite well networked with other country gay guys, would identify as bisexual rather than gay, an identity which would separate them from their family. And they would not use the label outwardly, but inwardly and personally.'

Tables 22 and 23 show the popularity of the bisexual label. It would appear that almost all (if not all) the men who had any sex with women identify as bisexual.

TABLE 22: HOW RESPONDENTS SEE THEMSELVES SEXUALLY

Sexuality	No.	%
Homo/gay	125	48%
Bi	95	37%
Het/str8	21	8%
Don't think about it	19	7%
No answer	24	
Total	284	

TABLE 23: WHO RESPONDENTS HAD SEX WITH IN LAST YEAR

Sex of person	No.	%
Men only	137	51%
More men than women	45	17%
More women than men	53	20%
Women only	14	5%
Man dressed as a woman	10	4%
Did not have sex in last year	11	4%
No answer	14	
Total	284	

7.4.2 'The wife / girlfriend knows'

As we explained earlier in this report, it would appear that many MSMs are married or in defacto relationships. The question then is whether their female partner knows of their homosexual activity. Of survey respondents who nominated as bisexual, 21% said 'yes'.

This would suggest the majority don't, which was also what interview respondents thought. Either they don't-know-don't-know, or, as one respondent said,

> 'Partners often "know, but don't know" … there's a level of knowing without knowing. They pretend it's not happening.'

And, and as another commented,

> 'You get plenty of older guys on the bat who are quite effeminate: their hair is perfect, their nails are perfect, their clothes are presented perfectly. You think, "God, is your wife blind or what?" But the thinking seems to be, "They can't be gay, they're married". Sometimes I think that a lot of the wives know, but don't want to know: they've got a nice family, a nice car, regular income, kids; it's a lot to upset.'

A 1991 study spoke to women in South Australia who 'knew'[7]. That study spoke of the distress felt by women about their partners homosexual behaviour (almost half of whom had left the relationship). We did not speak to female partners of bisexual men, and cannot tell their story, but one respondent said,

> 'When I do community or (social service) agency talks about this, most women find the notion that that their husband might be doing it with another man in a public toilet completely abhorrent. Their eyes widen in horror, they raise their hands to cover their mouths and they gasp.'

However, some of our respondents felt that many couples reached some sort of accommodation about his homosexual activity.

In the 1991 study, about one in five women knew about his homosexual interests before the relationships began. As one of our respondents said,

> 'I've known about my sexual preference since I was in primary school. I discussed it with my wife before we got married. There's a special bond between us, and it really works for us. But she doesn't like people to know about it; she'd be shocked if she knew that I was talking with you today.'

Others take a practical approach:

> 'I've been having occasional sex with a married guy for years. He's told his wife that he likes a man occasionally. She knows about me and accepts it. We never have sex at his place. I pick him up and drop him off, and she waves hello through the front window. That sort of situation is very rare. She understands that it's a side of him and something that he needs, but she's stipulated one person, and only occasionally.'

> ''I met a guy for sex who has been married for 30 years. His wife knows. She accepts his explanation that "it's an itch that has to be scratched occasionally". I also know a bisexual bodybuilder, whose wife knows. She was concerned about HIV; she was asking questions. She is aware that there's a possible problem.'

> 'I know one guy who's married and his wife is aware he has sex with men. Sometimes he has gay men stay with him, and his wife will make a quiet excuse to go to town for a while.'

> 'On rare occasions, the sistagirl and the wife might talk about it and come to some accommodation.'

> ' I do know one wife who suspects her husband. She watches *Queer as folk*, and one episode features a character she reckons is her husband. She taped it for him, and made jokes about it.'

Sometimes, of course, if the wife also likes sex with women, the accommodation might be particularly convenient for both:

> 'I know a gay guy who is married to a lesbian. They also have a house (away from here) and they don't live together much. Their kids know about the arrangement, but friends and neighbours don't. It works well for them, but it's not the sort of thing they could talk to work colleagues about.'

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[7] Mahamati, *When the 'other woman' is really another man: a report on the needs analysis for the women partners of bisexual men*, AIDS Council of South Australia, Adelaide, 1991.

There were also several stories about bisexuality in the context of threesomes and sex with other couples. As one respondent said,

> 'I like both sexes. Me and my girlfriend sometimes have threesomes, she likes it a lot. She would rather we did that than I go off on my own to be with a bloke.'

If this sounds like a rosy picture of accommodation and acceptance, we would again caution that we spoke almost exclusively to male respondents, and did not hear first-hand of the grief and pain suffered by many women in this situation.

7.4.3 Coming out

As we saw previously, about one quarter of survey respondents are known fairly widely to have sex with men (with close friends most likely to know, then most people, then close family, then close workmates), and almost half see themselves as homosexual or gay. Interview respondents also felt that close friends (usually female) were the most likely to know.

There are, of course, degrees of outness and an MSM will only come out if it is his interests to do so. Although we have presented these interests as peace-of-mind and well-being in this report, there is also the very important interest of finding sex. As one respondent noted,

> 'A person generally won't disclose their identity unless there's an opportunity for sex. There's no point disclosing it. And when they do disclose it, it might be in subtle ways. I might put a lot of energy into striking up conversations to determine if you're available. I might start wearing a gold bracelet that hangs down a bit. I might hang around in newsagents looking at the muscle magazines. And if the opportunity arises for sex, I'll make sure that I look drunk.'

The degree of difficulty faced by out men varied markedly according to different respondents. On the one hand, there were the stories of harassment, violence, discrimination and ostracism we have already reported. On the other, many respondents felt that out men didn't have a particularly hard time of it.

Young people, particularly, were felt to be able to form supportive groups where varieties of sexualities were known and acknowledged. As one said,

> 'In country towns, everyone seems straight – but they're not. Everyone knows about me being gay. In (the last town he lived in, population 13,000), I hung around in a group – about 15 lesbians, 10 bisexuals and 10 gay guys.'

Other men reported that being gay was not a major issue, or that it had been overcome:

> 'I've never had any problems being gay here. I've never been harassed. My family never had any problems with it, and neither did my workmates.'

> 'A lot of the out gay guys are "born and breds". They don't seem to have problems; they've been accepted by their families.'

> 'With the middle class professional men, coming out might be some comfort for them. Some do not find it a difficult social transition. Some maintain healthy social networks, including friends from the past when they were married.'

> 'At the nightclub (in a remote mining town), there were a few out guys arm in arm and cuddling. People didn't care, they've known one of the guys for years, and he's been out since he was a teenager.'

Among respondents, it appeared that those who were the most 'straight-acting' reported the least problems, and vice versa. The offence may not be the homosexuality as much as, as straight people are still heard to say, 'the shoving it down our throats'. These sentiments were explained by an Indigenous respondent:

> 'In the communities, 'straight' men will usually be having sex with sistagirls. The community might be aware of the situation, but no-one says anything. While sistagirls may be accepted, 'flaunting' their sexuality is not. It's not talked about: the community don't want to know the details. Individuals might be accepted individually for who they are, but the homosexuality is not condoned.'

However, another respondent felt, as he said, that the 'Priscilla / Mardi Gras types … don't seem to have a particularly hard life due to being gay:

> 'Most towns, even down to quite small sizes, have someone who is known or suspected or understood to be gay. These are generally people who think of themselves as gay, as in Priscilla / Mardi Gras gay. They often work in health, or in hospitality, and are typically in their 30s or 40s. They are generally not married. They either don't have sex locally (waiting till they travel) or they are selective about what they do, and who they tell they are gay. Sex partners might come from a particular set of late night drinkers, or from visitors to town.'

Although 'coming out' is the end of the spectrum of responses in this report, it by no means true that all out gay men live happily ever after. Some, as one respondent noted, succumb to the temptations of the straight life:

> 'One person I know came from a small town south of here. He was married with kids, then divorced, and then moved to Brisbane, came out and lived an openly homosexual life there for about five years. But then he went back to the country town, remarried and went back to being a model heterosexual. His new wife has no idea of this homosexual part of his life. Apparently, after his first divorce, he decided to explore his sexuality, but in the end couldn't deal with the fear that his mother and sisters would find out about it.'

Others, while recognising that accepting that a gay identity is the only path for them, nonetheless pine for the security and acceptance of the straight life they've left behind, often overlooking, as immigrants and exiles so often do, that the homeland they remember has itself changed out of sight:

> 'Country gay guys often say to me that they wish they were straight. One gay guy I know who wishes he was straight has a version of a man that is very narrow and misogynist. It's formed early from parents and school and sort of reinforced and even idolised by his knowledge of what he's missing out on. He understands the power that goes with identifying as a heterosexual white man. It's a very big thing to relinquish, and he knows that he gave it up when he came out.'

In the same light, others consider it a poisoned chalice: not a choice, but a tough hand that life has dealt them:

> 'I correct people when they talk about sexual preference, rather than sexual orientation. A man may prefer to have sex with another men, but it's not a preference in terms of a choice. It's the way we are, not a choice we make, like some people think. If you use the same logic, you must then say that all people have felt strong sexual and emotional desires for people of the same sex, but have "chosen" to be heterosexual. That's quite clearly absurd. It's equally absurd when you consider the benefits that accrue to being straight, and the enormous disadvantages of being identified as gay.'

Others convince themselves people don't know they're gay, or hope that they're seen as straight. As two respondents said,

> 'There's what I call the glass closet: when you live your life afraid that people will find out you're gay, when in fact everyone already knows. I know this mid-20s guy who's an absolute screamer: he minces around town flapping his wrists and being so camp. Yet he's terrified that "people will find out". I feel like grabbing him by the shoulders and yelling, "Everyone already knows".

> 'They would hope that the assumption was made about them that they are "het", rather than necessarily seeing themselves as "het". "Gay" is a label they take from the public domain and attached selectively and in bursts to themselves. To the world, they think they are seen as normal, straight guys.'

Finally, both the survey and interviews turned up respondents who considered themselves as gay but did not have sex with men (or only had sex very occasionally, and didn't seek it out). As one said,

> 'I'm happily married with kids. I'm gay, but not sexually active. I value my relationship with my wife more than having sex with other men. We've been together for 25 years. My sexual preference is gay. I'd choose men for sex and avoid sex with women; but I choose the lifestyle that suits me best, which is my marriage.'

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

8. 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[8].'

---

[8] 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

9. **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.

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

10. 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

11. 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

12. **To improve accessibility and the sense of confidentiality, that Queensland Health sexual health clinics do not prominently identify their premises as sexual health clinics.**
13. **That clinics provide areas where materials can be confidentially viewed and the means to confidentially take materials away.**
14. **That Queensland Health formally recognise the importance of gay-identifying staff at clinics.**
15. **That clinics, in promotions, focus more on the benefits they offer the public.**
16. **That there be statewide policy and action on evaluating the operations of clinics.**
17. **That Queensland Health establish formal links between mental health and sexual health clinics, to better coordinate the services provided to clients.**
18. **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

19. 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

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

21. 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

22. 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

23. 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

24. 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

25. 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