



Are young gay men really so different? Considering the HIV health promotion needs of young gay men

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Summary

Recent surveillance data and analysis of behavioural research suggest that we may be experiencing a rise in HIV infections among young gay men in Australia, that their behaviours may differ in some ways from older gay men, and that their sex/HIV education needs may not be adequately addressed.

This paper aims to consolidate evidence from diverse fields to consider HIV risk among young gay men and the effectiveness of efforts to address their sexual health needs. It reviews:

- epidemiological data
- social and behavioural research
- laws and policy mechanisms
- targeted programs and services.

Defining 'young gay men'

Young gay men are diverse, experiencing different degrees of awareness, ease, maturity and wellbeing related to sexuality. Sexual experiences are not uniform, and neither are experiences of 'coming out', identifying as gay and familial/community support. Some young gay men are in secondary or tertiary education while others have joined (or have failed to join) the workforce. Young gay men come from all ethnic backgrounds; may live in cities, regional towns or rural locations; and may or may not have a disability or mental illness.

Although individuals develop differently and at different rates, age-based indicators are useful. There are many definitions of young people to be found in policy and strategy documents although neither Australia's National HIV Strategy nor National STI Strategy employs them. The United Nations defines youth as 15 to 24 years of age, as (frequently) does the Australian Bureau of Statistics. The National Strategy for Young Australians covers those aged from 12 to 26.

This paper aims to be inclusive of all young men who identify as gay or are same-sex attracted ('young gay men'), and acknowledges that some of those men will not yet be sexually active. Although drawing largely on

epidemiological data from the 15 to 24 year old age range, it takes a broad view of 'young', ranging from adolescence – 13 or 14 years, to early adulthood – mid to late 20s.

Clearly the early years of this age range are below age of consent laws for sexual activity: generally 16 years of age in the ACT, NSW, NT, Victoria and WA; 17 years of age in South Australia and Tasmania; and 18 years of age in Queensland – the only state to stipulate a lower age of consent for heterosexual sex (16 years). Notably, four Australian states (ACT, SA, Victoria and WA) include formal defences to age of consent related crimes if the age difference between the two parties is between one and three years, suggesting legislators do not intend to criminalise sexual relationships between young peers. The dearth of prosecutions in other states suggests a similar attitude reflected by the lack of political will to enforce such laws when sex is between those of similar age. Most states also include a defence if the accused believed their sexual partner had achieved age of consent.

Our definition of 'young gay men' also overlaps with definitions of 'childhood', including the definition of 'child' provided in the United Nations' *Convention on the Rights of the Child* (up to 18 years). In this context, it is important to note the Convention's definition was

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developed to facilitate inclusivity, providing coverage to as many young people as possible as there is no UN Convention on the rights of youth (noting, the UN's own definition of 'youth' begins at age 15).

The inclusion of young men aged under the age of consent neither presumes the sexualisation of children nor condones sexual activity with those too young to consent. It acknowledges, however, that some males will have developed views on their sexuality and/or will be sexually active in their early to mid-teens, and recognises the incremental way in which understanding of sex, sexual risk, and sexual identity develops.

Many young people are sexually active while still at school. The 2008 National Survey of Secondary Students and Sexual Health found that 27% of Year 10 and 56% of Year 12 students had experienced sexual intercourse; data considered likely to be an underestimate.¹ The significant proportion of STI notifications among Aboriginal and Torres Strait Islander people under the age of 16 has been attributed to early sexual debut and/or sex with peer aged partners.²

It is estimated that up to 1 in 10 young people are same-sex attracted.³ In the most recent National Survey of Secondary Students and Sexual Health, 9% of Year 10 and Year 12 students reported they were not exclusively attracted to members of the opposite sex.⁴ *Writing Themselves In 3* (2010) revealed that many young people realised they were same-sex attracted when very young. In that study, 10% said they 'always knew', 26% said they knew by age 10, 60% knew by age 13 and 85% by age 15.⁵ Hillier and Mitchell (2008) suggest young people tend to experience sexual attraction before assigning themselves to a particular sexual identity.⁶ Conversely, same-sex sexual activity may precede the development of sexual identity:

I had been sexually active since eleven years old with other boys I knew. It was only at thirteen that I realised this probably had some correlation with my sexual orientation.

— Benjamin, 16 years.⁷

Homosexual experience is associated with onset of sexual intercourse before the age of 16.⁸ Although notably, 28% of those aged 14 to 21 years who identified as same-sex attracted in *Writing Themselves In 3* were not yet sexually active.

Age at first anal intercourse (which may occur some time after first 'sexual activity') is an issue with some relevance to HIV prevention because HIV infection has been linked to early sexual debut. In 2012, a nationwide online survey of Australian gay men found that of the 822 who reported having had anal intercourse, on average HIV-positive men were significantly younger

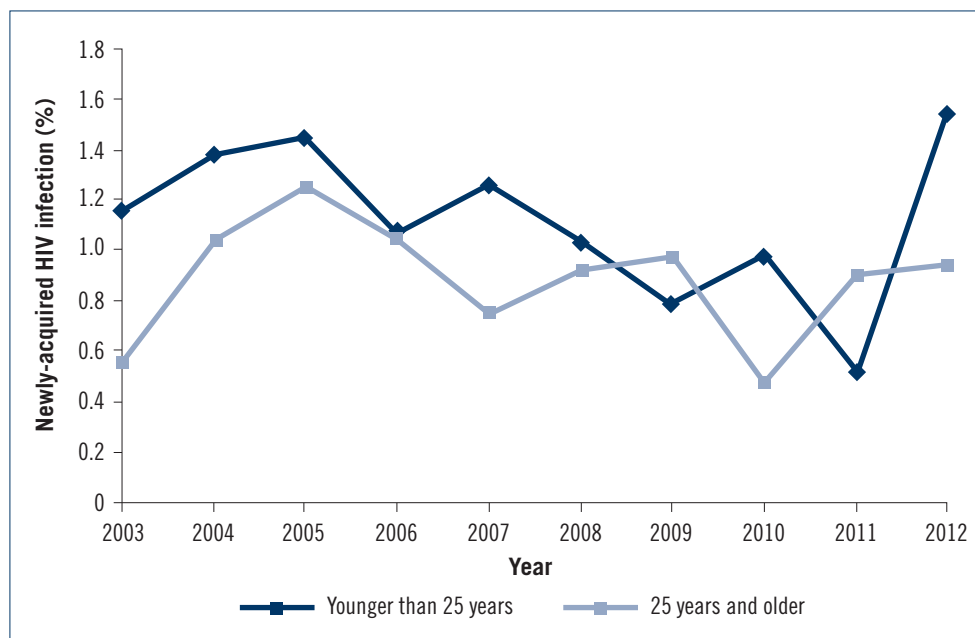


Figure 1: Newly-acquired HIV infection among men who have sex with men seen at sexual health clinics, 2003–2012, by year and age group. Source: Collaborative group on sentinel surveillance in sexual health clinics.

than HIV-negative men when they first had anal intercourse (18.5 vs 21.3 years).⁹ This may be a partial consequence of HIV transmission risk (which differs according to each sexual act) being cumulative over time, however, the study also found a link between earlier first anal intercourse and tendencies to engage in higher risk sexual behaviour. Although the reasons for this link are not well understood, the findings suggest 'a need for sex education aimed at gay-identified young men to ensure their sexual debut does not lead to poorer sexual health outcomes'.¹⁰ The young age at which some boys commence sexual activity is also why human papillomavirus vaccination for boys is scheduled at ages 12 to 13, given vaccination must precede first sexual intercourse.

During adolescence and into early adulthood, young gay men develop a sense of identity, attitudes and practices related to sexuality and sexual practice. Strategies to affect safe-sex practice can have immediate impact but critically, attitudes and behaviours developed during youth and early adulthood inform long-term health and wellbeing.¹¹ 'Youth' is an optimal time to target messages concerning sexual activity because behaviours at this age are strong predictors of behaviours in later life.¹²

HIV prevalence among young gay men

Almost half of all new HIV infections in the world are among people aged less than 25 years.¹³ However, this significant prevalence of HIV infection among young people is not evident in Australia. Nor is it evident among Australian subpopulations, including young men who have sex with men (MSM).

National HIV surveillance data reporting HIV diagnoses by age group shows that since HIV was first diagnosed in Australia, 516 males and 129 females aged 13 to 19 have been diagnosed HIV-positive. Although this is a lot of individuals, that figure represents only 2% of all diagnoses during that period. A far higher proportion have been diagnosed HIV-positive between the ages of 20 and 29: 8,762 males and 971 females, representing 31% of all diagnosed.

HIV surveillance data suggests there may have been a recent increase in HIV diagnoses among young gay men. Although no national surveillance figures are cited, data from sexual health clinics in 2012 reflect an increase in the percentage of men aged under 25 diagnosed with newly-acquired HIV infection (Figure 1). Importantly, these figures are only indicative and do not tell a straightforward story when considered over the last decade. The proportion of young MSM seen at sexual health clinics with newly-acquired HIV infection declined from 1.4% in 2005 to 0.5% in 2011 and then increased to 1.5% in 2012.¹⁴

How useful are current policy frameworks?

A number of policy frameworks guide Australia's efforts to safeguard the sexual health of young gay men. These include the:

- *National Strategy for Young Australians*¹⁵
- *Sixth National HIV Strategy 2010–2013*¹⁶
- *Second National Sexually Transmissible Infections Strategy 2010–2013*¹⁷
- *National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2010–2013*¹⁸

- *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*¹⁹
- United Nations *Political Declaration on HIV/AIDS* (UNPD)²⁰
- Millennium Development Goals²¹
- UN General Assembly Special Sessions (UNGASS) Indicators²².

Most fail to demarcate young same-sex attracted/gay men as having particular sexual health needs, including the National HIV Strategy 2010–2013. Although the Second National Sexually Transmissible Infections Strategy recognises ‘young men reporting same-sex attraction’ as a high priority subpopulation requiring specifically tailored interventions, that commitment is not referenced in the Strategy’s Implementation Plan. Aboriginal and Torres Strait Islander policies acknowledge the need for sex education among young people but at no point is ‘youth’ linked to ‘diverse sexual orientations’ or ‘HIV risk’. United Nations General Assembly Special Session (UNGASS) Indicators require Australia’s reported data on MSM to be disaggregated by age (>25/25+), but that data is not provided in Australia’s *Country Progress Report 2012*.²³ (An overview of policy frameworks guiding Australia’s efforts to safeguard the sexual health of young gay men is included as Appendix 1.)

What particular issues affect young gay men’s risk of HIV infection?

Despite young gay men’s diversity, a number of common factors intersect to impact their risk of HIV infection including:

Lower knowledge levels

Although often resourceful in learning about sex, many adolescents and young gay men are likely to have significant gaps in their sexual knowledge at the time of sexual debut and early in their sexual lives. Numerous Australian studies report young gay men’s assertions that school-based sex education was of little to no use.^{24,25,26,27} A 2011 online survey of 920 sexually active HIV-negative gay men in NSW identified that the sexual knowledge of young gay men (16–24 years old) was lower than their older counterparts, with some 25% of respondents having no recollection of ever seeing HIV prevention materials.²⁸ Lack of knowledge is likely to leave young gay men ill-equipped to advocate around their sexual health and contribute to high-risk sexual activities.

While knowledge of the mechanics of sex is important, sexual health is about far more than whether or not individuals understand how to minimise their HIV and sexually transmissible infection (STI) risk when participating in specific sexual acts. Young gay men require information, support and space for discussion and reflection to enable development of the

range of skills required to ensure sex is both physically and emotionally safe, including how to say ‘no’. Society’s preoccupation with ‘protecting girls’ disregards the reality that all young men, but particularly young gay men, require the physical, emotional and cognitive tools to negotiate safe sexual experiences. This has real implications for school-based sex education, but also for community organisations, which in their efforts to ensure gay targeted HIV messaging remains ‘sex positive’ must take care to ensure issues of vulnerability are not ignored.

Less social involvement in gay community

Young gay men may not feel part of ‘the gay community’ and may not rely on gay community events to socialise. Although research has established that many older men are only peripherally involved in gay life^{29,30}, Gay Community Periodic Survey data (2006–2010) show that men under 25 years are less likely to identify as gay or homosexual than older men (85% to 93%) and also tend to be less engaged in gay social life³¹. This may reflect changes to the cohesion of gay communities and their reduced centrality in many gay men’s lives, possibly as a result of reduced homophobia and increased opportunity in many areas of Australian life. It may reflect young gay men forming their own networks outside of traditional routes. It may also reflect young men being less likely to identify as gay because they have not (yet) come out and may not (yet) be involved in gay social life.

Limited involvement in ‘gay community’ may mean limited exposure to individual role models or mentors, which likely impacts the experiential ways in which young gay men ‘learn to be gay’. It may also mean limited experience of different models of same-sex relationships and safe sex based ‘sexual norms’. This may be particularly pronounced in regional locations. In *Writing Themselves In 3*, many young people living in rural and remote towns felt isolated and aspired to relocate to an urban environment ‘to become the person they wanted to be’³².

Less contact with HIV-positive people

Young gay men have no experience of the AIDS epidemic of the 1980s and 1990s when the constant physical devastation of HIV was a catalyst for safe sexual practice. HIV is now far less ‘visible’, including in gay communities in high-prevalence urban areas. Arguably, it is no longer a galvanising force for gay communities.

Among the many competing demands in their daily lives, young gay men may not consider HIV particularly relevant. Gay Community Periodic Survey data has found younger men were less likely than older gay men to know their own or their partners’ HIV serostatus. They were also less likely than their older counterparts to report knowing

people with HIV or to have friends who were HIV-positive.³³

The 2012 Stigma Barometer Survey by the Australian Federation of AIDS Organisations (AFAO) and the Centre for Social Research in Health, found HIV-negative young gay men were more likely than older men to be stigmatising of people with HIV. They were more likely to ‘blame’ HIV transmission on people with HIV, enact social distancing and sexual and romantic exclusion, and express excessive apprehension or negative emotional reactions.³⁴ This suggests that for some young gay men HIV is no longer ‘normalised’ as a feature of gay life, which may in turn undermine core HIV prevention messages of gay sexual partners sharing mutual responsibility for managing HIV infection risk.

Impact of ethnicity and religion

Gay identity is influenced by ethnicity and religious background, factors which may be particularly pronounced as young men develop from dependent adolescents into young adults. *Writing Themselves In 3*, found young people from religious or culturally and linguistically diverse (CALD) backgrounds were less likely to receive family support regarding their sexuality. This can also be an issue for young people from Aboriginal and Torres Strait Islander backgrounds, although notably experiences within cultures (including non-CALD cultures) vary. Young people who mentioned religion also felt less safe at home and were more likely to have experienced social exclusion.³⁵

The absence of social support, particularly family support, has been shown to increase risk. In the United States, Kimberly and Serovich found that the more family members were perceived as supportive, the less likely participants intended to behave in risky ways.³⁶ Garofalo et al., established that family connectedness significantly decreased the likelihood of an individual becoming HIV-positive.³⁷

Notably, some participants from *Writing Themselves In 3* reported a need to hide their religious identities within gay community. Similar themes were identified in a 2010 qualitative research project, which found MSM from CALD backgrounds faced prejudices from both their ethnic and gay communities – practices that may isolate people from support and services.³⁸ Awareness of the intersection of individual’s multiple ‘identities’ is imperative to the development of effective HIV prevention messaging.

High rates of STIs (among young people)

STIs increased the risk of HIV transmission and may also reflect unsafe sexual practices. Young people are grossly overrepresented in terms of STI transmission in Australia, with

an estimated 75% of STIs occurring among young people. In the past three years, the rate of STI diagnoses amongst people aged 15 to 29 has increased by 20%.³⁹ Much of that transmission is driven by heterosexual sex. Higher rates of partner changes⁴⁰, limited knowledge of STIs and their prevention⁴¹, and serious barriers to health service access and use^{42,43} contribute to increased prevalence of infections among all young people, but particularly among marginalised and at-risk youth. Substantially higher rates of chlamydia, gonorrhoea and syphilis are recorded in Aboriginal and Torres Strait Islander populations, with young people overrepresented among those diagnosed.⁴⁴ Consequently, two indicators from the *Third National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2010–2013* are the proportion of young Aboriginal and Torres Strait Islander people who report having had an STI test during the previous 12 months, and the proportion of young Aboriginal and Torres Strait Islander people receiving a chlamydia and gonorrhoea test during the previous 12 months.

While chlamydia is the STI most commonly associated with adolescence, other STIs are also common. Gonorrhoea is most common among men, especially those having sex with other men.⁴⁵ Given some people engage in both heterosexual and gay sex, there is likely some movement of STIs across risk categories although that process is not fully understood. It is known, however, that same-sex attracted young people have a five-fold risk of being diagnosed with an STI compared to their heterosexual peers.⁴⁶

General attitudes to health and perceptions of risk

Sexual interaction involves the negotiation of health – not only issues associated with STIs and other medical concerns but also bodily wellbeing and capacity.⁴⁷ Health is more than something negotiated prior to and then implemented in sexual interaction.⁴⁸

Individual's perception of what it means to be healthy and what is required to stay healthy generally changes over time. Consequently, young men's general perception of healthy practices may differ from that of their older counterparts. For example, recent AFAO market testing considered participant's attitudes to health, identifying a preoccupation with 'looking good' which was particularly strong among young men. While some young men were holistic in their approach, many conflated 'being healthy' with 'looking good' – a version of 'health' that may have implications for HIV prevention, particularly in relation to serosorting.

Similar to other young men, young gay men are likely to enjoy physical strength and indulge in greater risk taking behaviour than

women or older men^{49,50,51,52}; risk-taking that is to some extent developmentally appropriate and socially adaptive (e.g., developing new and more intimate relationships with peers, testing new levels of independence, establishing a new identity and developing values). Risk-taking includes drug use and sexually risky behaviours, and at times, their intersection.⁵³

Some work has been undertaken examining relationships between sexual sensation seeking and sexual risk-taking, with Kalichman's measure of sexual sensation seeking found to be strongly associated with sexual risk behaviour⁵⁴, however, the intersection between young men's propensity for risk-taking per se and sexual risk-taking has not been fully explored in HIV prevention messaging. While risk-taking may be reduced through exposure to HIV messaging, risk may also be modified by experience (over time), with evidence that some young gay men's perceptions of sexual risk changed after contracting an STI or having an HIV scare.⁵⁵

Risk behaviours are frequently influenced by social and psychological factors. Self-esteem and strong mental health is likely to impact individual's behaviour, including capacity to negotiate safe sex and to adopt other protective behaviours. Conversely, high self-esteem could also be linked to self-confidence, including 'over-confidence' that may lead to increased risk-taking.

There is little specific research on the mental health of young gay men, however, *The National Survey of Mental Health and Wellbeing* suggests men who are homosexual or bisexual are more likely to experience anxiety or depression than heterosexual people: 41% experiencing a mental disorder in the previous 12 months, compared to 20%.⁵⁶ The Australian Research Centre in Sex, Health and Society's (ARCSHS) review of literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people also suggests gay and other MSM have higher rates of depression than their heterosexual counterparts.⁵⁷ Gay men have reported far higher rates of self-harm: 21% compared to 5% of heterosexual men and 8% of heterosexual women.⁵⁸

A research project, Men's Own – Health Behaviours of Young Gay Men, is endeavouring to shed more light on the social and psychological predictors for health behaviours among gay men who have recently become sexually active, particularly issues associated with stigma, discrimination, self-esteem, and social support. Begun in June 2012, analysis of data from a national sample of approximately 1,200 young gay men commenced in late 2013.⁵⁹

Normative notions of relationships and romance

Young adolescents typically seek close and intimate sexual relationships, however, young gay men may experience some disadvantage negotiating safe sex and indeed constructing models of negotiated safety with regular partners due to limited exposure to role models (and mentors) and to models of same-sex relationships.

Recent Australian research (2011) considering young gay men's desire for intimate relationships found young gay men negotiate competing and contradictory ideas about sex and relationships, balancing desires for stable, committed, monogamous relationships with sexual autonomy typified by casual and serial dating. Monogamy was favoured by many respondents however, that ideal competed with sexual opportunities, pressures of the gay 'scene', and an emphasis on youthful sexual experience as a rite of passage.⁶⁰

A 2008 US study also identified young gay men's underlying desire to develop close and intimate relationships but found that participants tended to idealise intimate partners, often reporting that partners had 'no reason to lie to me' or relying on instincts that they could 'fully trust' them.⁶¹ Young men made assumptions about partners' HIV status based on behaviour or appearance such as looking 'clean', being smart, having a certain type of job, and having 'no reason to lie': saying they would be aware if someone was lying to them about their HIV status. Some also reported assuming a partner's HIV-negative status based on (what they perceived as) their partner's limited sexual experiences or lack of involvement in gay community. A reliance on instinct and feeling can have dire consequence for HIV prevention efforts. Notably, data from 2007 Gay Community Periodic Surveys reveal that 21% of the men who had seroconverted had been 'certain' their partner was HIV-negative during the event that led to their HIV seroconversion.⁶²

Recent research among young gay men suggests that a generational change in normative notions of romance and relationships may be underway.⁶³ Two US studies found many young gay men now anticipate raising children. D'Augelli et al.'s (2006–07) study found that the majority of young gay men in the United States expected to raise children, with only 14% reporting no interest in parenthood.⁶⁴ In Rabun and Oswald's 2009 study, all participants indicated a desire and intention to be a parent, with factors framing this intention including career and financial stability, moving to an area that was conducive to same-sex parenting, and developing a long-term partnership. Respondents imagined parenthood only in the context of a relationship.⁶⁵ Advocacy to legalise gay marriage in Australia continues.

Sexual risk practices

The HIV epidemic required significant changes to the sexual practices of gay men – most notably, the use of condoms for anal intercourse, which remains the basis of safe sex messaging today. AFAO's 2011 review of HIV risk reduction strategies found that Australian gay men consciously employ a range of other strategies to minimise HIV transmission risk including negotiated safety, withdrawal, strategic positioning, serosorting and viral load testing.⁶⁶ Unfortunately, there is little age-demarcated published data on the use of these varied risk reduction techniques by young gay men. (Data on condom use during unprotected anal intercourse is listed under 'Patterns of relationships and condom use' below.)

Everyone has a different sexual repertoire⁶⁷, however, recent Australian research suggests that young gay men may have only a slightly narrower sexual repertoire than their older counterparts. Considering 18 different sexual practices with casual partners, men aged 25 or under reported a mean of 7.0 practices, while those aged 25–44 reported a mean of 7.3 practices.⁶⁸ According to Gay Community Periodic Survey data (2006–2010), young gay men aged less than 25 years were less likely than older men to participate in group sex (28% to 44%).⁶⁹

Australian research also suggests that young gay men may take a different approach to managing HIV risk through the use of biomedical prevention:

- **Pre-exposure prophylaxis (PrEP)**
The use of antiretroviral therapies as PrEP is rare (<2%), so data must be considered very cautiously. 2011 Gay Community Periodic Surveys found use of PrEP before unprotected anal intercourse was highest among those who were less than 25 years old and second highest among those aged 25 to 29.⁷⁰ Given the small sample size, differences across age-groups were not considered statistically significant. A national survey (2012) suggests interest in using PrEP is higher among younger men.⁷¹
- **Post-exposure prophylaxis (PEP)**
Analysis of Gay Community Periodic Survey data (2006–2010) found that despite having less knowledge of PEP than older gay men (41% to 69%), during the previous six months young men had similar uptake of PEP (5% to 4%). Despite lower levels of awareness, young men were at least as likely as older men to report PEP use.

Unfortunately the above data does not indicate why young gay men's uptake of PEP and PrEP appears to be slightly higher than their older counterparts. It may or may not be associated with HIV transmission risk practices or may indicate a preference for biomedical

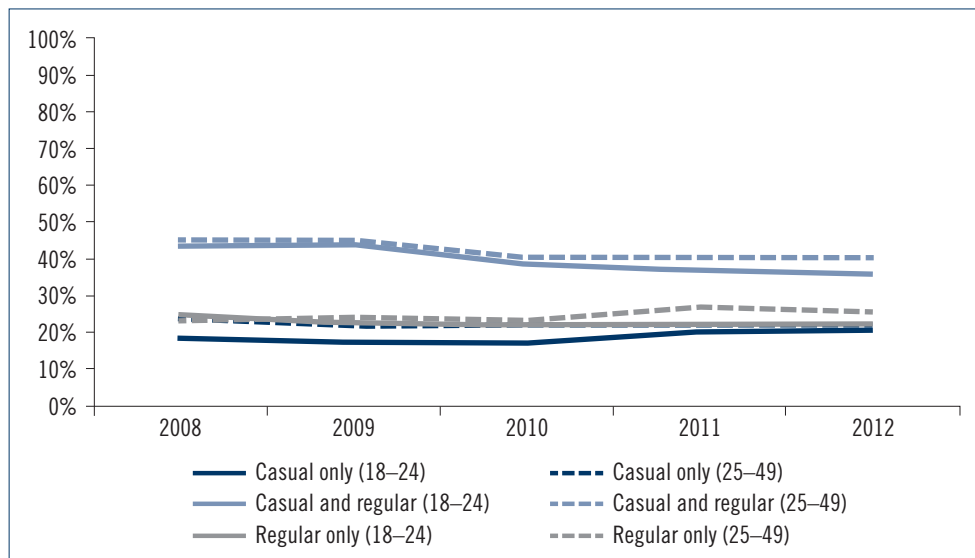


Figure 2: Relationships with men.

preventions. It may also be associated with young gay men's participation in specific networks and events, particularly parties.

Patterns of relationships and condom use

Recent analysis of Gay Community Periodic Survey data suggests that in 2012, gay men aged less than 25 were slightly less likely to be in a monogamous regular relationship than older gay men (22% to 26%) (Figure 2). They were slightly less likely to have both casual and regular partners (36% to 40%), and were slightly more likely to be engaging in sex with casual partners than they were five years ago (increasing from 18% to 20%). Young gay men had slightly lower but similar rates of casual (only) sex as their older counterparts (20% to 22%).⁷²

Annually collected data is frequently considered over a five or ten year period to identify trends over time. A number of 'snapshots' of Gay Community Periodic Survey data from different periods follow, providing varied accounts of changes in young gay men's risk-taking over the recent past.

Regular partners

- Analysis of a decade's data showed that reporting of any unprotected anal intercourse (UAI) had increased significantly among men aged under 25 (from 48% in 2003 to 54% in 2012), but had not increased in other age groups.⁷³
- Data from 2006–2010 reflects lower rates of (any) UAI by young men with a regular partner during the previous six months compared to older men (55%–60%).⁷⁴
- Analysis of data from 2008–2012 (Figure 3, overleaf) suggests young gay men were at least as likely as their older counterparts to have had (any) UAI with a regular partner during the previous six months (54% to 53%).⁷⁵ This reflects a slight decrease in any UAI among older

men aged 25–49 (54% to 53%) and a slight increase among younger men (53% to 54%). From 2008–2012, the percentage of those reporting only protected sex declined slightly in both groups: younger gay men (32% to 28%) and older gay men (27% to 24%).⁷⁶

- Data from the period 2003–2012 suggests the proportion of men having **non-concordant UAI** with a regular (untested, unknown or discordant) partner increased significantly (from 40% to 46%), and had only increased among men aged under 25.⁷⁷
- Analysis of data from 2006–2010 shows both HIV-positive and HIV-negative young gay men were more likely than their older counterparts to engage in UAI in a **non-concordant** relationships.⁷⁸ The sample of young gay men in non-concordant relationships was, however, small.

Casual partners

- Between 2003 and 2012, the proportion of young gay men reporting (any) UAI with a casual partner showed significant increases among men aged under 25 (30% to 35%), but not in other age groups.⁷⁹
- Between 2008 and 2012 (Figure 4, overleaf), the proportion of young gay men reporting (any) UAI with a casual partner increased very slightly from 32.7% to 34.4%, having peaked above 35% during 2010.⁸⁰ That data suggests trends in safe sex with casual partners have remained stable over time, with both younger men (18–24) and older men (25–49) similarly likely to report condom use or UAI, except for 2010 when younger men reported higher levels of unprotected sex.⁸¹

Where people meet partners

The 2012 Gay Community Periodic Surveys reflect different patterns relating to how and where young men met their sexual partners during the six months prior to the survey (Figure 5). The data reflects a continuing increase in the use of online and mobile platforms compared to physical venues among all age groups, however, compared to their older counterparts, younger men were more likely to use mobile apps, bars, and dance parties, and less likely to use internet, beats, saunas and sex on premises venues.⁸² This data has implications for both the content and location of HIV prevention messaging.

Age mixing

Of course young gay men do not only have sex with each other.^{83,84} Drawing on data from the PASH study involving some 1,500 Australian gay and bisexual men, Prestage et al., found that one in three reported their most recent casual sex partner had been more than 10 years older or younger than themselves, as had 20% of their regular partners.⁸⁵

Among men aged under 25 years, 15% reported a regular partner more than 10 years older. Twenty-five percent reported unprotected anal intercourse with casual partners more than 10 years older. Men whose partners were perceived to be at least 10 years older were more likely than other men to believe their partners were HIV-negative.

Given little evidence that men's age influenced the likelihood of unprotected anal intercourse, the study considered whether there may be particular issues around risk behaviour and age mixing. Respondents' age was associated with sexual position with regular partners and (to a lesser extent) casual partners. Men who restricted themselves to the insertive position were somewhat older and those who restricted themselves to the receptive position were somewhat younger.

This issue is relevant to HIV risk given the far higher prevalence of HIV among gay men in their 40s and 50s compared to younger men. Even if sexual risk behaviour is similar, young HIV-negative men who engage in unprotected anal intercourse with older partners have a greater chance of becoming HIV infected given higher HIV prevalence among older gay men.⁸⁶

The research did not find any clear relationship between 'age-based power' dynamics and condom use or sexual positioning.^{87,88,89} While decisions on sexual risk and sexual positioning may be based on relative power dynamics, power/agency may be exercised by either younger or older partner, be applied by each partner at different times, or be shared. Notably, some younger men specifically prefer older partners – suggesting agency in their choice of sexual partner.

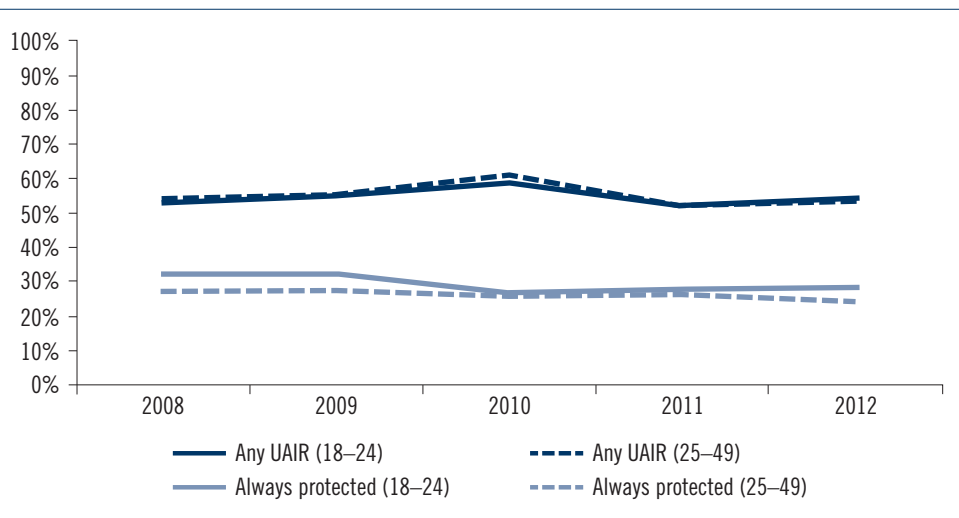


Figure 3: Sex with regular partners (2008–2012).

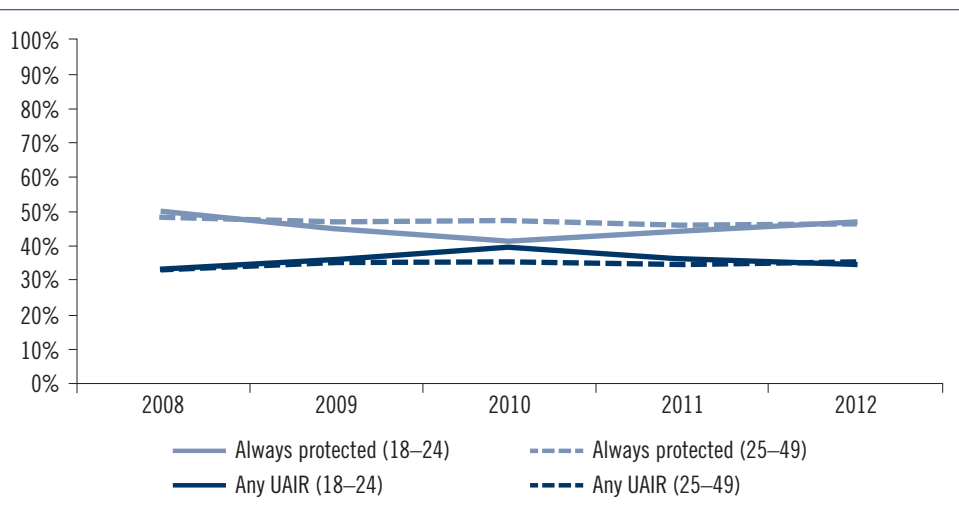


Figure 4: Sex with casual partners (2008–2012).

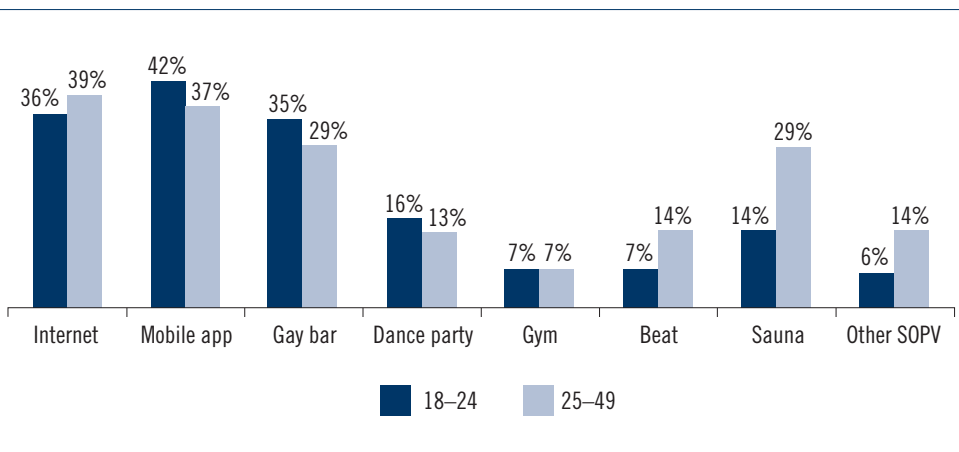


Figure 5: Where men met partners (2012).

The PASH study found that age, sexual sensation-seeking and identification as a 'boy' or as a 'daddy' were associated with age differences between regular partners. HIV prevention programs may benefit from the inclusion of messaging to target those with partners of dissimilar age, including those engaged in 'daddy/boy' sexual cultures. While important to make young men aware of the higher HIV prevalence among older gay men, messaging

should include the fact that some young gay men also have HIV. Work in this area may also represent an opportunity to reiterate messaging around cultures of care in gay communities, particularly that older gay men have a role to play in supporting young gay men as they develop sexuality through practice.

Limited understanding of safe injecting drug use

Young people new to injecting drug use have limited knowledge and access to information or equipment to enable safe drug use. Numerous studies have suggested that injecting drug use is more common among networks of gay, lesbian and bisexual people than among the general population^{90,91,92} – findings reiterated in the 2009 Big Day Out survey which found young people who did not identify as heterosexual were more likely to have been exposed to injecting.

Although incidence of injecting drug use was low (less than 4%), 26% of respondents reported being offered drugs to inject or had a friend or boyfriend/girlfriend who had injected during the previous 12 months.⁹³

Respondents had poor knowledge about health services available to those who injected drugs, with only 12% being able to correctly identify a place to obtain sterile needles and syringes. Importantly, approximately 3% of HIV diagnoses each year in Australia are attributed to unsafe sexual practice by a gay man or MSM who also inject drugs.

Low uptake of HIV testing

HIV testing enables identification of HIV infection, which in turn allows people to begin HIV antiretroviral treatment which can have long lasting benefits and contribute to reduced HIV transmission risk. It also allows people to make considered choices about sexual practice, further minimising HIV transmission risk.

Rates of undiagnosed HIV among MSM have been estimated at between 10% and 20%^{94,95}, and as high as 31% in some jurisdictions. Despite relatively high uptake of HIV testing among gay men and other MSM, late diagnosis remains a critical issue for MSM who accounted for more than 50% of all diagnoses of late or advanced HIV infection between 2002 and 2011.⁹⁶

Recent research suggests a gradual downward trend in the proportion of gay men and other MSM who have ever been tested for HIV (85%). That downward trend has been attributed to the increased participation of younger men and men new to traditional gay community events and venues over the last few years⁹⁷ – reflecting lower testing rates among these populations. The proportion of gay men and other MSM testing at least once a year appears to have stabilised (at around 60%), although that figure reflects increases and decreases in particular states.⁹⁸

A significant proportion of HIV transmission among gay men and other MSM is by people who do not know they are HIV-positive. It has been estimated that overall, a 25% rate of undiagnosed HIV among MSM would account for more than 48% of new infections.⁹⁹

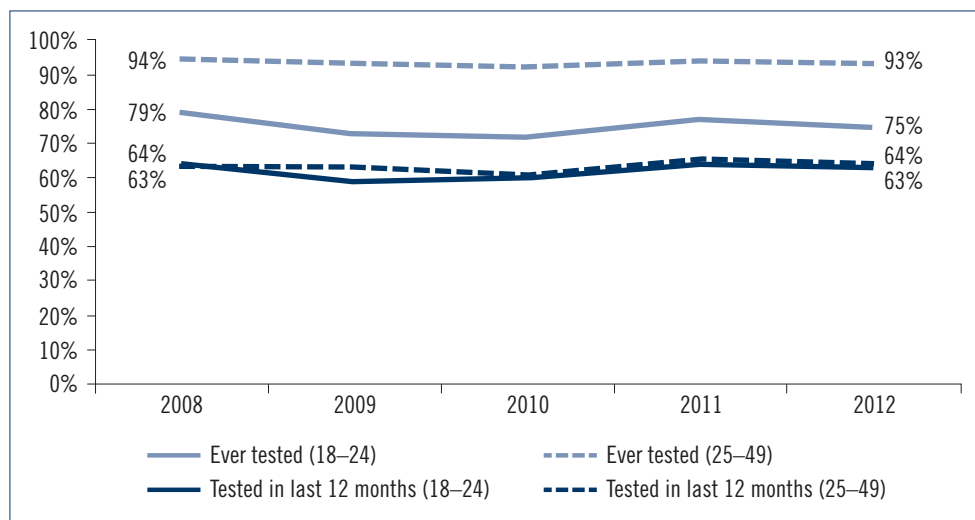


Figure 6: HIV testing.

Clinical data suggests that among gay men who have multiple sexual partners (more than ten partners in six months), only about a quarter are testing every three to six months as recommended by Australian testing guidelines.¹⁰⁰

Gay Community Periodic Survey data from 2012 (Figure 6) reflects lower rates of HIV testing among young men, with only 75% having ever been tested (compared to older men, 93%).¹⁰¹ Contrary to some assertions that young gay men are tested less frequently because of lower levels of risk taking, analysis of Gay Community Periodic Survey data (2006–2010) found that younger men with multiple sex partners (11 or more during the last six months) were less likely to have ever been tested for HIV than older men.¹⁰²

Another study, How Much Do You Care?, found that while young gay men (16–26 years) reported similar rates of unprotected anal intercourse as older gay men, almost 30% had never been tested for HIV/STIs. Poor knowledge and low testing rates among younger gay men seemed to be related to lack of exposure to HIV campaigns, reported by almost a quarter of participants.¹⁰³

Two analyses of Gay Community Periodic Survey data provide slightly differing views of young gay men's recent HIV testing. Holt and Lea's 2014 analysis showed that in 2012, 63% of young gay men (aged 18–24) had undergone HIV testing in the 12 months prior to survey.¹⁰⁴ That figure reflects a fairly consistent uptake of HIV testing over the five-year period. The Annual Report of Trends in Behaviour 2013 reports different figures. It suggests that between 2003 and 2012, testing by young gay men (aged under 25 years) in the 12 months prior to survey had decreased slightly, from 62% to 59%.¹⁰⁵ The two analyses differ in part because of the different time periods used (ten years and five years) and particularly, the inclusion of young men aged under 18 in the second sample. More work is needed to scrutinise the discrepancy between

the two data sets to ensure a synthesised analysis of young gay men's recent HIV testing.

In 2012, 63% of young gay men reported being tested during the previous 12 months – a rate almost identical to the rate reported by older men (64%), suggesting that once younger men begin HIV testing, they test at a similar rate to older men.¹⁰⁶ So, although the proportion of younger men who have ever tested for HIV is usually lower than among older men, younger men are more likely to have been recently tested. This contradiction suggests that for young men, **having a first test is a crucial tipping point into (more) regular testing.**

HIV testing routines are impacted by structural and psychosocial factors such as knowledge of HIV and STIs, attitudes towards testing, perceived benefits of testing, fears regarding testing and HIV stigma. During AFAO's recent market research to inform the development of HIV education campaigns, first time testers (particularly younger men) reported their initial HIV/STI testing experience was stressful and frightening. They expressed dissatisfaction with current testing arrangements and wanted the testing experience to be easier, more immediate and also free.¹⁰⁷ Gay men have high expectations of HIV testing, wanting it to be as easy as possible – quick, simple, and accessible. This is particularly important as it relates to young gay men as poor early experiences of HIV testing can be very influential in establishing subsequent testing patterns.

How do young gay men and other young MSM learn about sexuality, sexual norms and behaviours, and HIV/STI prevention?

Young gay men get information about sex and sexual health from a range of sources including school, family, friends, sexual partners, primary care providers, support services and the internet.

School

In one class the teacher set up an anonymous question box, so I put in 'I'm gay. How is this class relevant to me?' When the teacher pulled it out of the box she said 'Oh, that's just a silly question,' and threw it out.

— Dianne, 21 years
*Writing Themselves In 3*¹⁰⁸

Almost all young people attend formal schooling so schools form a pivotal 'catchment' for sex education programs. For many young people entering adulthood, school sex education is the only formal sex education opportunity they will have. It is nominated by young people as one of the sources they use most to educate themselves on sexuality¹⁰⁹, and students' support for comprehensive school-based sex education is high¹¹⁰. The importance of school-based programs is reiterated by the almost 300 teachers surveyed for the first National Survey of Australian Secondary Teachers of Sexuality Education (the Australian Teachers' Survey), 94% of whom said that sexuality education should be part of the national curriculum.

Sex education in schools can be contentious. Throughout Australia there are thousands of schools, state and private, with different religious and ethical values shaping their priorities. Importantly, research shows that young people are exposed to sexual topics and influences in their day to day lives and they want the appropriate knowledge and skills to protect themselves¹¹¹ – a reality prompting academics from the Australian Research Centre in Sex, Health and Society to argue, 'We live in an increasingly sexualised society [so] the issue of whether or not a young person will have their innocence destroyed by sexual health education in schools is no longer worth asking.'¹¹²

Numerous studies have failed to find any evidence that school-based sex education hastens the onset of sexual experience.¹¹³ Similarly, 11 evaluations of US abstinence-only sex education (costing US\$94.5 million) found little evidence of long-term changes in attitudes and intentions of youth but some showed negative impacts, including young participants' reported unwillingness to use contraception when engaging in sexual behaviours.¹¹⁴

There are numerous recent Australian studies suggesting that 'high quality sexuality education delivered by well trained and supported teachers remains the best means of educating young people about sexual and reproductive health.'^{115–119}

Brown et al.'s 2013 review of public health interventions found strong evidence that school-based sexual health programs that are comprehensive, well-facilitated and supported within a broader school community approach have the strongest impact on delaying sexual behaviour, increasing awareness and knowledge around STI prevention, and increasing protective behaviours. The review also found good evidence that such programs reduced STIs among young people.¹²⁰

Teaching about same-sex attraction and safe-sex practice

Homophobia remains widespread in schools. Of the 3,134 respondents to the *Writing Themselves In 3* survey, 61% reported being the subject of verbal homophobic abuse, and 18% the subject of physical abuse – 80% of which occurred at school. More than a third described their school as homophobic¹²¹, revealing both the importance of school-based interventions to address homophobia and the difficulty of including same-sex based content in classroom contexts.

The Australian Teachers' Survey reveals many key subjects are being taught, including social aspects related to sexual health and fact-based topics such as safe-sex practices, HIV and STIs (taught by at least 95% of those surveyed). However, school-based sexual health education has frequently been criticised for lacking information applicable to same-sex attracted young people¹²², including the central issue that frequently only 'straight sex' is discussed in classroom settings¹²³. In the Let's Talk About Sex survey¹²⁴, less than half (43%) of gay, lesbian, bisexual, transgender, queer or intersex respondents found school sex education to be relevant, and 69% felt excluded. In *Writing Themselves In 3*, less than one in five same-sex attracted and gender questioning young people stated school sex education was at all useful or was only moderately useful – and far less useful than the internet. Those assertions are supported by a 2007 Western Australian study in which young people expressed their frustration at school based education's failure to include same-sex relationships.¹²⁵

There is general consensus that sexuality education needs to be age appropriate and incremental. The Australian Teachers' Survey¹²⁶ reported when different topics are taught (Table 1) although the content and quality of those topics is not recorded.

Teachers were also asked their opinion on when topics **should** be taught for the first time at school. Most thought they should be taught earlier, with more than 50% saying safe-sex practices should be taught in year 7 or 8, and sexual orientation and same-sex attraction should be taught in year 9 or 10. This is in line with findings from *Writing Ourselves In 3*, in which young people stated sex education classes often came too late. Notably, in that report, at least half of the same-sex attracted young people realised they were same-sex attracted while still in primary school, suggesting the importance of inclusive materials in the primary school curriculum even if they are not necessarily presented in a sexual context.

Obstacles to education about same-sex attraction

Training – Recognition of the importance of teacher training is not new.¹²⁷ The Australian Teachers' Survey found sexuality education is currently undermined by a lack of specific sex

education teacher training. Of those surveyed 16% had no training and the majority relied on in-service training, which was often a one-off, short session. Most wanted assistance, particularly in areas related to same-sex attraction (Table 2).

Teacher's beliefs – School-based sex education is affected by the personal opinions of teachers: an important issue given many teachers' conservative beliefs as indicated by the Australian Teachers' Survey, in which more than a quarter of teachers (27%) was undecided whether sex before marriage was acceptable.¹²⁸ More pointedly, the survey identified that 13% believed that 'homosexuality is always wrong', and 13% also thought sexual orientation and same-sex issues should not be included in sexuality education (Table 3).

Underutilised peer and expert educators – The Let's Talk About Sex study found strong support from young people for the engagement of external agencies to support the delivery of sexual health education in the classroom. While only 32% of respondents preferred Health and Physical Education teachers, 68% supported both peer educators and sexual health educators from community organisations. Support for external educators was echoed in the Australian Teachers' Survey.

Community reaction – Sex education is also affected by a reticence to generate a negative community response, with just under 50% of teachers from the National Teacher's Survey stating they were careful about the topics they taught because of a possible hostile community response.

Inclusion in the curriculum – Even given all of the above, the main factor affecting whether specific sexuality education topics are taught appears to be their inclusion or not in the school curriculum. When the National Teacher's Survey asked why particular subjects had not been taught, the most common reasons were the subject's exclusion from the school curriculum (54%) and time constraints (which might also be understood as competition with other subjects mandated by the curriculum).¹²⁹

In some ways, the July 2013 Revised Australian Curriculum¹³⁰ is a major step forward, acknowledging that 'same-sex attracted and gender diverse young people are becoming increasingly visible in Australian schools', with the curriculum 'designed to allow schools flexibility to meet the needs of these young people, particularly in the health context of relationships and sexuality'. It points to all schools' responsibility 'to ensure teaching is inclusive and relevant to the lived experiences of all students'.

Unfortunately, the Revised Australian Curriculum fails to specifically address safe-sex practice, HIV or STIs, despite 'increasing young people's knowledge of STIs ...through

Table 1: What topics were taught and when (percentage)

Sexuality topics	Taught Year 7	Taught Year 8	Taught Year 9	Taught Year 10	Taught Year 11	Taught Year 12	Not taught
Safe-sex practice including condoms	8	36	64	61	13	7	4
HIV/AIDS	11	34	59	54	14	10	4
STIs other than HIV	9	32	65	56	13	6	3
Sexual orientation/same-sex attraction	14	20	56	44	14	8	16
Sex acts other than intercourse	6	17	51	39	9	5	25

Table 2: Teachers' perceptions on assistance needed for teaching topics (percentage)

	No assistance needed	Factual information needed	Teaching material needed	Teaching strategy	Topic not covered
Sexual orientation/same-sex attraction	39	20	37	27	9
Sex acts other than intercourse	55	12	25	16	15
HIV/AIDS	68	17	19	9	2
STIs other than HIV/AIDS	71	14	17	7	2
Safe-sex practices including using condoms	80	4	10	6	44

Table 3: Teacher's personal opinion on same-sex attraction and school sex education (percentage)

	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
Homosexuality is always wrong.	79	8	11	0.3	2
Sexual orientation and same-sex issues should not be included in sexuality education at school.	62	25	8	3	2

improved delivery of age-appropriate education within the school curriculum' being a national policy priority through its inclusion as an objective of the Second National STI Strategy.

Arguably, the poor effort to ensure inclusion of information on safe-sex practice and HIV reflects the 'disconnect' between health and education portfolios, as well as the low government priority afforded HIV education for young people in Australia. In this context it is important to note that Australia did not provide data on the following UNGASS indicators within its most recent (2012) UNGASS report¹³¹:

- Does the country have a policy or strategy to promote life-skills based HIV education for young people?
- Is HIV education part of the curriculum in primary schools, secondary schools, teacher training?
- Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?
- Does the country have an HIV education strategy for out-of-school young people?

- To what extent has HIV prevention been implemented [including] school-based HIV education for young people and HIV prevention for out-of-school young people?

Safe sex, including the particular risks associated with different STIs, should be explicitly referenced in the Health and Physical Education Curriculum.

Parents

[My Mum's] reaction was not good ... I got a tirade of homophobic abuse from her, was told I'd die of AIDS, told that God thinks it's wrong, told that marriage is between a man and a woman and that I was unnatural and disgusting.

Roman, 21
Writing Themselves In 3¹³²

There is considerable research establishing that parents (and other family members) play a crucial role shaping adolescents' sexual behaviour.^{133,134,135} Most obvious is the provision of sex education by parents, education which is overtly effected by its quality, frequency

and timeliness – ideally capitalising on 'teachable moments' when young people are feeling open to learning new information.¹³⁶ Parent-adolescent communication about sex is associated with decreased sexual risk-taking behaviour,^{137–141} and communication with mothers who are open, skilled and comfortable during discussions about sex and HIV-related issues has been linked to more consistent condom use¹⁴².

For young gay men, the effectiveness of sex education will be overtly affected by whether such 'education' includes information about sex between men, HIV and other STIs. While some parents may include information about gay sex and STI risk, this seems highly likely to be influenced by whether parents are aware of their son's non-heterosexual sexuality and parents' knowledge and comfort discussing sex.

For many, disclosure to parents remains fraught, and for some 'a traumatic event' given the importance of child-parent relationships.¹⁴³ The *Writing Themselves In* 3 study found that although the majority of young people had disclosed their sexuality to at least one parent, and the majority of those had been supported, many had not been supported. In some instances, parents were so distressed or angered by their child's disclosure that the young person could no longer live at home. Many others had not disclosed, with young people from CALD and religious backgrounds less likely to tell their parents and also less likely to be supported.

Although some studies report a dearth of sex education by parents of same-sex attracted youth, the problem is not universal. For example, a 2007 US study found 83% of parents of young gay and bisexual men worried that their sons would contract HIV and tried to discuss safer sex with them.¹⁴⁴ The form, content and productivity of those discussions is not known.

The role parents and other family play in developing young people's sexual values and behaviours extends far beyond sex education talks. Family cohesion, support and 'connectedness' has been shown to mitigate high-risk behaviours, including increasing condom use.^{145–153} Notably, a recent US study of 30 families with a gay son indicated that those young men felt obligated to remain healthy 'for parents', which was an important factor in their decision to practice safer sex.¹⁵⁴

There is some evidence to suggest that social media campaigns may have a role to play. A US study found that a public media campaign encouraging parents to talk to their children about sex was positively associated with the frequency that parents talked to children about safe sex.¹⁵⁵ Such a rationale has likely informed the inclusion of parents in the Queensland Government's recent End HIV television advertisement which includes a parent saying 'I'll talk to my kids armed with facts, not fear'. Parents are 'referred' to a website.

Friends

If you really know the person then you don't really have to worry about [STIs]... Cause if you really know the person, you know that they don't have anything cause you know them for a long time. Like I told Gary – he used to go find some random persons – you don't know anything cause you just met that person.

Gertrude

'Gay boy talk' meets 'girl talk'¹⁵⁶

For many young gay men, friends play an important role in sex education as talking frankly about sex and sexuality is often easier with friends and peers than with parents, teachers or other adults.^{157,158} Meeting other young men who are openly gay is key to young gay men's ability to gather information about sex, including the mechanics of anal sex but also 'what it means' to be gay. However, recent work by Mutchler suggests that while sexual health communication between young gay men and their gay male and female friends may be a key source for the 'scripts' that guide sexual risk behaviours^{159,160}, conversations may be based on faulty assumptions. For example, conversations may reflect widespread cultural scripts about romantic love^{161,162}, implying sex in a 'monogamous' relationship is always safer, thereby emphasising partner selection over condom use¹⁶³. Also, conversations may lack depth, for example, they may establish whether or not a condom had been used but if not, fail to explore motivations or the circumstances of the encounter. Mutchler's research found conversations rarely touched on questions of how to advocate for condom use with a reluctant partner, whether to use condoms for oral sex, or the steps involved in giving up condoms in a relationship'.¹⁶⁴

Informal 'sex education' through dialogue with friends may also involve the misinterpretation of information on same-sex practice: a real issue as even HIV prevention services struggle to come up with the words to accurately and succinctly describe HIV infection risk in this era of myriad risk reduction strategies and emerging understanding of low viral load, PrEP and PEP. The notion of friends 'teaching' friends (or inadvertently playing 'Chinese Whispers') reinforces the importance of clear, simple HIV prevention messaging and supporting cultures of care and support among gay community.

Partners

If you're not strong and you're not secure within yourself, you tend to be a little bit more lenient and be a little bit more passive in terms of what you won't do or will do.

— Dwayne

Integrating Professional and Folk Models of HIV Risk¹⁶⁵

As well as learning about sex through formal mechanisms, most people learn about sex and

sexuality through experience, including trial and error in situations that are momentary and spontaneous.¹⁶⁶ That learning may occur with short- or long-term sexual partners, in casual or monogamous relationships.

Research has shown that in the absence of alternative sources of sex education, some young gay men rely on sexual partners to educate them, sometimes to their detriment. For example, Kubicek's US study found some young MSM relied on more experienced sexual partners to guide them through early sexual encounters. More experienced partners often determined the nature of the sexual interaction because they 'seemed pretty educated': typically controlling the sexual encounter including determining the sexual role of the respondent. Respondents relied on more experienced partners to teach them some of the mechanics of anal sex, such as sexual positions, use of lube, etc. Some activities and advice reduced risk while others increased risk, including erroneous advice that certain actions did not include HIV transmission risk or recommending using 'lotion' or Vaseline as lube. Some young men reported feeling 'too shy' to ask for a condom or to express sexual preferences. In most cases, these types of relationships seemed to be more risky, often putting the less-experienced (and typically younger) partner at risk.¹⁶⁷

Healthcare providers

I learned it from when I used to go and take my test. They told me about them, STDs, what they are and what [happens] if you don't protect yourself.

— Anonymous
In the Dark¹⁶⁸

Healthcare providers are at the front line of HIV and STI diagnosis but they also play a role addressing issues of sexual risk taking and sexual orientation. Their role may be particularly important for those young gay men who have been failed by mainstream education.¹⁶⁹

There is some evidence to suggest that young gay men may not typically approach health care providers about HIV risk or same-sex practice until in their early twenties for reasons including discomfort seeing a family doctor, fear of loss of privacy, or lack of knowledge of MSM specific services. Young gay men's reticence to engage with healthcare providers may also relate to patterns of men and women's health seeking behaviour. Women's increased utility and greater comfort with the health system has been attributed to the normalisation of health seeking behaviour through their early engagement for non-illness related reasons at a younger age (e.g., for contraceptive and screening programs).^{170,171}

Typically, young gay men will seek advice from a health professional only if they suspect a

medical problem, for example, having had an HIV scare or symptoms of an STI. Notably, young gay men in Australia report lower rates of HIV testing than their older counterparts (see '**Low uptake of HIV testing**' above).

Kipke argues that physicians should be proactive because:

*... most non-heterosexual youths are 'invisible' and will pass through pediatricians' offices without raising the issue of sexual orientation on their own. Therefore, health care professionals should raise issues of sexual orientation and sexual behavior with all adolescent patients or refer them to a colleague who can. Such discussions normalise the notion that there is a range of sexual orientation.*¹⁷²

Interaction with a healthcare provider may give adolescents a rare opportunity to discuss their concerns about sexual orientation and/or activities. The 2013 review of efforts to reduce STI infections in young people found strong evidence that one-to-one structured counselling interventions with sexually active young people can be effective in behaviour change, and can be cost-effective. There was also good evidence that such programs are more likely to be effective when they target those identified as high-risk, emphasise motivation, self-efficacy, and factors that underlie risk-taking, and are implemented as part of a broader STI prevention program.¹⁷³

Internet and social media

From online, it was probably how I learned of everything or guessed of everything or thought about everything.

— Anonymous

Integrating Professional and Folk Models of HIV Risk¹⁷⁴

The National Strategy for Young Australians recognises the key role of technology (including mobile phones, internet and email), and suggests that:

For many young people communities exist, at least partly, in the online environment. ... it is an important tool for social interaction. This makes digital technology an important fact of life and a powerful enabler for young people building their own lives.

The UNPD also argues that prevention efforts should ensure that all people, particularly young people, have the means to exploit the potential of new modes of connection and communication.

It is clear that the internet is an important source of information for many young gay men because of its accessibility, confidentiality and the heterosexist focus of other more conventional modes of sexual health education.¹⁷⁵ Research has also shown that the internet and virtual communities for young gay men offer a safe, supportive and

anonymous space to practice and explore sexuality^{176,177,178,179}: a cultural context where young gay men can learn how to be same-sex attracted, and participate in a sexually specific subculture without fear of community reprisal¹⁸⁰.

In *Writing Themselves In 3*, the internet was described as 'unjudging' with many same-sex attracted young people going online when 'discovering' their sexuality in their pre-teen years or when they were unsure what their feelings meant. Seventy-six percent had used the internet to explore their sexual identity. Those who did so were more likely to be male, over 18, and attracted exclusively to the same sex. They had sought online information about non-heterosexual sex, sexual health issues, same-sex relationships and community: information which was not otherwise always available to them.

As well as a resource to inform the development of sexuality and sexual practice, young gay men use the internet to find sexual partners, recognising web-based imagery and interaction as a mechanism for 'inciting desire rather than merely representing it'.¹⁸¹

*It is not just the presence of the camera that has smashed through the wall of shame that surrounds desire. Now one can perform, entice, embody desire and claim it as one's own ... declaring oneself phallic, desiring, desirable ...*¹⁸²

Gay Community Periodic surveys reflect a continuing increase in the use of online and mobile platforms compared to physical venues among all age groups. For example, in Sydney in 2013, the most commonly used methods to meet male partners during the previous six months were the internet and mobile applications.¹⁸³ In Melbourne, there has been a rapid uptake of mobile applications to find sex partners, with mobile apps the most common means to meet partners among all men in 2013.¹⁸⁴

Data from 2012 Gay Community Periodic Surveys across Australia shows that 36% of young gay men (aged 18 to 24) had used the internet to find a sexual partner during the previous six months. However, compared to their older counterparts, younger men were less likely to use the internet and more likely to use mobile apps.¹⁸⁵

More work is needed to understand how young gay men use the internet and mobile phones to explore sexuality and to develop sexual relationships. Albury's work with young people on sexual self-representation and communication through mobile phone use warns against the moral panic associated with 'sexting': an adult or media-constructed term which young people in her study did not use or believe an accurate description of their use of mobile phones.¹⁸⁶ In fact, research suggests young people's sexting may sometimes be a

method to delay sex¹⁸⁷ or a 'safer alternative to real life sexual activity'.¹⁸⁸ That being said, mobile phones are a tool for finding and engaging with sexual partners.

Gay men's use of the internet and mobile apps to identify and select intimate partners is a factor informing whether and how risk behaviours occur.¹⁸⁹ Questions remain about how HIV education may intervene more strategically, seamlessly and effectively during internet and mobile phone use for this purpose. In 2012, the Cybersex study was conducted among gay men in NSW, with the aims of examining the dynamics of cruising/dating online and identifying factors that contribute to planned and unplanned sexual risk-taking among men who find their partners on the internet. AFAO and the Centre for Social Research in Health are now analysing those findings to inform future HIV education interventions.

Considering electronic interventions more broadly, Brown et al.'s recent review of computer-mediated communication technology and social media interventions to reduce STIs among young people found 'moderate'¹⁹⁰ evidence that sexual health education delivered through these mechanisms may improve young people's sexual health knowledge and attitudes. It also found that computer-based interventions compared well with face-to-face interventions, particularly if tailored to individuals' needs, developmental stage and sexual experience and able to provide immediate feedback. Further, because of information technologies' reach at limited cost, they are likely to have significant impact.¹⁹¹

Few social media interventions have been formally evaluated to determine impact although there is some evidence that social networking sites have potential for accessing sub-groups of young people.¹⁹² ACON's recent evaluation of its expanded Facebook presence suggests this strategy has borne results. At March 2014, 46% percent of their fan base of almost 12,000 were aged under 30, as were 54% of the 34,000 reached with daily posts, and 45% of the 1,400 who engage (who 'like', 'share' or 'comment').¹⁹³

It seems likely that as well as making core safe-sex information available online, there is a need to stay innovative as inventive strategies may reach young MSM inaccessible through other interventions.

Social marketing and media campaigns

The HIV community sector has long endorsed media campaigns and social marketing (use of traditional marketing techniques to promote behaviour change) as a means to promote HIV messaging and decrease risk practices. Media campaigns and social marketing are important because even small estimates of behavioural change

can translate into significant impact at the population level.¹⁹⁴

Academic review of such campaigns is not common, as campaign urgency and limited budgets frequently preclude academic evaluation mechanisms (e.g., cohort studies) due to cost, difficulty of implementation and lengthy follow-up.¹⁹⁵ Consequently, such campaigns rely on a combination of instinct (of campaign designers based within affected communities), the skill of marketing and community education specialists, focus testing, and campaign-specific evaluations considering indicators such as HIV knowledge, campaign awareness, buy-in and changes in health seeking behaviour.

Brown et al.'s recent review of Australian social marketing and media campaigns targeting STI interventions among young people found 'moderate' evidence that mass media can impact on awareness, knowledge and behavioural intentions and can increase STI testing in the short-term.¹⁹⁶ Kang et al.,¹⁹⁷ also found that media campaigns targeting young people are promising, with media campaigns promoting STI testing having a positive impact on testing rates.

Pedrana et al.'s 2010 review of the effectiveness of social marketing campaigns in changing HIV and STI-related behaviour among MSM in Victoria¹⁹⁸ found evidence to be mixed: high recall of at least one HIV prevention campaign (91%), and significant increases in reported frequency of health seeking behaviours, knowledge and community dialogue about sexual health over the life of the campaign but no significant changes in the reported frequency of risk behaviours. The 2012 evaluation of the Drama Downunder social marketing campaign on STI testing established it had engaged the target audience, increased awareness and knowledge of HIV/STIs, and led to increased health-seeking behaviours including seeking testing for STIs. ACON's March 2014 evaluation of the 'I'm On' campaign promoting condom use found that compared to their older counterparts, those aged under 30 were more positive about the campaign, and the campaign had a more positive impact on their attitudes to condom use (62% reporting a positive impact, and 36% reporting no impact).¹⁹⁹

Face-to-face services (support groups and workshops)

During the first decade of Australia's HIV epidemic, sexuality and HIV-based workshops and support groups became a cornerstone of support services. Many of these included young gay men while some were specific to the needs of young gay men. In 2012, AFAO received funding from the AIDS Trust of Australia to undertake a feasibility study to better understand whether current HIV support services targeting young gay and

bisexual men could be extended into rural and regional areas.²⁰⁰ In the process of mapping existing services available to young gay and bisexual men (not just HIV programs)²⁰¹ some important findings were revealed: in particular, the reduced demand for workshops and support programs even in urban areas.

The study identified 44 organisations providing support programs: two in the ACT; 13 in NSW, five in Queensland; two in Tasmania, 20 in Victoria; and two in WA.²⁰² There were no specific services for gay, lesbian, bisexual or transgender young people in SA or NT. Services were being provided in urban and regional locations by a range of organisations:

■ Youth service	11
■ Community service	9
■ AIDS Council/GLBT Health	7
■ GLBT organisation	7
■ Health services	6
■ HIV organisation	1

Most offered a group or workshop, with the most frequent being a ‘social support group’ (24), variety of services (9), social group (4), workshops (3), support group (2) or other (2). Services focussed on improving the health and wellbeing of young gay men, and often included strategies to address homophobia and discrimination and to build community resilience.

Services faced a number of challenges to providing effective services for the target group:

- Ensuring the group attracts enough members (impacting both start up and sustainability). Most groups ran with ten to 14 members, but some with five to ten and a few with less than five.
- Addressing transport issues in regional and rural areas
- Addressing issues of anonymity and privacy
- Establishing a balance of social, support, structured and unstructured activities
- Ensuring an effective demographic mix of participants
- Ensuring resourcing (particularly human resources)
- Development of promotional materials and relationships with other service providers.

Only three AIDS Councils (the AIDS Action Council of the ACT [AAACT], ACON and the Victorian AIDS Council/Gay Men’s Health Centre [VAC/GMHC]) had run HIV prevention programs targeting young gay or bisexual men during the previous 12 months (see Table 4).

These programs focussed on peer education workshops which were run for between four to six sessions. HIV and sexual health were addressed within a broader context of coming out, relationships, sexuality, and gay community.

Table 4: AIDS Council programs targeting young gay or bisexual men held during 2012

Agency	Workshop title	Number of workshops held per annum
AACT	Out There	2
ACON ²⁰³	Start Making Sense	6–8
VAC/GMHC	Young and Gay	3

The Western Australian AIDS Council (WAAC) had previously run a workshop called Finding Common Ground (2007/8). WAAC had twice attempted to run the workshop during the previous 12 months but had not been able to identify enough participants (first attempt) or had not identified enough participants able to agree on dates (second attempt). In South Australia, the Second Story Youth Health Centre’s Inside Out Program for gay and bisexual men had not been run since 2011.

Support services for young gay men remain highly desirable. AIDS Council-based programs are effective because they use peer education to address sexual health and HIV prevention thoroughly, locating HIV prevention in the broader context of health and wellbeing. They also consider ‘being gay’ in a positive, fun way that counters isolation and homophobia. They have a low attrition rate and are well tested over time. Reduced demand for such programs was attributed to a number of intersecting reasons including the increased availability of social groups for young gay and bisexual men, the impact of social media and mobile apps which facilitate alternative means to meet other gay men, and reduced homophobia/increased societal acceptance of gay men which has likely reduced some individual’s need to seek out peer support.

In summary, the study found that although existing HIV prevention programs are held in high regard, they cannot be extended into rural and regional areas because of the difficulty of attracting enough participants but also because there is greater need in those areas such as programs and services to improve young gay men’s mental health and general wellbeing.

An alternative to face-to-face support is being trialled by QLife, which involves peer-based, telephone counselling and referral services for people of diverse sex, genders and sexualities. QLife also provides education and support for service providers.

Conclusion

Adolescents and young gay men with limited exposure to sexual and health education are vulnerable to risk of HIV and STI infection when initiating sex: vulnerability that continues as long as they remain misinformed or lack judgement or power to negotiate safe sexual practice.

In the early days of Australia’s HIV epidemic, HIV education was developed and delivered in a context of crisis driven by gay men’s desire for specific and explicit instruction.²⁰⁴ Messaging was authoritative and directive. As the epidemic has evolved, so too have educational responses. The relevance of HIV to young gay men is less crisis-oriented and consequently requires a different kind of pedagogy more dynamically linked to their everyday lives. The question is not ‘What do we need to teach them about preventing HIV?’ but ‘What do they want to learn about and how do they want to “do sex”’, so that we might be useful in developing strategies to reduce their HIV risk.²⁰⁵

Young gay men receive sex education in a variety of ways: in formal settings (in schools and from healthcare and other service providers); through information technology (the internet and social media) and through personal relationships (parents, friends and partners). Not all of that sex education is accurate or ‘sex positive’. Consequently, HIV education must include targeted, integrated strategies wherever possible: seeking to speak directly with young gay men but also to others likely to deliver formal or informal sex education to this target group.

Research suggests young gay men may experience particular issues that increase their vulnerability to HIV infection: lack of sexual/relationship experience, limited capacity to negotiate safe sex, reticence to commence HIV testing, and importantly, limited exposure to sex and HIV education. More effective targeting of education to the needs of young gay men (and indeed to successive cohorts of young gay men), is vital to Australia’s long-term HIV response.



Some issues for consideration

School

- ◆ Changes to the Australian physical education curriculum acknowledging the needs of same-sex attracted students is a major step forward, however, the curriculum is weakened by the absence of reference to HIV or STIs or any specific evidence-based content. That lack is particularly concerning given high rates of STIs among young people and its identification as a national priority issue in the Second National STI Strategy. For young gay men, for whom knowledge of HIV and STI transmission risk is critical, its absence represents a fundamental lost opportunity. This issue is pressing given media reports suggesting that current review (February 2014) of the National Curriculum²⁰⁶ may seek to undo efforts to address the needs of same-sex attracted and gender diverse.
- ◆ Sex education training of teachers is currently inadequate. AFAO and its members should support efforts to improve teacher training and possibly participate in or provide some of that training.
- ◆ Both student and teacher surveys suggest strong support for external expert and peer educators. AFAO and its members should consider support for such initiatives at both programmatic and service delivery levels.
- ◆ Teacher, student and community values related to same-sex practice clearly impact the inclusion of same-sex content in school sex education. AFAO and its members should support efforts to reduce community homophobia and explain the public health imperative to include same-sex education in school curricula.

Parents

- ◆ Parents can significantly impact young people's sexual knowledge and risk-taking behaviours. AFAO and its members should consider opportunities to partner with organisations to better resource parents of young gay men with HIV prevention information.

Friends

- ◆ Friends inform understanding of sex and safe-sex practice but are not necessarily equipped with accurate information or 'educative' skills. AFAO and its members should consider means to deliver HIV prevention interventions that help young people have more constructive conversations with friends about sexual health and sexual risk taking, and to affirm constructive norms about sexual health and sexual behaviour.

Partners

- ◆ Many young gay men become sexually active at a time when ill-equipped to advocate for safe sexual practice. AFAO and its members should consider this an important issue to be addressed through HIV prevention campaigns.

Healthcare providers

- ◆ Healthcare providers have a central role to play in the provision of information on risk taking behaviours. AFAO and its members should further develop strategies with the Australasian Society for HIV Medicine (ASHM) where possible to ensure health care practitioners are resourced to address the needs of young gay men, and conversely, to entrench mechanisms facilitating the experience of healthcare providers being passed on to HIV educators.

Internet and social media

- ◆ AFAO and its members should consider how to make sexual health information more accessible to young gay men so that current information is readily available online and through social media networks.
- ◆ Community service providers, such as youth and accommodation services, should ensure sexual health information targeting young gay men is accessible and included in relevant programmatic responses.
- ◆ The technology and context of young gay men's use of information technology and social media interventions changes rapidly: a challenge for application of previous evaluation results. Information technology based interventions need to include innovative strategies: the development of which may benefit from the involvement of the target group.
- ◆ Information technology offers structured web-based or app-based education opportunities (e.g., webinars) that could overcome the need for people to be in one place at the same time.

Social marketing and media campaigns

- ◆ HIV service providers should continue to develop and deliver social marketing campaigns drawing on best practice identified through evaluation of previous campaigns, understanding of local HIV prevention priorities and current research, however, renewed effort is required to ensure these are (exclusively or inclusively) effectively targeting and reaching young gay men.

Face-to-face services (support groups and workshops)

- ◆ Sexuality and HIV-based workshops and support groups offer young gay men a best-practice forum in which to learn about being gay in a fun and positive way. Community services should continue to offer these or other innovative strategies to ensure this area of need is met.

The above are simply a starting point for discussion. We look forward to further development of ideas as AFAO, its members and other partners in Australia's HIV response continue to pursue strategies to address the education needs of young gay men.

Appendix 1: Policy frameworks guiding Australia's efforts to safeguard the sexual health of young gay men

Strategy	Scope: inclusion of young people, including gay youth	Exclusions/shortfalls
National Strategy for Young Australians ²⁰⁷	<ul style="list-style-type: none"> ■ Aims 'for all young people to grow up safe, healthy, happy and resilient and to have the opportunities and skills they need to learn, work, engage in community life and influence decisions that affect them'. ■ Identifies young people as particularly concerned about sexual health.²⁰⁷ ■ Notes the importance of communication technology to access information and community. 	<ul style="list-style-type: none"> ■ Acknowledges young Australians' diversity but does not identify subpopulations, including those based on gender or sexual identity.
National HIV Strategy 2010–2013 ²⁰⁹	<ul style="list-style-type: none"> ■ Identifies 'gay men and other men who have sex with men' as a priority population group. ■ Identifies resurgent HIV epidemics among gay men in several states and territories since 2000. 	<ul style="list-style-type: none"> ■ Young people identified as a priority only in relation to detention. ■ Young gay men not specifically identified.
Second National Sexually Transmissible Infections Strategy 2010–2013 ²¹⁰	<ul style="list-style-type: none"> ■ 'Gay men and other MSM' and 'young people' are two of four priority populations. ■ Gay men and other MSM a priority because of high STI prevalence, the role of STIs in HIV transmission, higher risk sexual practices, and barriers to service access (recognises gay men and other MSM are not a homogeneous group). ■ Young people a priority group because of increased risk of STI infection resulting from earlier sexual debut, higher rates of partner change, limited health literacy and skills, and barriers to services. ■ Both sections on young people and gay men and other MSM recognise 'young men reporting same-sex attraction' as a high priority subpopulation requiring specifically tailored interventions. ■ Notes the needs of same-sex-attracted young people, and recognises the importance of sex education in schools, education for those who have left school and increased access to services. 	<ul style="list-style-type: none"> ■ Implementation is lacking.
National Aboriginal And Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2010–2013 ²¹¹	<ul style="list-style-type: none"> ■ Recognises similar rates of HIV diagnosis among Aboriginal and Torres Strait Islander populations and the non-indigenous population, with the most frequently reported route of HIV transmission among Aboriginal and Torres Strait Islander peoples being sexual contact between men. ■ Recognises sexually-active young people aged 15 to 30 years as a priority population because of higher STI rates than non-indigenous people of similar ages, levels of health education and health literacy that may be lower than that of older community members. ■ Recognises gay men, other MSM, sistergirls and transgender people are at particular risk of infection because of factors including barriers to accessing some health services, high levels of population mobility, low levels of HIV awareness, lack of acceptance of homosexuality and transgender status within some Aboriginal and Torres Strait Islander communities (including some violence), and alcohol and other drug use. 	<ul style="list-style-type: none"> ■ Neither young gay men nor young sistergirls explicitly recognised, however the strategy recommends investigation of models that normalise health-seeking behaviour and specifically reach those aged 15 to 19 years, and the development of testing, treatment and care guidelines for specific target groups including those aged 15 to 30 years and gay men, other MSM, sistergirls and transgender people.
National Aboriginal and Torres Strait Islander Health Plan 2013–2023 ²¹²	<ul style="list-style-type: none"> ■ Recognises Aboriginal and Torres Strait Islander people and communities include diverse sexual orientations. ■ States governments need to focus on the greatest disparity where quality of life is significantly reduced, including fundamental issues such as safe sexual health practices. ■ Recognises that Indigenous youth are at the forefront of Aboriginal and Torres Strait Islander health and recommends a number of strategies targeting adolescents and youth. ■ A key strategy supports initiatives that reduce systemic barriers and encourage young Aboriginal and Torres Strait Islander people to establish healthy lifestyle behaviours, reduce the risk of chronic disease, and empower young people to make informed choices about sexual health, mental health and risk-taking behaviours. ■ Recommends improved education about safe-sex practices and encouraging young people to make informed choices about sexual health and risk-taking behaviours. 	<ul style="list-style-type: none"> ■ Strategies do not include mention of HIV, gay men or MSM. ■ Sections on young people do not consider sexual identity.

Appendix 1: Policy frameworks guiding Australia's efforts to safeguard the sexual health of young gay men (continued)

Strategy	Scope: inclusion of young people, including gay youth	Exclusions/shortfalls
United Nations Political Declaration on HIV/AIDS (UNPD) ²¹³	<ul style="list-style-type: none"> ■ First time MSM specifically identified in a UN Political Declaration. ■ Recognises young people's 'limited access to sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves'. ■ Argues for expansion of 'good quality youth friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning' and inclusion of HIV among sexual health school based curricula for adolescents. ■ Recognises the increasing potential of technology use among young people. 	<ul style="list-style-type: none"> ■ Specifically addresses the increased risk of HIV infection among MSM at only one point where it notes many national HIV prevention strategies inadequately focus on populations at higher risk, including MSM.
Millennium Development Goals ²¹⁴	<ul style="list-style-type: none"> ■ Based on broad goals that include indicators and time-bound targets. ■ Goal 6: to 'combat HIV and AIDS, malaria and other diseases' includes target 6a – 'halt and begin to reverse the spread of HIV and AIDS', and uses a number of indicators including HIV prevalence among the population aged 15–24 years (6.1), and the proportion of the population aged 15–24 years with comprehensive correct knowledge of HIV and AIDS (6.3). 	<ul style="list-style-type: none"> ■ Goals are very broad and do not include specific reference to most at risk populations, young people, gay men or MSM.
UNGASS Indicators	<ul style="list-style-type: none"> ■ Requires UN member states to report data referencing specific HIV-related questions every two years. ■ Include a number of indicators specifically relating to young people and to MSM.²¹⁵ ■ Australia's most recent <i>Country Progress Report 2012</i>²¹⁶ notes that some 39% to 89.7% of MSM reported using a condom the last time they had anal sex, 71.5% of MSM had had an HIV test in the previous 12 months, and 11.2% of MSM are living with HIV. 	<ul style="list-style-type: none"> ■ Despite the requirement that UNGASS Indicators related to MSM be disaggregated by age ('less than 25 years old' and '25 years old and above'), and data on young people be disaggregated by gender, that data is not provided in Australia's <i>Country Progress Report 2012</i>.

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