

Vital Statistics Ireland

Findings from the All-Ireland Gay Men's Sex Survey, 2000

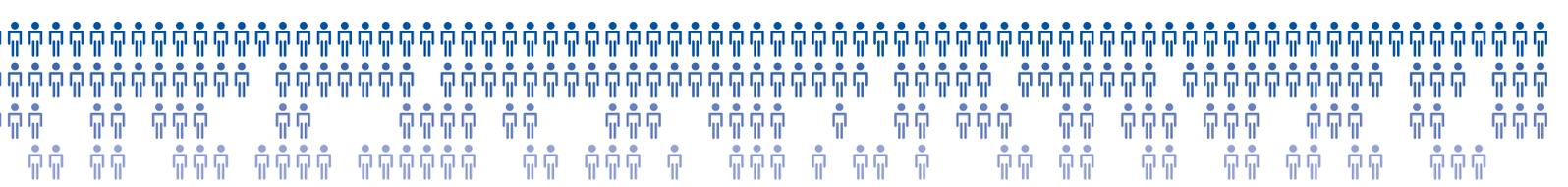
May 2002

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RESEARCH





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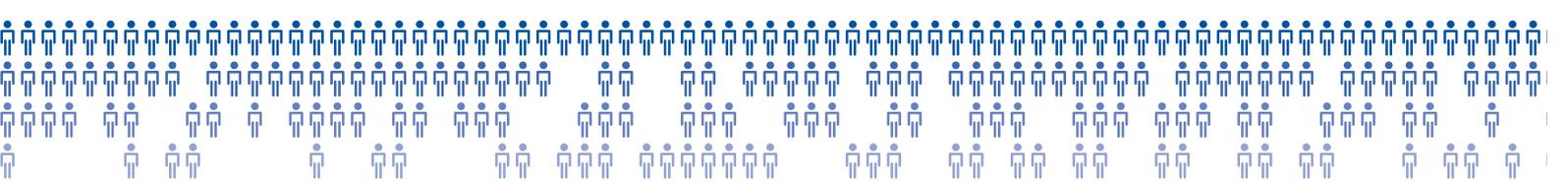
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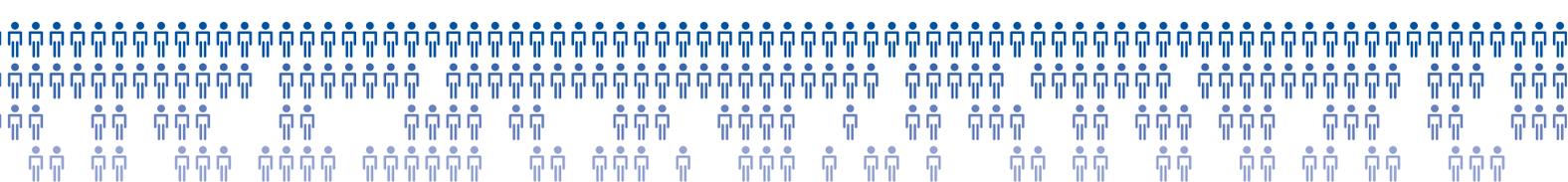
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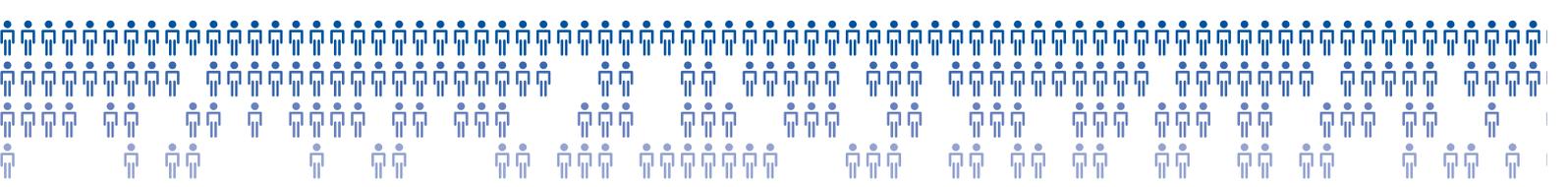
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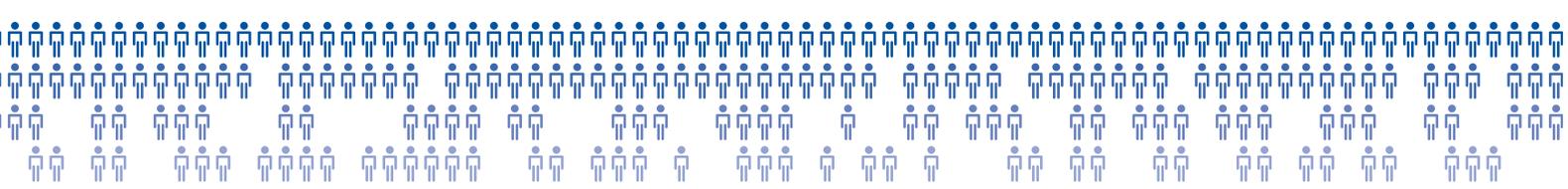


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Dublin Outhouse Community Centre, OutYouth, Bi-Irish, The George, Out on the Liffey, Republica, Freedom, Playground, Baby2K, HAM, Lynch's, The Boilerhouse, Incognito, The Dock, The Vortex and the GMHP Drop-In Clinic.

Belfast The Kremlin, The Crow's Nest

Derry Ascension

Galway Zulus

Cork The Other Place, Loafers

Pride Committees:

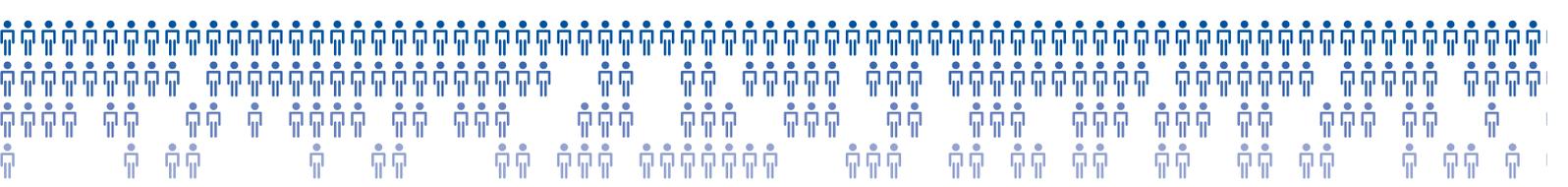
Much of the recruitment was done at Pride events throughout the summer of 2000, which enabled us to reach large numbers of men relatively easily. Our thanks to the Pride Committees for making this possible - in Dublin, Belfast, Derry, Limerick, Galway and Waterford.

The Men:

1 420 people took the time to complete the questionnaire, often in the middle of their Pride events. Thank you for taking the time, and telling us about yourselves.

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Further copies of the report are available from Gay Health Network members or from Gay Men's Health Project, OutHouse, 105 Capel St, Dublin 1. (01) 8734952 Website www.gayhealthnetwork.ie.

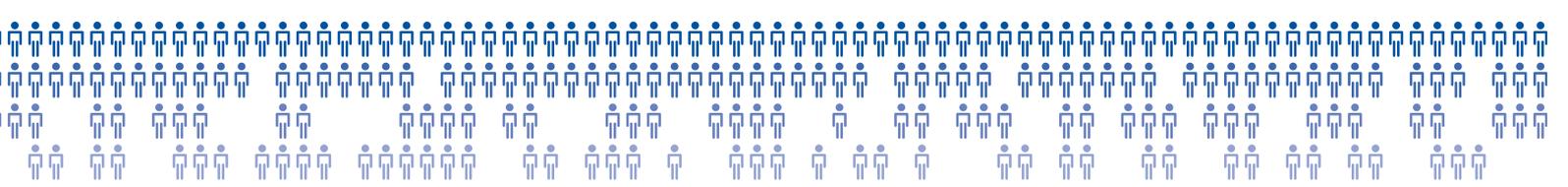


Abbreviations and statistical significance

Letters	What they stand for	Further explanation of their use in this report
AI	anal intercourse	penetrative anal intercourse
PAI	protected anal intercourse	AI always with a condom
UAI	unprotected anal intercourse	AI without a condom
HIV	human immune deficiency virus	an infectious agent often acquired during sex between men
STI	sexually transmitted infection	infectious agents acquired during sex (including HIV)
sdUAI	sero-discordant unprotected anal intercourse	UAI between HIV infected and uninfected men

All group differences highlighted in this report are significant at the 5% ($p < .05$) level. This means that if we had done the survey multiple times, this difference would probably be observed in fewer than one in twenty of the surveys, purely by chance.

In the tables, reporting HIV prevention needs and use of settings, the group showing the greatest amount of need or use of that setting is shaded and features an asterisk (*); the group showing the least need or use of the setting is underlined.



Foreword

Gay Health Network

Gay Health Network (GHN), set up in 1994, is a network of individual gay and bisexual men from a wide range of HIV and sexual health promotion agencies, voluntary and statutory, governmental and non-governmental throughout the island of Ireland. GHN develops its work program based on needs identified by its members through their work with clients in the wide range of agencies represented and based on international patterns in HIV prevention and sexual promotion for gay men. As part of our commitment to research - based programs we undertook this survey and to report on the results.

The primary aims of this research are to:

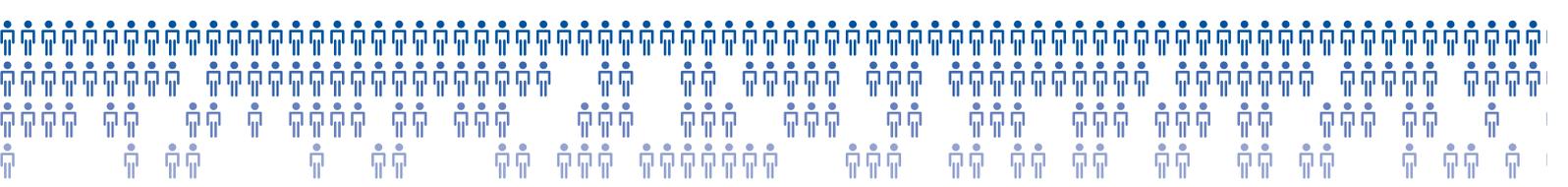
- Provide a snapshot insight into a community that GHN and all sexual health providers are targeting
- Identify some of the sexual health and HIV prevention needs of gay and bisexual men
- Generate data with which to plan future interventions and services
- Provide an evaluation of GHN interventions to date.

We were pleased to work with Sigma Research in developing and publishing this report. Sigma Research are a London-based organisation with many years of experience in researching the social and sexual activity of gay and bisexual men. As such their insight and experience was invaluable throughout the research.

Early efforts at HIV prevention assumed that sexual behaviours were discrete and constant and that supporting behaviour change was relatively straightforward. This study finds that individual behaviours are more complex and indeed variable. It identifies key needs around HIV, including that up to half of HIV infections remain undiagnosed, that knowledge of HIV and its prevention is variable, with particular needs outside Dublin, among younger men and among those with lower levels of education. It also identifies broader areas of need around sexual assertiveness and social supports and integration, needs that require considerable resources to address. Social integration and supports have been identified as key determinants of health in a range of national health and health promotion policies. Given the extent of social isolation demonstrated in this survey, building gay community infrastructures is clearly a key strategy for health promotion with gay and bisexual men.

Meeting the needs identified in this study presents a major challenge to existing statutory services, to the health authorities locally and nationally, and to the gay community. The needs identified cannot to be met within current service provision, even where the services that have developed are at their most concentrated. It is essential that all health boards and health service providers develop broad ranging strategies to meet the sexual health needs of gay men in their areas - strategies that include building the capacity of the gay community and gay community services. Models of service in the Dublin area, where they are effective, can be mirrored in other health board areas. Targeted initiatives and services are needed and are going to require additional resources.

That the identified needs must be urgently addressed is underlined by the HIV figures for 2000 which show that there has been an almost 100% increase in diagnosed HIV infections among gay men since 1998.



1 Introduction

1.0 Sex between men and HIV infection in Ireland

HIV is a major health hazard for gay men and bisexual men in Ireland and gay men and bisexual men will be a major part of the HIV epidemic in Ireland for the foreseeable future. The National Health Promotion Strategy 2000-2005 recognises the gay community as one of a number of "population groups with different requirements, which need to be identified and accommodated when planning and implementing health promotion strategies" (DOHC, 2000, p.45). The Strategy proposes initiating research projects to help guide health promotion programs. The current survey is a contribution to that end.

The National Aids Strategy Committee Report *AIDS Strategy 2000* recognises that "transmission of HIV in the gay community has remained steady, despite the heightened awareness brought about by the campaigns, outreach work and the direct experience which a number of gay men have had of friends and partners dying of AIDS" (DOHC, 2000, p37). The Report recommended that HIV prevention and sexual health promotion work in the gay community continue. The findings reported here aim to provide information on which to base future work within the gay community.

1.1 Existing sources of data for HIV prevention programme planning

HIV is not a notifiable disease in either the Republic of Ireland or in Northern Ireland. However, both countries have a system of voluntary reporting. In the Republic this exists for AIDS (but not HIV) through the Regional AIDS Coordinators directly to the National AIDS Coordinator in the Department of Health and Children (DOHC). All confirmatory HIV test results are carried out by the Virus Reference Laboratory (Dublin) where they are recorded, collated and passed to the DOHC. At present, there is only one other EU country still using this old system of AIDS case reporting rather than HIV diagnoses reporting. Reporting is to be taken over by the National Disease Surveillance Committee (NDSC) and is expected to move over to an HIV individual case-based reporting system.

In Northern Ireland, the UK's Public Health Laboratory Service co-ordinates the Survey of Prevalent Diagnosed HIV Infection (SOPHID) which counts people with diagnosed HIV infection who are in touch with services. In addition, the Royal Victoria Hospital in Belfast collaborates in the Unlinked Anonymous HIV Prevalence Monitoring Programme. This on-going study uses blood samples from GUM clinic attenders to measure the prevalence of HIV in this population (Unlinked Anonymous Surveys Steering Group, 2000).

Two previous surveys about HIV and sex have been carried out with Irish gay men and bisexual men. In 1988 the voluntary group Gay Health Action recruited 265 men from gay venues to a self-completion survey (GHA, 1989). Men were asked to take away, complete and return the survey forms. At the beginning of 1992, the Eastern Health Board's Gay Men's Health Project carried out another self-completion survey, recruiting 481 men in Dublin's gay venues (GMHP, 1992). This survey was completed on-the-spot and returned to a sealed box. Despite the differences in method and questions asked, both these surveys provide useful comparisons with the current survey. All three samples are from gay men who use the gay scene in Ireland, particularly in Dublin.

1.2 Sex between men and HIV infection in Ireland

Sex between men was decriminalised in the Republic of Ireland in 1993. The age of consent for homosexual and heterosexual sexual activity for both men and women is now 17 years. In Northern Ireland, the common age of consent for sexual activity is 17 years.

In 1998, the VRL confirmed 124 new HIV infections, diagnosed in the Republic, where the route of transmission was known (the route for another 12 were not known). Of these 63% were acquired through sex, 21% through needle use and 16% from mother to infant. Of those acquired sexually, 71% were acquired through sex with a man. Of those acquiring HIV through sex with a man, 67% were men (Quinlan, 2000, p.22). The incidence of HIV infection through sex between men has remained at about 45 cases per year between 1992 and 1999 (National AIDS Strategy Committee, 2000; p.13).

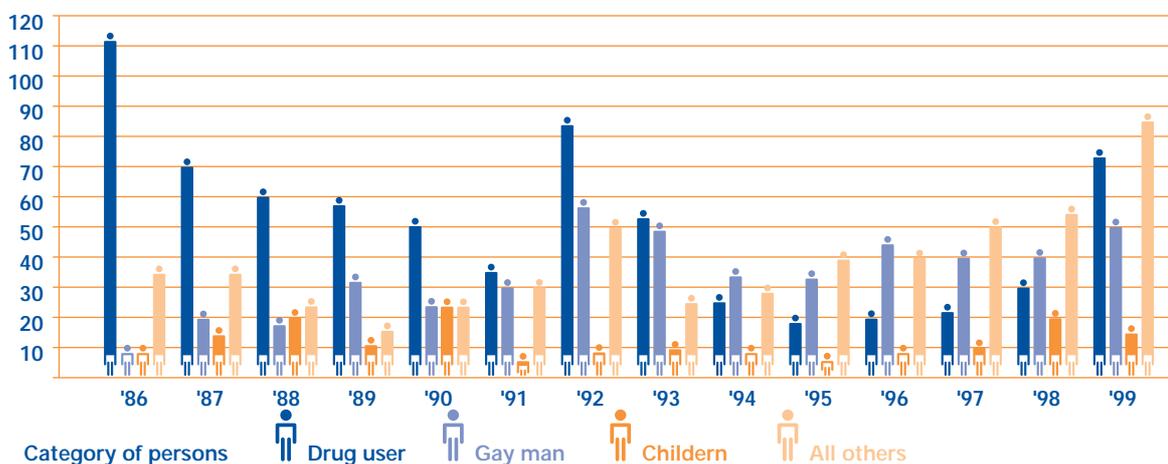
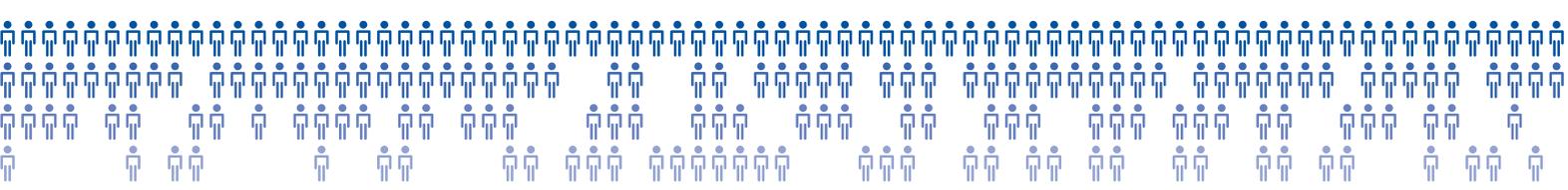


Figure 1.2: Illustrates the results of the VRL system of reporting since 1986

In 2000 the Surveillance Sub-Committee of the National AIDS Strategy Committee concluded that "transmission among homosexuals has continued to rise at a steady rate" (p.20). In the first six months of 2000 there were at least 32 new diagnoses of HIV infection acquired during sex between men.

In total, to June 2000, the VRL had made 530 diagnoses of HIV in men, acquired through sex with another man, of whom at least 120 have died (HIV/AIDS statistics 6/2000, Department of Health & Children). This suggests there are at least 410 homosexually active men living with diagnosed HIV infection in the Republic of Ireland.

In Belfast, the Unlinked Anonymous (UA) survey between 1992 and 1995 tested 531 blood samples from homosexually active men attending a GUM clinic, of whom sixteen had HIV (3.0%), of which only two (12.5%) knew of their infection (Larkin et al., 1997). This meant the prevalence of diagnosed infection in this group was 0.3%, plus another 2.7% with undiagnosed infection. This picture remained identical over the following four year period from 1996 to 1999 inclusive. The UA survey tested 559 samples, of which seventeen were positive (3.0%) and three (17.6%) previously diagnosed (Dr Raymond Maw, personal communication). This suggests only a small proportion of prevalent HIV infections in



homosexually active men in Northern Ireland are diagnosed. SOPHID (www.phls.org.uk) estimated there were 58 homosexually active men living with diagnosed HIV infection in mid-1999. The preceding data suggests there were approximately 300 other men with undiagnosed infection.

The 'official' invisibility of gay men has inevitably meant that the impact of HIV infection on gay men in Ireland was for many years played down or denied. However in 1988, a third of gay men knew someone with HIV (GHA, 1989). By 1992, this had risen to 66% (GMHP, 1992).

1.3 *HIV health promotion for gay men in Ireland*

HIV prevention and sexual health promotion work for gay and bisexual men in Ireland is carried out by a combination of non-governmental organisations, gay community services, and the statutory health services. There is one specialised statutory project in the Republic - the Gay Men's Health Project in Dublin. There are few other dedicated, state supported projects. The Southern Gay Health Project in Cork is co-funded by the local health board. Most other cities have NGO HIV prevention and care projects that are broad-based, but that include gay men as a particular client group, with varying degrees of targeted services to this group.

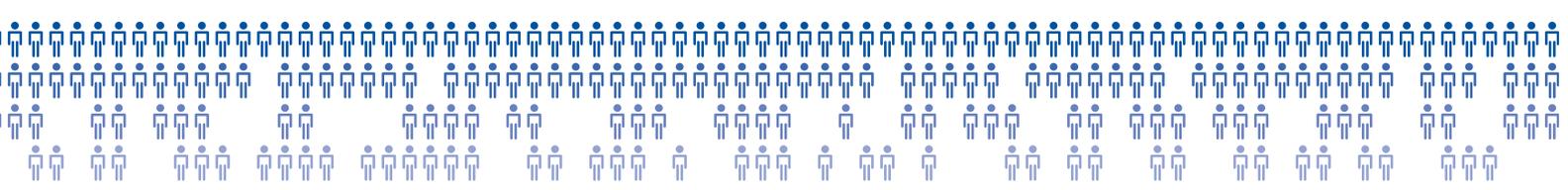
A useful background to the development of services is the report *HIV Prevention and the Gay Community* GLEN/Nexus 1996. The following are some of the key services available.

1.3.1 *Key services in Ireland*

Gay Health Network was set up in 1994 by members of the Gay Men's Health Project. The Network is comprised of individual gay and bisexual men from a wide range of HIV and sexual health agencies, voluntary and statutory, governmental and non-governmental. It is organised as a network to facilitate communication between its members, and between agencies, on issues relating to the provision and development of HIV/AIDS services and prevention strategies, targeting gay men. Any gay or bisexual man working in a HIV prevention and care, or sexual health promotion agency anywhere in Ireland or any HIV positive man is welcome to attend meetings. These meetings are held six times a year, usually in Dublin.

The Network aims are:

- To provide a forum to encourage the exchange of information, resources and ideas, and to provide mutual support for its members
- To help identify the needs of gay and bisexual men regarding health interventions, particularly in relation to sexual health and HIV/AIDS
- To help ensure that local and national (all-Ireland) health and HIV/AIDS agencies develop gay and bisexual friendly services
- To identify gaps in services, particularly in relation to prevention and information needs and to endeavour to fill those gaps where possible.

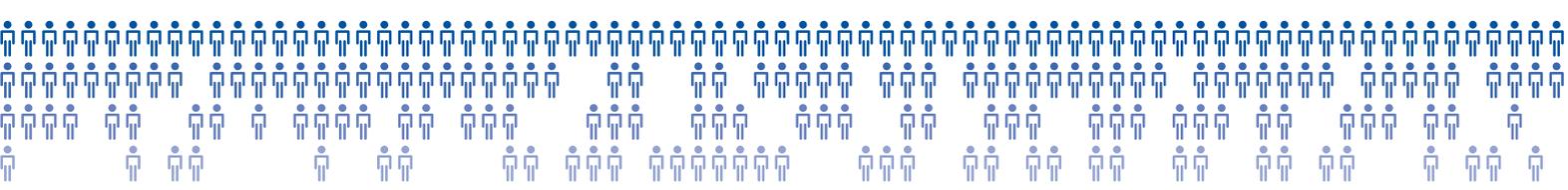


Since it began its work the Network has developed a wide range of publications primarily relating to HIV prevention. These leaflets are widely distributed in gay and bisexual communities in Ireland. GHN have also produced a series of campaigns published in the Irish gay press *GCN (Gay Community News)* informing gay men about HIV testing, Hepatitis B vaccinations, STI screenings, Drug Use and Safer Sex practices, among others. Members of the network also regularly contribute to the Health section of *GCN*. Much of the administrative work of GHN is done by GMHP staff, and the GMHP is the prime distributor of material generated by GHN.

Gay HIV Strategies was set up in 1997, following on from the report *HIV Prevention Strategies and the Gay Community*. It is core-funded by the Department of Health and Children, and it aims to facilitate linkages between statutory, community and other services towards effective HIV prevention strategies. GHS recognises that many agencies have key roles to play, and has worked with a range of service providers: the Gardaí, Education, Youth Services, the Health sector, and the Community Development infrastructure. Building the capacity of gay community services to respond to the challenges of HIV prevention is a key goal. A major GHS project in 1998 initiated links between the then Eastern Health Board and gay community services in Dublin, such as OutYouth, Gay Switchboard Dublin, Parents' Support, GayPoz and Outhouse. These links have led to increased support and funding for these organisations, and an increased engagement with the gay commercial sector on HIV prevention initiatives.

The Gay Men's Health Project: was established in 1992 by the Eastern Health Board in Dublin. The project provides both drop-in and outreach services. The gay specific drop-in clinic was established at the Baggot Street Hospital GUM clinic for a once weekly evening session, where counseling and advice on sexual health issues were provided in a relaxed and informal setting. STI and HIV screening and Hepatitis B (and subsequently A) vaccinations were available. The clinical service was very quickly running at capacity, demonstrating the extent of unmet sexual health needs among gay and bisexual men in the catchment area. In 1993 the opening hours were extended to two nights per week, and in 1999, due to increasing demand, the clinic moved to Baggot Street Community Hospital. The numbers of men attending have continued to rise since its establishment, with 2 054 different men using the clinic services in 1999 (Quinlan, 2000). GMHP also provide staff training for other Health Board services.

GMHP still provides the only gay men's clinic in Ireland, and also provides the only outreach services to the gay community in Dublin. It distributes over 100 000 condom packs annually through this outreach work, through the gay community centre OutHouse and through the clinic. The outreach service operates on the gay scene, at cruising sites, at gay events and with college societies. The outreach operates on a gay peer level and comprises face-to-face interaction and resource distribution. GMHP also operates a non-clinical drop-in service at the gay and lesbian community resource centre, OutHouse in Capel St.



Johnny is a peer education group for gay and bisexual men. Established in 1999 by GMHP and Gay Health Network, the group's main aim is to promote sexual health and well-being among men on the commercial gay scene. This is carried out through a number of activities such as the distribution of condom packs, the staging of sexual health awareness nights in gay venues and the publication of health-related postcards, leaflets and posters.

Open Heart House, Dublin established in 1997, is a peer-led organisation where people living with HIV and AIDS can enlist peer support. In conjunction with its many services and facilities it also facilitates the largest peer support network nationwide. It established the first and only HIV+ gay club in October 1999.

Dublin AIDS Alliance is a long established NGO which provides information to the general population, support and training to those living with HIV or AIDS.

Rainbow Project, Belfast and Derry covers the six counties of Northern Ireland, and is a volunteer-led organisation. With innovative outreach they distributed publications widely, and have established a drop-in in the city centre. In 2000, funding was reduced and as a consequence so were staffing levels and the level of sexual health promotion activity. The Project continues to be the focal point for gay health work in Northern Ireland. The Body Positive group and the Northern Ireland AIDS Helpline are other groups offering HIV support and information.

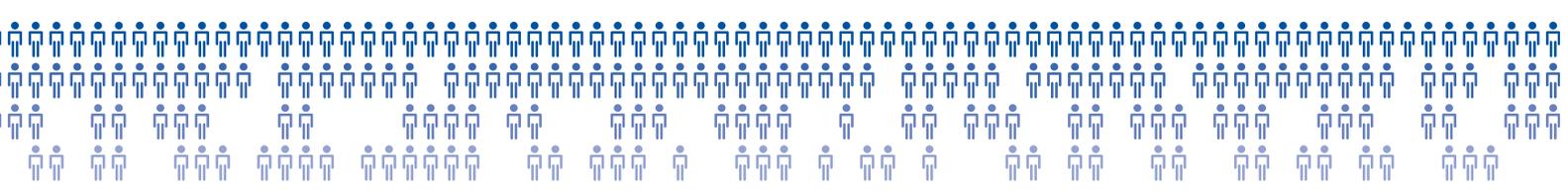
Foyle Friend, Derry operate a drop-in and a helpline service to provide information support and advice to lesbian, gay, bisexual and transgendered people.

Southern Gay Health Project, Cork is based in the Other Place community centre, it provides sexual health promotion work and support for HIV positive men, and up to 1999 had outreach workers in the community.

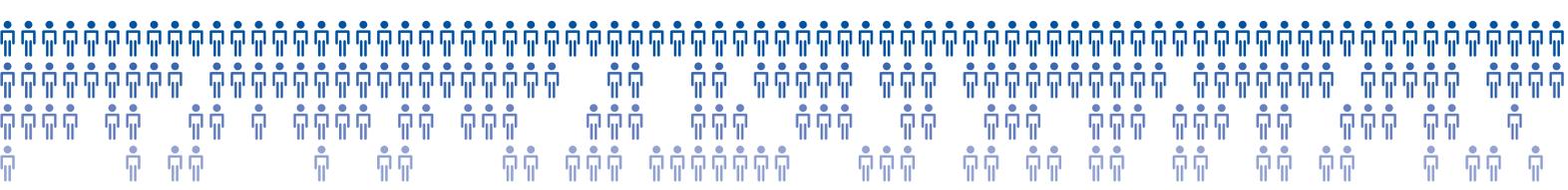
The Alliance Centre for Sexual Health, Cork provides sexual health information and support to the general population in the Munster area - it is also used by gay and bisexual men.

Red Ribbon Project, Limerick although funded for outreach, currently has a support worker, but no outreach worker.

AIDS Help West, Galway was funded by the Western Health Board to employ an outreach worker for the gay community. They had one worker in the area from 1994 to 1999. There has been no designated gay outreach worker since this post fell vacant.



WLRGC, Waterford was established in 1999 as a resource group to respond to the needs of gay men and women in the Waterford area. This is supported by the local youth services, Area Partnership and Health Board. Their main task is to support the growth of the gay community and the capacity of gay community services in Waterford. A drop-in/community centre has been opened which provides information and support. As pointed out throughout the report, the existence of gay community infrastructures such as these are pre-requisites for HIV prevention and sexual health work.



2. Aims and methods of the survey

2.1 Study aims

The aims of the current study are:

1. To collect and make available a current snapshot of sexual behaviour related to HIV transmission and HIV prevention needs among gay and bisexual men in Ireland, both to inform programme planning and to act as a baseline for future studies
2. To generate data which will contribute to the evaluation of interventions to date and which will inform future interventions.

Our target audience for the current report are all those engaged in activity intended to contribute to a reduction in HIV incidence during sex between men in Ireland:

be it funding, designing, planning, implementing or researching interventions.

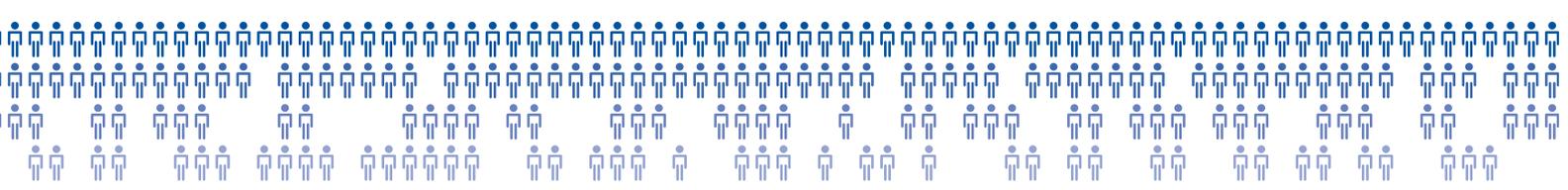
As many men's HIV prevention needs are met while interacting with a wide variety of services (not just HIV prevention services but also social and welfare services, etc.), the target audience for this report includes all those providing social and health services to gay and bisexual men.

2.2 Methods

A comprehensive health promotion programme to prevent HIV infection during sex between men must be concerned with the HIV prevention needs of all homosexually active men (and those who wish to become so). Similarly, programmes will benefit from planning data about all homosexually active men. However, we recognise that research faces similar problems as interventions with regard to targeting homosexually active men who are covert about their sexual behaviour. Men who are 'out' about their sexuality share social and sexual spaces that can be used both as settings for interventions and for recruitment to research. It is much more difficult to contact similar numbers of men who are either 'in the closet' or who keep their sex with men compartmentalised and discrete from the rest of their lives. It is not impossible to recruit such men to studies (see Weatherburn, Reid et al, 1996), but it is far more expensive per respondent. Given our finite resources for the current investigation, and the absence of basic planning data for the accessible population, the current survey was predominantly concerned with 'out' gay men.

To carry out activity of benefit to HIV health promoters throughout Ireland within the available resources, the aims of this study were considered best met by a short self-completion survey of gay and bisexual men, recruited by community members in community settings. It was also recognised that self-completion surveys have the potential to act as HIV prevention interventions in themselves and we sought to maximise this impact.

The survey form was designed by Sigma Research under direction from members of the Gay Health Network. The Network drew up a number of areas they wished to investigate and potential questions were discussed and designed.



As it was a self-completion survey, simplicity and ease of completion were characteristics we required. It was decided that the survey should occupy no more than four sides of A4 paper, and take no more than fifteen minutes to complete.

The population we wished to recruit were gay men, bisexual men and other homosexually active men living in Ireland. The inclusion criteria were therefore (1) males, (2) aged 16 or older, (3) resident in Ireland and (4) either gay or bisexual identity and/or homosexually active. Homosexually active was defined as sex with another man in the last year (where the respondent defines what counts as sex).

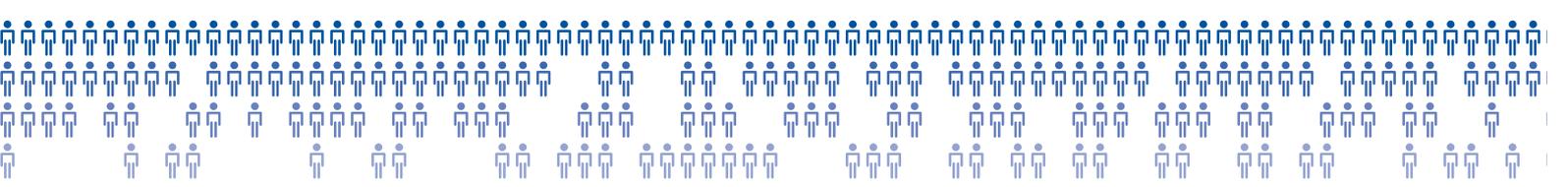
Following an initial meeting between researchers and Gay Health Network health promoters, a range of potential questions was drawn up by Sigma on the basis of the information needs of GHN members. The questions drew on previous surveys carried out by Sigma Research. After discussions and narrowing down, a draft questionnaire was piloted among twenty men by GHN in the GMHP Drop-In Centre and in two Dublin gay pubs (The George and Out on the Liffey). The pilot exercise demonstrated a positive response from men themselves and highlighted several useful points about the questionnaire. Minor adjustments were made to the questionnaire based on the pilot.

In total, 1 500 copies of the questionnaire were printed. Recruitment was co-ordinated by the Gay Men's Health Project. Distribution and collection started at Dublin Pride on June 24th 2000 when a team of ten recruited 380 men in two and a half hours. Recruitment in bars and clubs started the same weekend as Dublin Pride. In these the response rate was estimated at between 80% and 90%. Further recruitment took part at Belfast Pride over two weekends and in one weekend at events in Derry, Galway, Limerick and Waterford. Cork had no Pride event but two recruiters spent one weekend there in the bar and club. Social groups in more rural areas of the country were sent a number of questionnaires with an explanatory letter and a request to distribute them to their members.

A commercial data input agency was commissioned to input the data to an Excel data sheet. Cleaning, coding and counts were carried out by Sigma and a data report submitted to GHN, followed by a meeting between Sigma and GHN to discuss the aims and objectives of the survey report.

Data analysis was carried out by Sigma who wrote the first draft of the survey report. After discussion of the first draft between GHN members and Sigma, further analysis took place and additions from GHN members were incorporated. A second draft was distributed and final discussion and amendments took place. After completion of the survey report, research conclusions were jointly agreed by Sigma and GHN, who took forward the recommendations for programme planning. This, the final report, is published by GHN.

The distribution of this report was being launched at inter-disciplinary events in Dublin, Belfast, Cork and Galway, followed by mail-outs to groups and agencies. A separate pull-out section in *Gay Community News* draws out relevant highlights in an accessible manner.



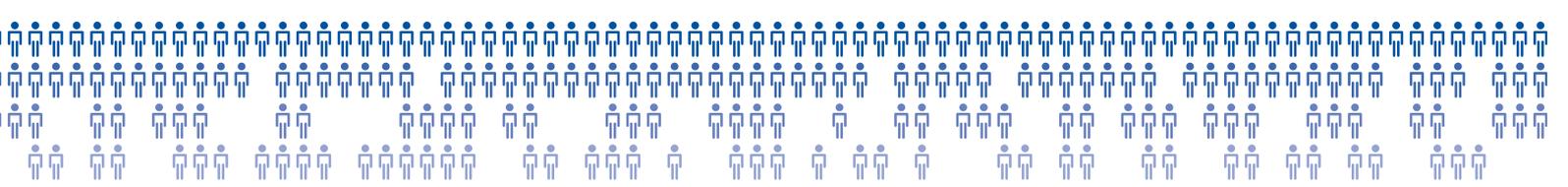
2.3 Exclusions

There were 1 420 questionnaires returned during the recruitment period. The following table gives the number excluded from the sample for different reasons and the final sample size.

Returned questionnaires (n=1 420)	number	% of returns
No sex with men and not gay or bisexual	48	3.4
Resident outside of Ireland	57	4.0
Female	1	0.1
Fewer than 30% of questions completed	24	1.7
Gay men, bisexual men and other homosexually active men resident in Ireland	1 290	90.8

Figure 2.3: Questionnaire returns, exclusions and final sample size

In the 1989 GHA survey, 3.6% of men recruited in the Irish gay community lived outside of Ireland, very similar to the 4.0% excluded here. The overall proportion of exclusions is similar to the exclusions in community recruited surveys of gay men in England and Wales (Hickson et al., 1999; Weatherburn et al., 2000).



3. Sample description

This chapter describes the 1 290 men who responded to the survey using a number of demographic variables. Starting with their sexuality and the gender of their sexual partners (as this is how the sample was defined), the findings show where in Ireland they live and the kind of area they live in. Age, education level, employment, partnership status, household and an indication of the extent of drug use are then examined.

In the absence of a sexual behaviour denominator study for Ireland (for example, a population-based, representative survey asking about sexual behaviour and sexual identity), it is impossible to judge how representative any sample of homosexually active men is of all homosexually active men. The results of the survey give a description of the population that health promoters such as GHN members work with. As noted above, compared to all homosexually active men in Ireland it is reasonable to assume that they are: more likely to identify as gay; more 'out' about their sexuality; less likely to have sex with women as well as men. Given that the sample was recruited at gay Pride events and on the gay scene, it may also be reasonable to assume the sample to be younger and more sexually active.

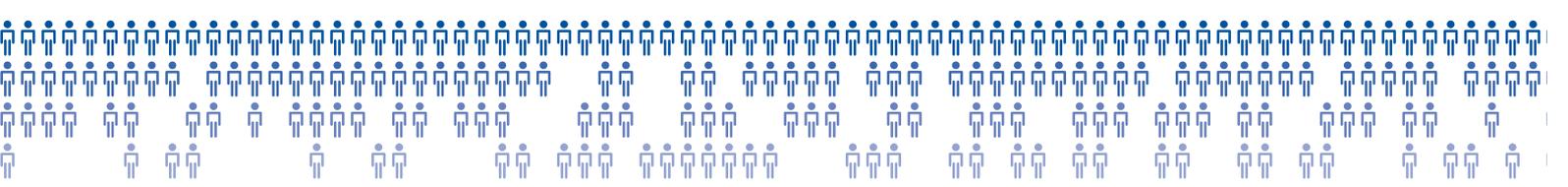
3.1 Sexuality

queer (6) · sexual (3) · homosexual (2) · exceptional (2) · anything but straight · available · confused · drag queen · drama queen · heterosexual · I don't know yet · I was married · married · other · one of them · poof · queen · sleep with men · straight · straight gay guy · supersexual · transsexual · whatever

Men were asked: ***What term do you usually use to describe yourself sexually...?***

The vast majority (85.7%) indicated 'gay', with smaller proportions indicating 'bisexual' (7.1%) and 'I don't usually use a term' (4.6%). The remaining 2.6% who indicated 'any other term' specified a wide variety of other terms (see box above). In the 1992 survey, 81% of respondents identified as gay and 11% as bisexual. The sexual identity of the two samples is very similar.

Sexual identity and sexual behaviour are not always co-terminus. Men were also asked the gender of their sexual partners. The following table shows the proportions of men having male, female or both male and female partners by the terms men used for their sexual identity. Since the inclusion criteria were sex with men and/or gay or bisexual identity, men who had no sex or sex with women only and identified other than gay or bisexual are excluded (the shaded area below).



In the last year, have you had sex with...? (missing = 13)	% all sample	% by sexuality What term do you usually use to describe yourself sexually...?			
		gay (n=1,094)	bisexual (n=89)	I don't usually use a term (n=59)	any other term (n=32)
Men only	89.1	94.1	37.1	81.4	78.1
Both men & women	7.8	2.9	55.1	18.6	21.9
Women only	0.7	0.4	5.6		
No one	2.3	2.6	2.2		

Figure 3.1: Gender of sexual partners by term used for sexuality

The vast majority of all the sample (96.9%) had sex with another man in the last year, most (92.0%) of whom had sex only with men. Overall, 8.5% had sex with a woman in the last year, most (91.7%) of whom also had sex with men. This is similar to the 10% found in the 1988 GHA survey (GHA, 1988) and the 13% found in the 1992 GMHP survey (GMHP, 1992). Overall, the majority of men who identified as 'gay' had sex with men only, while more than half of the bisexual men had sex with women as well.

- The sample is predominantly men who have sex with men only, and who identify as gay.

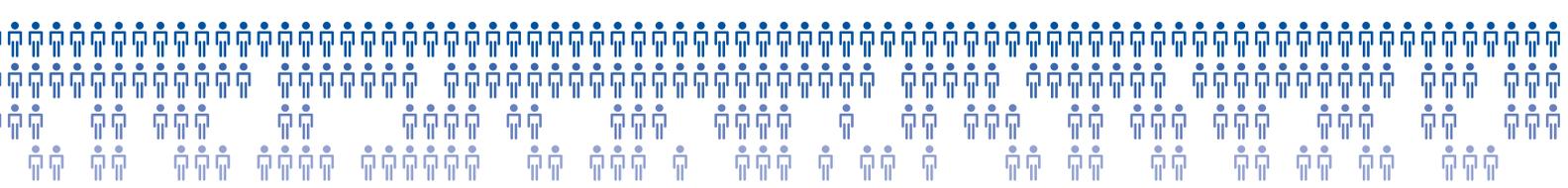
3.2 Residence

Men were asked two questions about where they lived: their county and the type of area they lived in (city, town, village, etc.). They were given four options: a city (78.2%), a town (11.6%), a village (5.4%) or a rural area (4.3%). Forty six men (3.5% of the sample) did not complete their county of residence. These have been left in the sample on the basis that they are more likely to live in Ireland than not.

Figure 3.2 shows the health boards of the Republic and the health authorities of Northern Ireland, the total population of each, the number of men in the sample resident in each, the counties each covers and the number of men in living in each county.

Overall, 18.7% of the sample lived in Northern Ireland. This compares with 31.0% of the entire male population that lives in Northern Ireland.

Although the sample contains men resident in all parts of Ireland, over half the sample (54.7%) lived in Dublin county. If the case that gay men were distributed in similar numbers as the general population; then the Eastern Regional Health Authority is over-represented and all other areas are more or less under-represented. However, there has been no denominator study of sexual identity and behaviour in Ireland which could tell us where gay men (and other homosexually active men) live. It is extremely unlikely that the distribution of gay men's residence is the same as the total population's. We think that gay men are more likely to live in Dublin than elsewhere in the Republic as that is where men



are most likely to feel supported in their sexuality and have access to the gay scene and gay community infrastructures. Hence, while it is not possible to comment definitively on the geographic representativeness of the sample, we feel the apparent over-representation of men from Dublin reflects actual differences in where gay men in Ireland live, and is not simply a sampling artefact.

- Half the sample live in Dublin while the rest are resident across the Republic and Northern Ireland.

Since Dublin appears to be a major social magnet for gay men in Ireland, and since more HIV and sexual health services are available there, in the rest of the report we have considered differences between men living in Dublin and those living elsewhere in Ireland (both the Republic and Northern Ireland).

There are five health boards with 20 or more respondents in each. The demographic, behavioural and needs data for these groups of men is reported separately in the Appendix, as is the data for men living in Northern Ireland.

Health Board / Authority	Total population (% of All Ireland)	Sample size N=1 244 (missing 46) (% of sample)	County	Sample size
Eastern Region Area Health Authority	1 300 000 (24.7%)	712 (57.2%)	Dublin	681
			Kildare	18
			Wicklow	13
Southern Health Board	540 000 (10.3%)	98 (7.9%)	Cork	93
			Kerry	5
South-Eastern Health Board	391 046 (7.4%)	33 (2.7%)	Kilkenny	4
			Carlow	2
			Waterford	21
			Wexford	6
Western Health Board	350 000 (6.6%)	77 (6.2%)	Galway	69
			Roscommon	1
			Mayo	7
Mid-Western Health Board	317 069 (6.0%)	44 (3.5%)	Limerick	29
			Clare	9
			Tipperary	6
Midland Health Board	202 000 (3.8%)	14 (1.1%)	Offaly	3
			Westmeath	4
			Laois	6
			Longford	1
North-Western Health Board	211 000 (4.0%)	15 (1.2%)	Donegal	6
			Sligo	3
			Lietrim	6
North-Eastern Health Board	306 155 (5.8%)	18 (1.4%)	Cavan	2
			Louth	8
			Meath	6
			Monaghan	2
Eastern HSSB / Northern HSSB	667 500 +411 200 (20.5%)	(15.2%) 189	Antrim	149
			Down	40
Southern HSSB	298 800 (5.7%)	3 (0.2%)	Armagh	0
			Tyrone	3
Western HSSB	271 400 (5.2%)	41 (3.3%)	Derry	35
			Fermanagh	6

Figure 3.2: County and health board of residence

3.3 Age

The average (median) age (n = 1 256, missing 34) was 29 years old (mean = 29.77, standard deviation 8.31) half were between 23 and 35. The minimum was 16 and the maximum 63 years old.

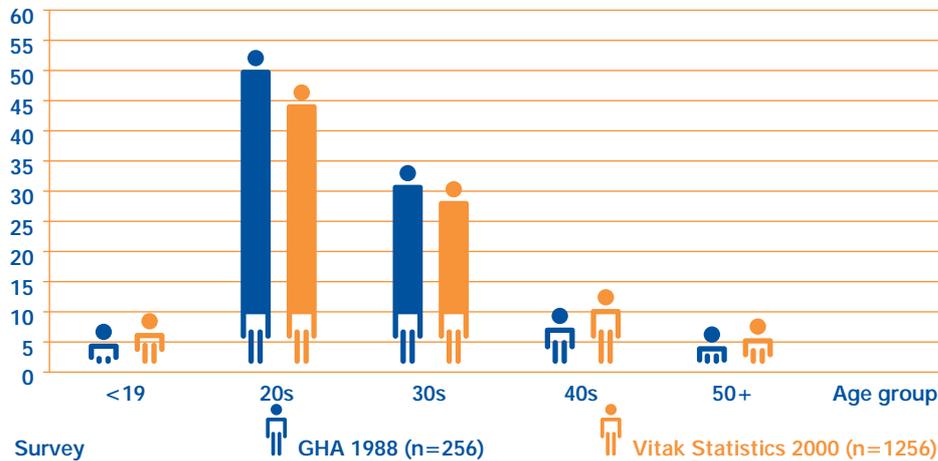


Figure 3.3: Comparative figures with GHA 1988 sample

The age profile of the sample was very similar to that of the 1988 GHA sample, with the largest group being men in their twenties, then thirties. The bisexual men were not significantly older or younger than the gay men in either sample.

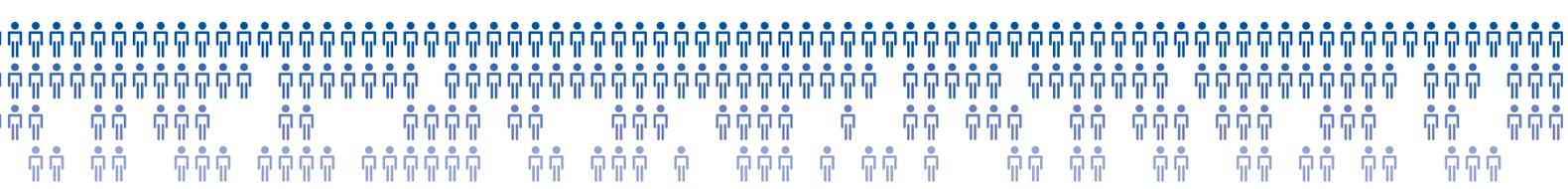
- The sample are mainly in their 20s and 30s.

3.4 Education and employment

Men were asked: *What is your highest educational qualification?* and were asked to indicate one of the options in the table below. This table also shows the proportion of men indicating each option overall and separately for men living in Dublin and elsewhere.

What is your highest educational qualification? (missing = 14)	% total sample	County of residence	
		Dublin	Rest of Ireland
Primary level	2.6	1.8	3.5
Secondary level 1 (Intermediate, Junior, O-levels/CSEs)	10.6	8.3	13.2
Secondary level 2 (Leaving Certificate or A-levels)	20.1	17.1	23.4
Recognised Training/Apprenticeship	3.8	3.1	4.7
Third level (PLC, Degree or Diploma)	60.3	67.7	52.0
Other	2.6	2.1	3.2

Figure 3.4a: Formal education



Overall, 60.3% of the sample had been educated to Third Level and this proportion was significantly higher among men living in Dublin (67.7%) than among those living elsewhere (52.0%). Men living in Northern Ireland were least likely to have Third Level education (see Appendix). High levels of formal education are found among all gay community recruited samples throughout Europe, North America and Australia. Ireland appears no different in this regard. In the rest of the report, we combine men educated to Primary or Secondary 1 (see figure 3.4a) as 'low education', those educated to Third Level as 'high' education, and the remainder of men as 'medium' education.

- Over half the sample had higher education.

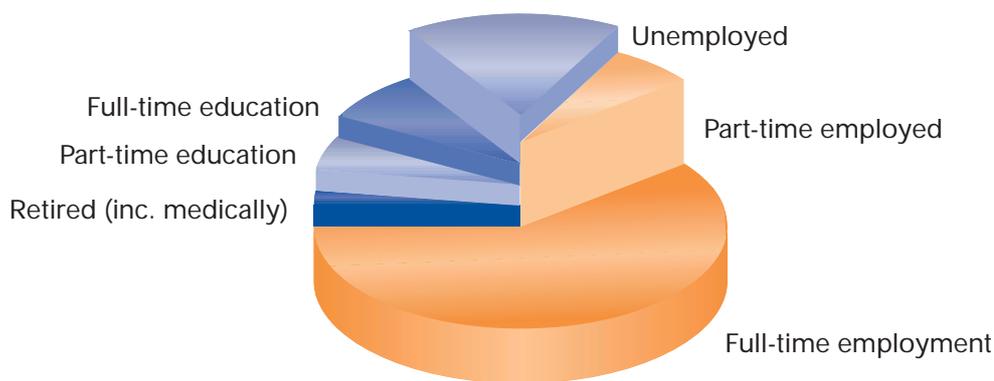


Figure 3.4b: Current employment status

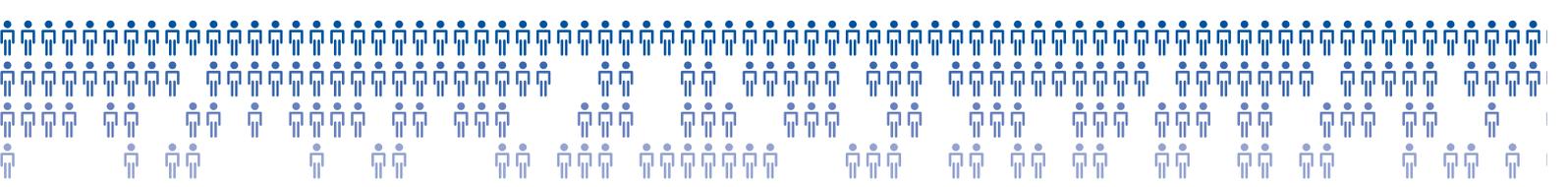
Men were also asked about their current employment status. Over two thirds (71.9%) were employed full-time and another 7.9% were employed part-time (of whom a small number were in part or full time education also). Of the 20.2% who were not employed, half (9.6% of the entire sample) were in full-time education and a further 1.3% were in part-time education (but no employment). A total of 6.5% of the sample (n=83) were unemployed and this was significantly higher in Northern Ireland (see Appendix). The remaining 2.8% were retired, the majority of whom (2.2%) indicated medically retired.

- The majority of men surveyed were employed full-time.

In the rest of the report, we compare those in full-time employment with those in full-time education and those who are unemployed.

3.5 Partnership and household

Although gay men are often portrayed simply as a group of isolated individuals, their social networks and interpersonal relationships are a strong and important source of support and health. Men were asked ***Do you currently have a regular male sexual partner...?*** Overall, 50.3% said yes (missing 73). Previous surveys have found similar figures: 43% in the 1988 GHA survey and 42% in the 1992 GHMP survey. This question was concerned with current regular sexual partners and more men may have had a regular sexual partner recently, but not currently. Those with a regular partner were asked



how long they and their partner had been together. The minimum was 1 month and the maximum was 315 months (over 26 years). The average (median) length of time was 14 months (mean = 32.3 months, standard deviation 45.1, n=581, missing 31). Of those in a relationship, 34% had been with their partner for over two years. The 1988 GHA survey found 23% of those currently in a relationship had been with their partner for over two years.

- Half the men had a current regular male sexual partner and of those half had been together for over two years.

Men were asked to indicate who they lived with from the list below.

'Who do you live with...?' [more than one response possible (2 missing)]	% total sample (n = 1288)
I live by myself	29.5
Friends	23.4
Male partner	20.7
Parents	16.7
Other family members	5.4
Female partner	1.8
Children	1.3
Other people	4.3

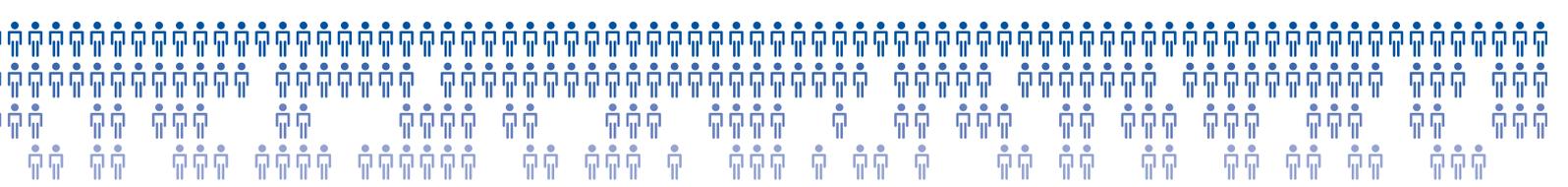
Those who listed other included: 13 who said 'house/flat share', 9 who said 'flatmate/s', 4 who said 'land lady/lord' 2 who said 'lodgers' and single instances of the following, '2 males', '3 women straight 1 gay 1 straight', 'a lesbian', 'a psycho', 'all as above', 'an asshole of a guy', 'brother & two freaks', 'college campus', 'evil housemates', 'ex-wife', 'ex boyfriend', 'his mother', 'hospital', 'it varies', 'people just moved with', 'queer man and lesbian', 'rent rooms in house'. 12 people did not specify.

Figure 3.5: Household

Almost a third of men (29.5%) lived alone. A fifth (20.7%) lived with their male partner, and the majority of these men (91.7%) lived with their male partner only. Of the men who lived with a male partner, small proportions also lived with their own or their partner's parents (2.3%), children (2.3%), friends (3.4%), or a female partner (1.1%, n=3).

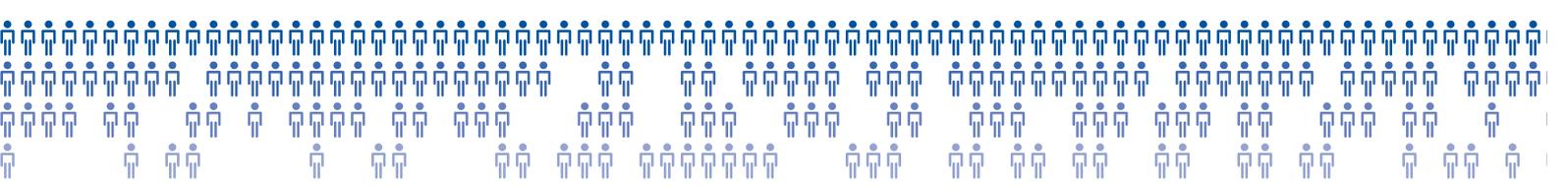
After living alone or with a male partner, the next most common household for this sample was with friends. Almost a quarter (23.4%) lived with friends and almost all of those lived only with friends. Although only small proportions of men lived with a female partner (1.8%) or with children (1.3%), it was significantly more common for bisexual men than gay men to live with a female partner (10.9% compared with 0.7%) or children (4.3% compared with 0.6%).

- The sample live in a variety of household structures, with half living either alone or with a male partner only.



3.6 Implications for generalising from the sample

The similarities between this sample and earlier gay community recruited samples suggests they are drawn from the same population. However, without knowing the profile of the gay and bisexual population of Ireland, it is not possible to say to what extent this and earlier samples are representative of the population with regard to demographic characteristics. It seems likely though that compared to the population of homosexually active men in Ireland, the men in this sample are more likely both to have sex with men only and to be younger. Since the response rate to the survey was high, we feel it will be most accurate to consider the sample as representative of the men that HIV prevention work accesses.



4. HIV infection:

Testing history and status belief

In 1985, the first leaflet by the first AIDS group in Ireland discouraged HIV testing, primarily due to the prevalence of discrimination against people with HIV at that time and the absence of HIV treatment options. In the past fifteen years, discrimination has declined (although not disappeared) and treatment options have improved dramatically. Consequently, a number of more recent leaflets and articles in the gay press have underlined the benefits of having HIV diagnosed.

4.1 HIV testing history

In 1996 the GLEN/Nexus Research Co-operative claimed "HIV testing has consistently shown that 7.5% of gay men testing in Ireland have been exposed to the virus" (1996, page v). This was based on the proportion of HIV tests taken by gay and bisexual men that were positive recorded by the VRL between 1986 and 1995 (325 positive results in 4 415 tests (p.12)). However, at Dublin's Gay Men's Health Project in 1998 there were 475 new visitors, of which 249 tested for HIV, of whom two (less than 1% of testers) tested positive (Quinlan et al., 1999).

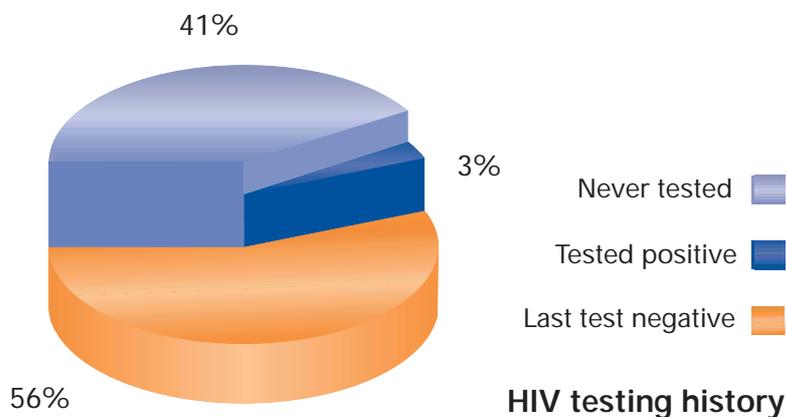


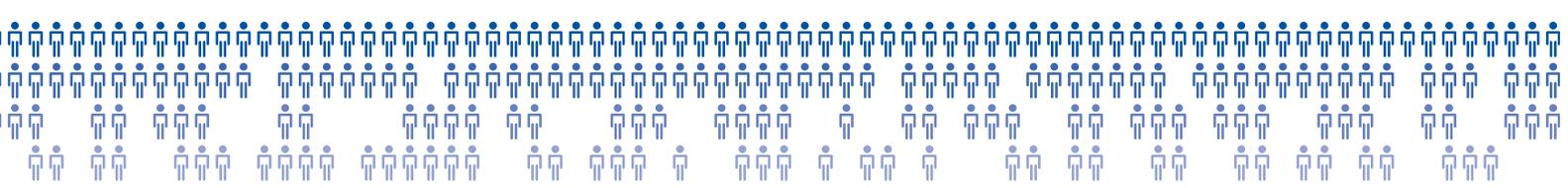
Figure 4.1a: Testing history

In the current survey, men were asked: *Have you ever received an HIV test result...?* Nineteen of 1 290 men (1.5%) declined to answer this question. Of those who did, 59.6% said they had tested at some point in the past.

- 60% of men had ever tested for HIV.

Men who had tested were asked: *What was your most recent test result...?* and twelve declined to answer (1.6% of those who had tested). Of those who had tested and who answered, 5.1% (n = 38) had tested positive and the remainder had tested negative. No man said their most recent test result was indeterminate.

- Overall, 3.0% had tested HIV positive (or 5.1% of those who had ever tested).



In addition it is likely that some of the men who have never tested have undiagnosed HIV infection, as will some of those whose last test was negative, but who have since seroconverted. How many men have undiagnosed infection is, however, unclear. In England, the Unlinked Anonymous HIV Surveillance Study estimates 63% of prevalent infections among homosexually active men have been diagnosed (Unlinked Anonymous Surveys Steering Group, 2000, p.8).

It seems probable that men who have been at risk of HIV are more likely to test than men who have not been at risk. As over half the sample have tested, this would mean men with HIV are more likely to have tested than not, and hence it is likely that at least half of prevalent infections have been diagnosed. This would suggest that in addition to the 3% of the sample with diagnosed infection, up to another 3% have undiagnosed infection.

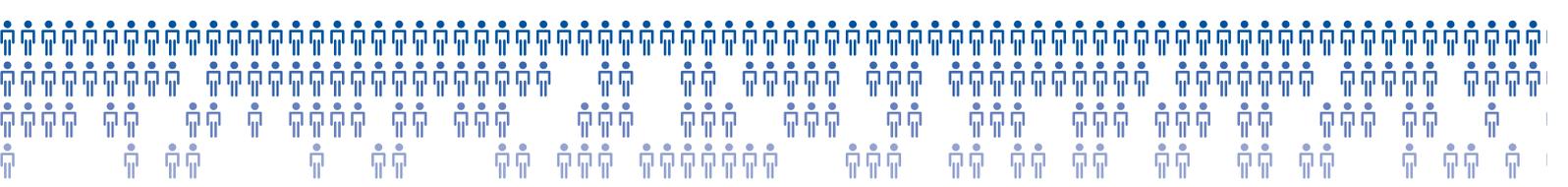
- The survey suggests that there are up to another 3% with undiagnosed HIV infections.

Study	GHA	GMHP	VS
Year	1988	1992	2000
n	253	469	1 259
% ever tested	39.9	44.1	59.6
number of positive men	9	6	38
% tested positive (of tested)	8.9	2.9	5.1
% tested positive (of total)	3.6	1.3	3.0

Figure 4.1b: Comparative testing figures

In the 1988 GHA survey 40% had tested for HIV and in the 1992 GMHP survey 44% had (see figure 4.1b). This suggests that more men have decided to test for HIV in recent years.

The 1988 GHA survey found 3.6% of their respondents (9 of 252 men) had tested positive and the 1992 survey found 1.3% to have tested positive (6 of 469 men). These figures suggest that for the past ten years, the prevalence of diagnosed HIV infection among gay men has remained fairly level. For every man who has died with HIV infection, another has become infected and the overall proportion of men with HIV has remained the same. This picture may now be changing with combination therapy. As men with HIV stay well longer, the rate at which men die is slower than the rate at which they are becoming infected. The overall effect will be an increase in HIV prevalence in the future.



4.1.1 Residence

Men who lived in Dublin were more likely to have ever tested (65.8% had) than men who lived elsewhere in the Republic (54.3% had tested) or in Northern Ireland (49.8% had tested). This may be a reflection of the comparatively greater number of HIV testing locations available in Dublin, and suggests more testing sites elsewhere would increase the proportion of men testing (and hence reduce undiagnosed infection).

Among those who had tested, we found no evidence for men who live in Dublin being more or less likely to have tested positive than men who lived elsewhere.

- Testing for HIV is more common in Dublin than elsewhere.

In Northern Ireland (see Appendix) exactly half the men had tested and 7% of those were positive, giving a prevalence of diagnosed infection of 3.5%. This is ten times higher than the 0.3% measured in the Unlinked Anonymous Surveys (see Section 1.2). Two possible explanations for this discrepancy are that men with diagnosed infection were much more likely to take part in this survey, and that they are much less likely to use the GUM clinic for their sexual health needs.

4.1.2 Age

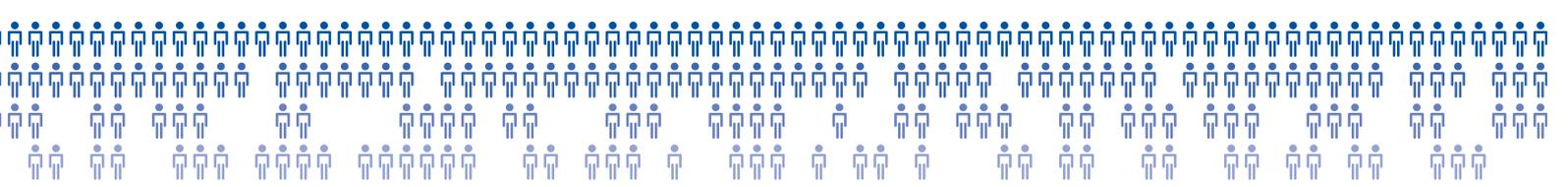
Age group	<19	20s	30s	40s	50+
n	98	578	391	132	31
Never tested (%)	67.3	42.6	33.8	32.6	35.5
Last negative (%)	31.6	55.7	61.9	62.1	61.3
Tested positive (%)	1.0	1.7	4.3	5.3	3.2

Figure 4.1.2: Testing varied by age

The National AIDS Strategy Committee has estimated that "the median age associated with transmission by homosexual sex is 34" (NASC, 2000, p.37). As we might expect, in the current survey HIV testing significantly varied by age (Figure 4.1.2). A third of men under 20 had tested for HIV. Having ever tested became more common with age. Although there were men who had tested positive in all five age bands, having tested positive was most common among men in their 40s.

- Most gay men acquiring HIV are under 40.

This strongly suggests that an HIV prevention program should prioritise the HIV prevention needs of men under 40, rather than those over 40.



4.1.3 Education and employment

Compared to men who had not tested HIV positive, those who had were less likely to be in full-time employment (60% compared to with 72%) or full-time education (3% compared to 10%) and were more likely to be unemployed (11% to 6%) or retired [including medically retired] (14% to 2%). Differences in employment are likely to be a consequence of having HIV illness.

Associations between HIV testing history and education, where education usually occurs before HIV is acquired, might suggest differences in the rate at which men acquire HIV by formal education group. However, we found no evidence for an association between education and HIV testing history in these data (unlike in the UK, see Hickson et al., 1998).

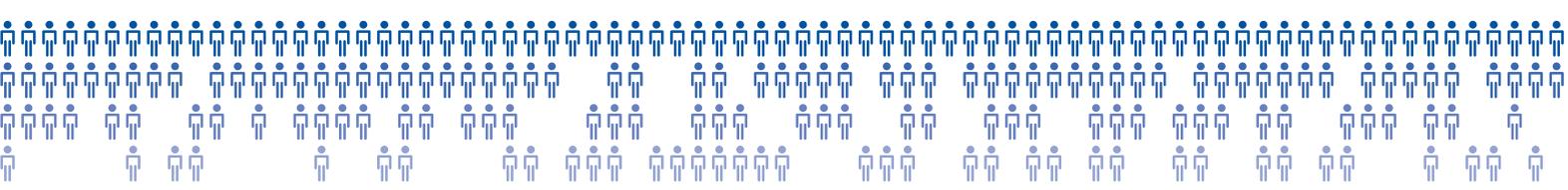
4.2 Current status belief

After being asked about their HIV testing history, all men were asked: *What do you believe your HIV status is currently?* and to indicate one of the following: definitely negative; probably negative; don't know/couldn't say; probably positive; definitely positive; or Other. Men who indicated Other were asked to specify what they meant.

Overall, 6.1% of men declined to answer this question, 78.0% thought they were definitely or probably negative, 3.1% thought they were definitely or probably positive and the remaining 19.0% were unsure (including a small number who gave other answers). These responses were not co-terminus with men's HIV testing histories. That is, some of the men who thought they were HIV negative had never tested. Also, some of the men who were unsure of their status had received a test result in the past and finally some men thought they were positive although they had not been diagnosed as such. The following table shows the proportions of men in each of the HIV testing history groups who indicated each of the status beliefs (excluding the six men who indicated Other).

'What do you believe your HIV status is currently ...?' (missing = 79)	% of total sample (n=1 211)	% by HIV testing history		
		never tested (n=476)	last test negative (n=675)	tested positive (n=36)
Definitely HIV negative	53.6	48.5	59.5	11.1
Probably HIV negative	24.4	18.4	29.7	8.3
Couldn't say or don't know	18.5	32.4	9.7	5.6
Probably HIV positive	0.5	0.4	0.6	0.0
Definitely HIV positive	2.6	0.2	0.4	75.0
Other	0.5			

Figure 4.2: Current HIV status belief and HIV testing history



Most men who had tested positive thought they were currently positive (75.0%). However, 9 of the 36 men (25.0%) who had tested positive and who answered the question indicated they thought their status was other than positive (compare 6% in the UK in 1999 (Weatherburn et al., 2000) and 0.8% in London in 2000 (Hickson, Hartely, Weatherburn, 2001). Two men (5.6%) indicated couldn't say/don't know, and the other seven indicated they thought they were negative. Among men who had tested positive, we found no evidence for demographic differences between those men who thought they were currently positive and those who thought otherwise, although the small numbers involved may mean we are overlooking demographic differences that are actually there.

Most men who had tested negative in the past thought they were currently HIV negative (89.2%). A small group (1.0%, n=7) thought they were currently HIV positive and 9.7% (n=66) were unsure of their current status. Most men who had never tested for HIV thought they were currently HIV negative (66.8%). Only a very small group (0.6%, n=3) thought they were positive, but a third (32.4%) were unsure of their status.

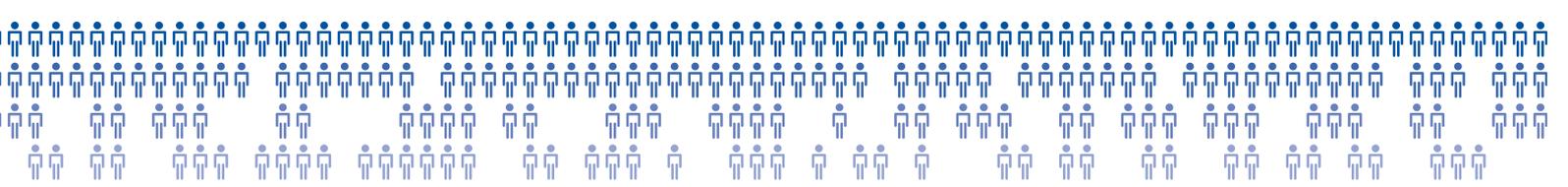
- HIV testing history is not the same as men's current belief in their HIV status, although they are strongly related.

4.3 Implications for addressing men on the basis of their HIV infection status

At the level of population monitoring for HIV prevention planning, HIV testing history is probably the best indicator we have of HIV infection status, but a more graduated measure may be achieved using current status belief as well. However, at the level of individuals, HIV testing history, current status belief and actual infection status are not the same thing. Although past testing history clearly influences current status belief, it does not determine it. HIV prevention texts themselves often maintain, if not generate, the confusion between HIV infection, HIV testing and current status belief. For instance, introducing leaflets as being "for all gay men whether you're HIV negative, HIV positive or unsure" suggests there are three groups. But it is unclear as to what the groups actually are.

If we think about the size of these three groups we can see there are not three groups at all: 'HIV negative' could mean last test negative, or believe negative or, both tested negative and believe negative; 'HIV positive' could mean tested positive, or believe they are positive, or both; and 'unsure' could mean never tested, or tested and still not sure / don't know their current status. As shown above, most men who had never tested did 'know their status'. The confusion arises because the statement collapses infection status, testing history and status belief. Each of the following statements would be preferable to the one above. Which one to use would depend on why they are being addressed:

- For all gay men whether you've got HIV or not
- For all gay men whether you've ever tested or not and whatever the result was
- For all gay men whether you know you've got HIV, know you haven't, or are unsure.



5. Health-related behaviours

This chapter looks at the respondents' sexual health-related behaviours. These concern both behaviours associated with the acquisition of infections and their prevention. The behaviours are sex, condom use and condom failure, vaccination against hepatitis B, attendance for STI check-ups and drug use. In the population of gay men in Ireland, these are the parameters that impact on national levels of incident infection. When considering differences across population groups, as well as residence, age, education and employment, we add another demographic variable – HIV testing history.

5.1 Sex with men

As described above, 3% of the sample had not had sex with a man in the last year. The following section concerns the 97.0% of men who did have sex with another man. Of these men, 8.1% also had one or more female sexual partners in the last year.

5.1.1 Number of male sexual partners

Men were asked: *In the last year, how many different male partners have you had sex with?* and were given a line to write on. They were also asked: *How many of these were casual partners?* Of the men who had sex in the last year, 22.8% had no casual partners but only regular partners, 26.1% had only casual partners and 51.1% had both regular and casual partners. While casual sex is common among these men, having a regular sexual partner is as common, and the majority of men have a sex life that combines both.

The median number of sexual partners for those who had a sexual partner ($n = 1\,056$) was five (that is half the men had five partners or fewer and half had five or more). The mean was 17.9 (standard deviation 88.4). The minimum was 1 and the maximum specified was 2 000 (although we feel this latter number is highly improbable it suggests some men have more sexual partners than they could count). Since the distribution is highly skewed, the median is our preferred measure of central tendency.

21%	had only 1 partner
30%	had fewer than 3 partners
40%	had fewer than 4 partners
46%	had fewer than 5 partners
53%	had fewer than 6 partners
73%	had fewer than 11 partners
81%	had fewer than 16 partners
88%	had fewer than 21 partners
97%	had fewer than 51 partners

Figure 5.1.1: Number of partners

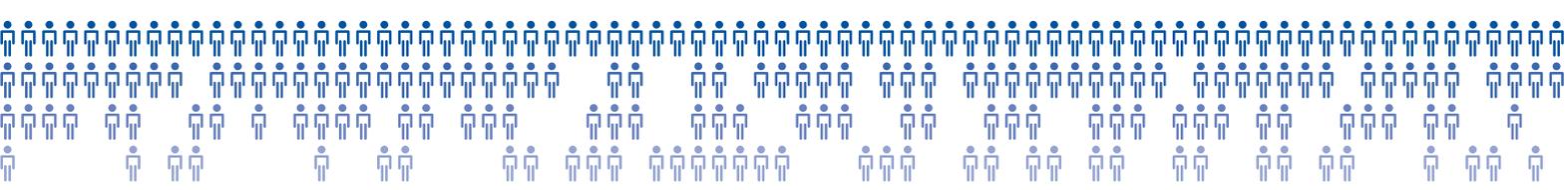


Figure 5.1.1 shows the cumulative percent of the sample that had different partner numbers. A fifth of the sample (21%) had one partner only in the last year, 40% had three or fewer, 73% had ten or fewer, etc.

The average (median) number of casual sexual partners for those who had a casual sexual partner (n = 679) was 5 (mean = 15.4, standard deviation 56.1). Half had between 2 and 13 sexual partners in the previous year. The minimum was 1 and the maximum was 1 036.

While having a regular partner was equally common for men living in and outside Dublin, those living in the capital were more likely to have a casual partner, but not emphatically so (81.0% compared with 72.5%).

We found no significant differences in the number of sexual partners men had by whether they lived in Dublin or not, by their age or by their employment status. However, men's number of sexual partners did vary by their education level. Men with either lower or higher levels of education had more partners (each a median of five) than men in the middle education group (who had a median of four partners). Men in the middle group were more likely to have two, three or four partners and were less likely to have more than thirty.

Men who had tested HIV positive (median of ten partners) had significantly more partners than those who had tested negative (median of six) or who had never tested (median of four).

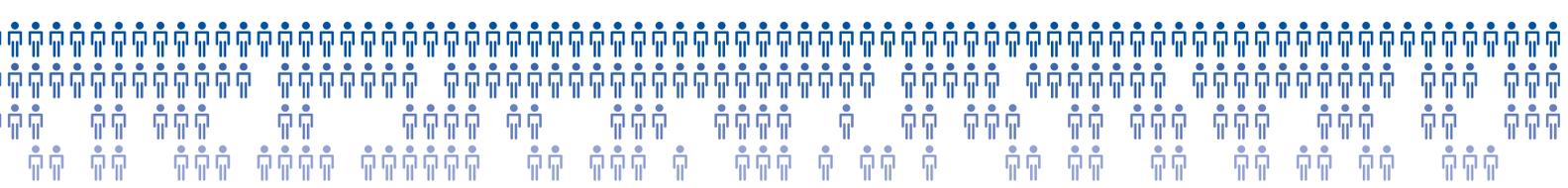
- The average (median) number of sexual partners in the last year was five with men in the middle education group and those who had tested HIV positive averaging more partners than other groups.

5.1.2 Sources of new sexual partners

Men were asked: *Where in Ireland, did you meet any new sexual partners you've had in the last year...?* and were given a list of eight potential places, plus a space for specifying other places. Having had a new sexual partner in the last year was normative for this population. Overall, 10.1% of men ticked 'I've not met any new sexual partners' and this proportion did not significantly vary by where men lived, nor by their age group, education, employment or HIV testing history. Although new sexual partners were the norm for all groups, men who had sex with women as well as men were more likely to have had a new male sexual partner in the past year (99.0% had) than were men who had sex with men only (92.4% had a new partner).

- Almost all men had met a new sexual partner in the last year.

The following table concerns men who did have a new sexual partner in the last year. It shows the overall proportion who had met a partner in each of the specified sites, and the proportion who met new sexual partners in that site only (that is, met no new sexual partners elsewhere).



'Where in Ireland, did you meet any new sexual partners you've had in the last year...?' [those who had a new sexual partner in last year, n = 1 150]	% who met a new partner in that site	% who met new partners in that site only
In a pub/ club	66.1	29.2
In a sauna	32.5	5.6
At a (gay) social group	19.5	5.6
At a private party	18.3	1.9
At a cruising ground	14.9	1.3
On the Internet	12.2	1.5
At a public toilet (<i>cottage</i>)	7.9	0.6
Through personal ads	6.3	1.0
Other	6.1	2.7
Other included: a friend (7), 'street' (5), 'work' (5), 'college/university' (4), 'school' (2), 'on holidays' (2), 'a bus stop', 'anywhere', 'beach', 'body building compo', 'brought them over here', 'bus/restaurant/shop', 'chat line', 'chinese restaurant', 'christian group', 'city centre', 'disco', 'everywhere', 'holidays', 'in a café', 'in a hostel', 'my house', 'my own house', 'on currain mount', 'on the beach', 'on the dart', 'on the train', 'Outhouse for my one & only (community forum)', 'partner', 'people I know', 'phone line', 'sex line', 'spiritual group', 'the quay', 'through my boyfriend', 'variable', 'working as masseur', 'Zulus' and 'none of these' (4).		

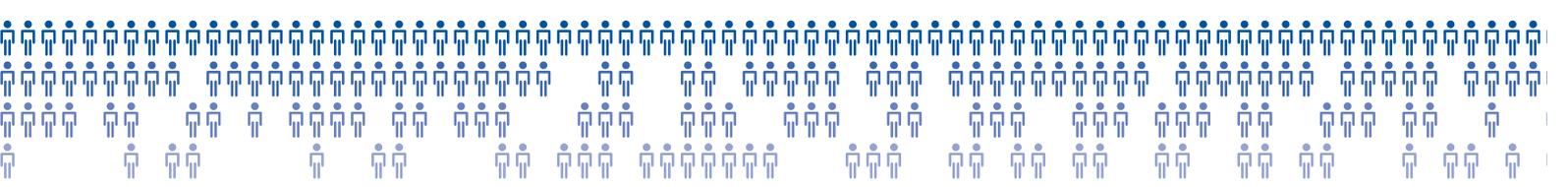
Figure 5.1.2a: Where men met new sexual partners

The most popular site by far is the commercial gay scene: two thirds (66.1%) had met new partners in pubs and clubs. Gay bars are the mainstay of gay men's sexual networks. A third of men (32.5%) met partners in the next most common site, saunas. Perhaps contrary to popular perceptions, gay social groups (19.5%) and private parties (18.3%) were more common sources of sexual partners for these gay men than were outdoor cruising grounds (14.9%) and particularly *cottages* (public toilet, which had been used by 7.9%). A relatively new site for gay men to meet each other is the Internet, used by 12.2%.

Considering the second column of figures, of the men who had a new sexual partner in the last year, half (50.6%) met new partners in more than one site. Another 29.2% met new partners only in bars and clubs. Much smaller percentages of men exclusively used one other site.

- Bars and clubs are by far the most common place to meet new sexual partners with two thirds of men meeting a partner there: almost a third met new partners only in bars in clubs.

The following table shows the proportion of men who met a new sexual partner in the last year at each of the eight sites, by their residence and by their age.

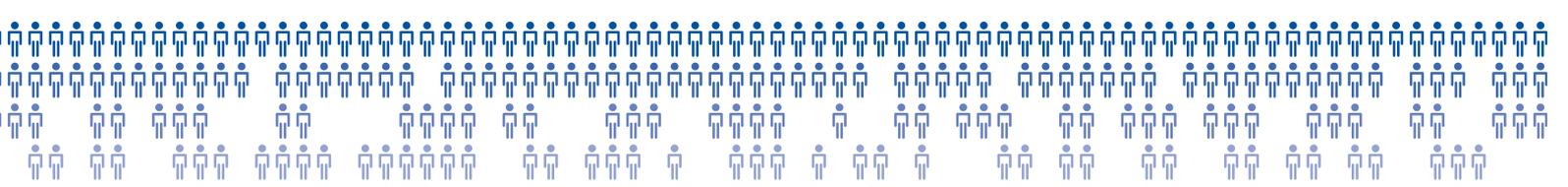


'Where in Ireland, did you meet any new sexual partners you've had in the last year...?'	% who met a new partner in that site by residence [those who had a new sexual partner in last year, n = 1 150]						
	By residence		By age				
	Dublin (n=614)	Elsewhere (n=543)	<19 (n=89)	20s (n=539)	30s (n=352)	40s (n=120)	50+ (n=26)
In a pub/ club	68.2	63.7	* 75.3	71.8	62.8	45.8	57.7
In a sauna	* 39.3	24.9	<u>18.0</u>	24.7	41.2	43.3	* 57.7
At a social group	17.4	21.9	21.3	19.3	19.6	17.5	19.2
At a private party	17.9	19.0	* 25.8	20.0	15.6	13.3	<u>7.7</u>
At a cruising ground	13.8	16.2	<u>6.7</u>	10.6	19.6	20.8	* 26.9
On the Internet	11.2	13.3	20.2	12.4	10.8	10.8	7.7
At a public toilet (<i>cottage</i>)	5.0	* 11.4	10.1	4.1	10.2	10.0	* 19.2
Through personal ads	4.7	* 8.7	6.7	5.6	6.3	9.2	7.7

Figure 5.1.2b: Where men met new sexual partners by residence and age

Among men who had a new sexual partner, those men living in Dublin were significantly more likely to have met one at a sauna (39.3%) than those men living elsewhere in Ireland. However, all the other sites were more commonly used by men living outside Dublin, being significantly more likely to have met a new partner at a *cottage* or through personal ads.

Sources of new sexual partners vary strongly across the age range. Younger men were significantly more likely than older men to meet their new partners in pubs and clubs and at private parties. Older men were more likely than younger men to have used saunas, cruising grounds and *cottages*.



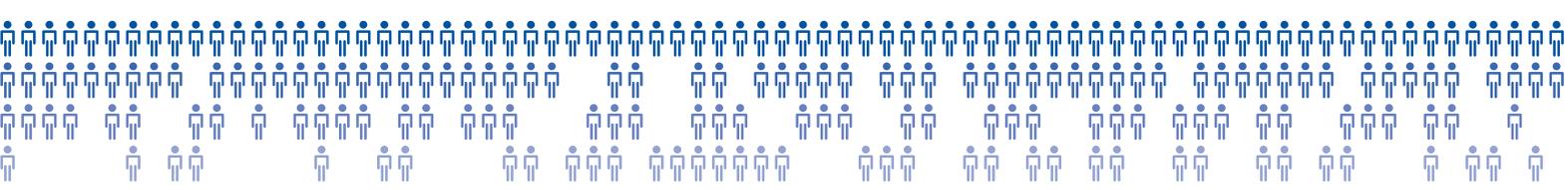
'Where in Ireland, did you meet any new sexual partners you've had in the last year...?'	% who met a new partner in that site by residence [those who had a new sexual partner in last year, n = 1 150]					
	by education			by occupation full time		
	low (n=154)	medium (n=225)	high (n=686)	employment (n=828)	education (n=106)	unemployed (n=74)
In a pub/ club	55.2	67.6	68.1	65.1	62.2	75.5
In a sauna	29.9	28.9	34.5	* 34.2	21.7	28.4
At a (gay) social group	* 27.3	16.9	18.1	18.6	17.9	23.0
At a private party	11.0	13.8	* 21.1	18.8	21.7	14.9
At a cruising ground	18.2	9.8	15.9	15.0	9.4	16.2
On the Internet	9.7	13.3	12.8	12.4	18.9	10.8
At a public toilet	* 13.0	5.3	6.4	7.0	8.5	9.5
Through personal ads	7.8	6.2	5.8	6.5	5.7	8.1

Figure 5.1.2c: Where men met new sexual partners by education and occupation

Lower levels of education were associated with being more likely to meet sexual partners at social groups and *cottages*, and with being less likely to meet them at pubs/clubs. Men with higher levels of education were significantly more likely to meet partners at private parties.

While education was associated with several sites, use of only one varied by occupation: saunas were more popular with those in employment than either students or unemployed men. As payment is required to enter saunas this may not be surprising. There has been a considerable increase in commercial saunas catering to gay men in Ireland over recent years. Not unreasonably attention has been drawn to their potential role in providing opportunities for the sexual transmission of HIV and other infections. Saunas have also been argued to be important settings for HIV/STI prevention interventions.

In order to ask: *What are the characteristics of men who use saunas?* we distinguish those men who met new sexual partners only at a sauna in the last year (n=60), those who met them at a sauna as well as some other site (n=316), and those who met new sexual partners in places other than saunas (n=711). Men who had not met at a sauna were less likely to live in Dublin than the other two groups, while those who only used saunas were older and less well educated. We found no evidence that sauna use was associated with also having had sex with women.



5.1.3 Anal intercourse

Men were asked: ***In the last year, have you fucked a man (been the active partner in anal intercourse) or been fucked by a man (been passive)?*** and were given the options: no; yes with a regular partner; yes with a casual partner. Respondents could tick yes for both regular and casual partners. The definitions of regular and casual partners were left to the respondent. Of those who had sex with a man in the last year, 79.9% indicated they had some anal intercourse (AI).

The 1992 survey found 58% of men had AI in the last year which may suggest that since the fearful climate of that time, men have become more relaxed about having anal intercourse - a source of sexual pleasure and emotional significance for many gay men (Davies, Hickson, Weatherburn & Hunt, 1993).

AI was slightly but significantly more common with regular than with casual partner. Of the men who had AI, 62.1% had AI with a regular partner and 52.1% had AI with a casual partner (and therefore 14.6% had AI with both regular and casual partners).

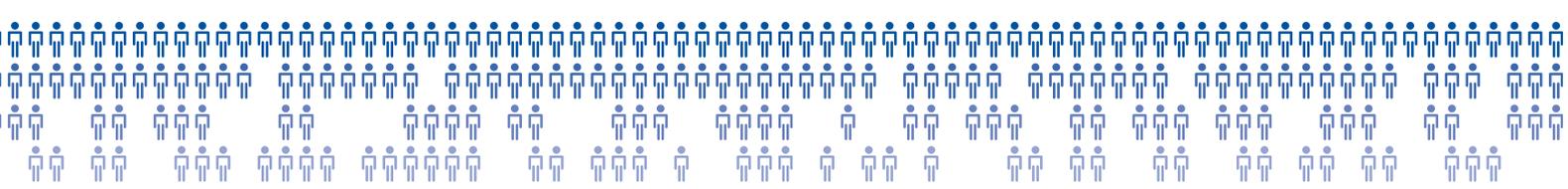
Having anal intercourse did not vary by living in Dublin or not, education or employment. It did vary by age and HIV testing history. While 73.3% of men under 20 had AI, this increased to 84.2% among men in their 20s then declined again with increasing age: 79.0% of men in their 30s, 72.0% of those in their 40s and 60.0% of men aged 50 or older.

Engagement in anal intercourse significantly varied by HIV testing history. It was most common among men who had tested HIV positive (89.5% had in the last year) than among those whose last test was negative (81.6%). Men who had never tested for HIV were least likely to have had AI (70.9%), which is probably part of the reason they have never tested for HIV. As noted above, a major reason for HIV testing is the possibility of having the virus. Men who have never had AI (and have not engaged in other HIV - risk behaviours) are unlikely to have HIV and lack this major reason to test.

5.1.4 Unprotected anal intercourse

Men who had anal intercourse were then asked: ***In the last year, have you fucked or been fucked without a condom (with a man)?*** The options were the same as above. Of those who had AI (n=949), 54.0% (95% confidence interval of 50.8% to 57.2%) indicated they had some unprotected anal intercourse (UAI). This was 42.6% of the men who had sex, or 41.5% of the entire sample. The 1992 survey found 47% of men who had AI had some UAI in the preceding year. Since the data also suggest there has been an increase in the proportion of men having AI, this means there has probably been an increase in either the proportion of men who have UAI or the frequency with which they do so.

Having UAI was far more common with regular than with casual partners. Among men who had UAI (n=478), 70.5% did it with a regular partner and 36.8% with a casual (which meant 7.3% did it with both regular and casual partners).



Among those men who had AI, having any UAI did not significantly vary by age, HIV testing history or education, but it did vary by residence and employment. Men living in Dublin were more likely to have always used a condom (50.0% had) compared with men elsewhere (41.5%). Compared with men in full-time employment (of whom 52.5% had UAI), those in full-time education were less likely to have UAI (46.1%) and those who are unemployed were more likely to have UAI (66.1%).

5.1.5 Knowledge of HIV status of UAI partners

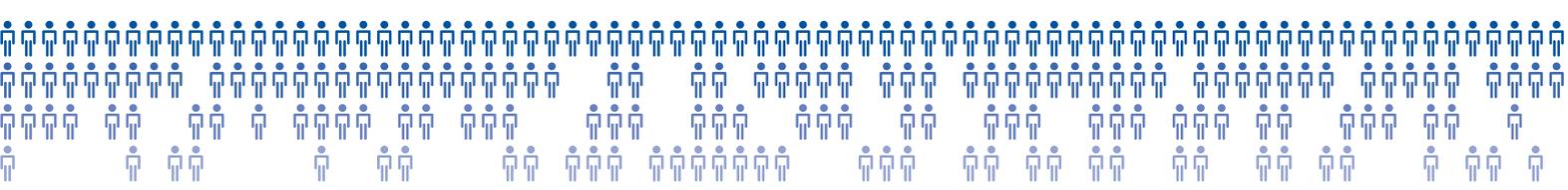
Unprotected anal intercourse involves sexual HIV exposure and a risk of transmission only when it occurs between a man with HIV and a man without HIV. It has been known for some time that many men who engage in UAI are not necessarily disregarding HIV, but may be engaging in UAI with men they think have the same HIV status as themselves. To estimate the proportion who may be doing this, men who indicated they had engaged in anal intercourse were asked three questions about the HIV status of men they had UAI with. The following table shows the overall proportions, and the proportions in each testing history group, who had AI, UAI and UAI with partners known to be HIV negative, HIV positive and HIV status unknown.

% of those who had UAI (number of men)		Homo- sexually active sample	by HIV testing history		
			never tested	last test negative	tested positive
'In the last year have you fucked without a condom (either way) with a man....'	...who you knew at the time was HIV negative (missing 89)	61.8 286/463	62.7 101/161	63.0 179/284	<u>33.3</u> 6/18
	...who you knew at the time was HIV positive (missing 129)	9.0 38/422	9.8 14/143	6.0 16/265	* 57.1 8/14
	...whose HIV status you did not know (missing 170)	43.8 167/381	42.4 56/132	44.3 104/235	50.0 7/14

Figure 5.1.6: Anal intercourse (AI), unprotected AI (UAI) and knowledge of HIV status of UAI partners

Men who had tested positive were most likely to have AI, those who had never tested were least likely. However, among men who had AI there was no difference across HIV testing histories in the proportion who did not always use a condom.

Among men who had UAI, it was most common overall with men known at the time to be HIV negative (61.8% of men who had UAI or 24.7% of homosexually active respondents had done this). A significantly smaller proportion of men who had tested HIV positive had UAI with a negative partner (33.3%) than those who had not tested positive (62.7% and 63%). Far fewer men (9% of those who had UAI or 3.5% of homosexually active men) had UAI with a man they knew at the time was HIV positive. This was far more common among men who had tested positive (57.1% of those who had UAI) than among men who had not tested positive.



Both of these findings suggest that some men attend to their own and their partners HIV status when they engage in UAI.

Although men who had never tested were less likely to have UAI, they were by definition unable to know they were doing so with a man of the same HIV status as themselves (see Section 9.3).

Finally, 43.8% of those who had UAI (or 15.8% of homosexually active men) had UAI with a man whose HIV status they did not know at the time. This proportion did not significantly differ between men who had tested and those who had not, or between those who had tested negative and those who had tested positive. This finding suggests that while some men may be engaging in UAI only with men they believe to have the same HIV status as themselves, many others are engaging in UAI they cannot know is HIV sero – concordant.

- Men who had never tested or had tested negative were most likely to have UAI with a man they knew at the time was negative: those who knew they were positive were most likely to have UAI with a man they knew was positive.

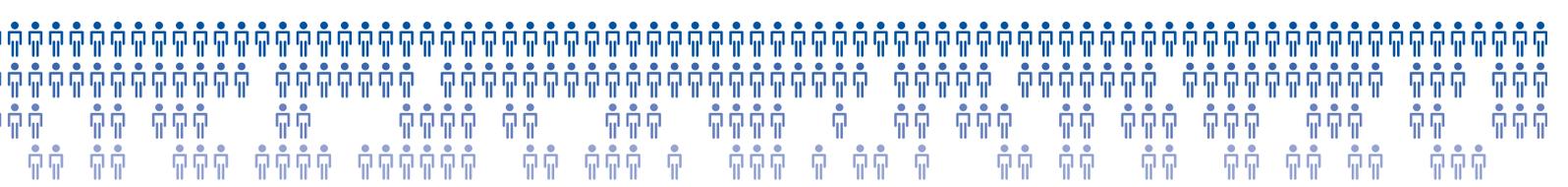
This finding suggests that at least some men having UAI are doing so intentionally and with regard to both their own and their partners HIV status. However, the majority of men who had UAI either had not tested themselves, or did not know that their partner had the same status as themselves. ‘Negotiated safety’ is still a minority practice among these men.

As men with HIV are in the minority, unknown UAI among this group is more likely to be sero-discordant than for men who do not have HIV. Therefore, HIV prevention programmes should prioritise the needs of men with diagnosed HIV infection in order to have maximum impact on incidence (see Section 9.3).

5.1.6 Overall involvement in unknown or sero-discordant UAI

Numbers of sexual partners, the probability of having anal intercourse with each, the probability of not always using a condom when they do, and the knowledge of the HIV status of their UAI partners, all contribute to the likelihood a man has been involved in sexual HIV exposure. When all these measures are collapsed together and we look at whether men engaged in UAI with a partner of unknown or sero-discordant HIV status, we found no evidence that this varies by age, residence, education, occupation, employment or HIV testing history.

Although different sexual behaviours vary in different directions within the demographic categories used in the study, we found little evidence for overall variation in sexual HIV exposure. With no over-riding patterns in sexual HIV exposure evident from the study, targeting specific groups on the basis of their likelihood of involvement in sexual exposure is not possible. This suggests that HIV prevention may best be planned on the basis of unmet need rather than on likelihood of involvement in exposure.



5.2 Condom use and failure

A source of sexual HIV exposure other than UAI is condom failure during protected anal intercourse (PAI). We attempted to measure the proportion of condom users who experienced condom failure. In order not to double count failures, we asked men only about failures while they (rather than their partners) were wearing the condom. We first wanted to establish whether men had used condoms for insertive anal intercourse. We asked: *Have you fucked a man (been the active partner) with a condom in the last year?* Overall, 59.8% said they had.

It is interesting to note that protected anal intercourse is positively associated with unprotected anal intercourse. That is, men who had PAI were more likely to have had UAI than men who had not worn a condom. This is because both UAI and PAI occur in the same men (those who have AI), and that the same men can have both unsafe and safer sex. This suggests condom use is selective.

Men who had worn a condom were asked: *Have any of the condoms you've worn in the last year split or come off while you were fucking?* Overall, 13.4% of men who had worn a condom indicated 'yes' to this question. This is very similar to the 15.7% of condom wearers who had experienced failure in the last year in England (Hickson et al., 1989, p.44).

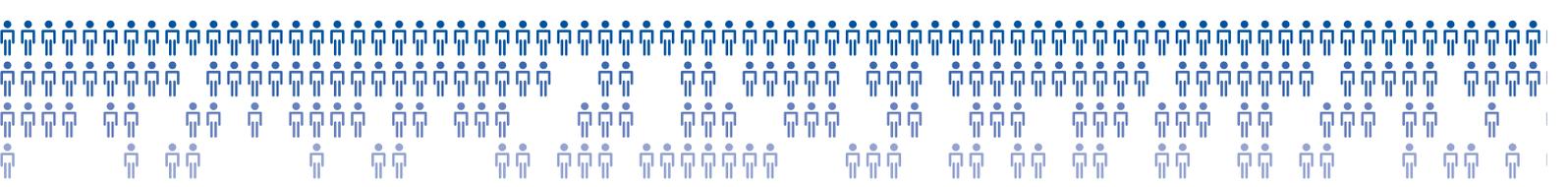
- Over a year period, one in eight condom users experiences some condom failure.

Men who had experienced failure were asked how many times this had happened. Just over half (56%) had one failure only (making the median one, mean=2.2, standard deviation 3.2, n=61, missing 32).

Using a condom in the last year became less common with increasing age. This is at least partly because insertive (as well as receptive) anal intercourse becomes less common with increasing age. Therefore, younger men have more opportunity to experience condom failure than older men because they are more likely to be users. However, among those men who had used condoms, younger men were also more likely to experience failure than older men. Among users, 16.1% of those under 30 experienced failure compared with 9.4% of those 30 or older. Together these differences result in a large difference in experience of condom failure across the age range (Figure 5.2). This may be both because younger men have a higher proportion of condoms fail and because they use them more often.

Age group	<19	20s	30s	40s	50+
n	86	527	357	125	30
no use	40.7	35.3	39.8	53.6	53.3
no failure	46.5	54.8	54.6	41.6	43.3
any failure	12.8	9.9	5.6	4.8	3.3

Figure 5.2: Condom failure



- Most condom failure was experienced by younger men.

This suggests prioritising the condom failure needs of younger men rather than older men, as unmet need in this area is likely to be more hazardous than among older men. Although men in Dublin were more likely to have worn a condom in the last year (63.4% had) than those living elsewhere (55.5%), among users experience of failure did not vary by residence. We found no significant variation in wearing condoms or experiencing failure with either education or occupation.

5.3 Hepatitis B vaccination

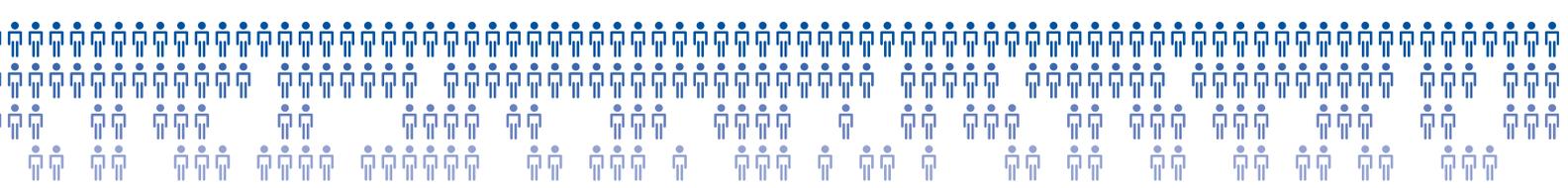
The 1992 survey found 14% of that sample had been vaccinated against Hepatitis B. That report stated that "poor availability of free vaccine and lack of accessible information on Hepatitis B as a sexual health risk may account for this low figure" (GMHP, 1992). Soon after this study the Gay Men's Health Project started proactively informing men of the availability of the vaccine during outreach in gay venues and at their clinic. In 1996 the Gay Health Network with Southern Gay Health Project published and distributed the Hepatitis B information leaflet throughout Ireland and placed adverts in *Gay Community News*.

In the current survey men were asked: ***Have you been vaccinated against Hepatitis B?*** The following table shows the proportions indicating each of five possible answers. We suspect the relatively large number of missing cases on this question (n=275) is a consequence of the questionnaire layout.

Have you been vaccinated against Hepatitis B?	% of total sample (n=1 015)		Susceptibility
No, but I'm naturally immune to Hep B	5.3	43.3	Not susceptible
Yes, I completed the course of vaccine (3 injections)	38.0		
Yes, but I didn't complete the course	8.8	56.4	Susceptible
No, and I don't know whether I'm immune or not	31.1		
Don't know	16.7		

Figure 5.3: Hepatitis B susceptibility status

The proportion of men who indicated having completed a course of vaccination (38%) was much higher than in the 1992 survey (14%), suggesting significant advances in this target. While serial cross-sectional surveys such as these cannot conclusively demonstrate this change to be a result of health promotion activity, the existence of the Gay Men's Health Project in Dublin, and its response to the 1992 survey suggest this increase is a result of the promotion of Hepatitis vaccination and an increase in its availability. That the increase in vaccination uptake is a result of health promotion activity since 1992



is supported by the fact that men in Dublin were more likely to have been vaccinated or to know they were immune (ie. for fewer men to be susceptible to Hepatitis B) than men living elsewhere in Ireland. They were more likely to have completed a course of vaccination (41.7% compared with 33.6%), but were also more likely to have started a course they did not finish (11.3% compared with 5.8%).

Susceptibility also decreased with increasing age. The proportion of men who had been vaccinated peaked among men in their 30s and 40s (16.0%, 35.0%, 45.6%, 44.3% and 33.3% among men in their teens, 20s, 30s, 40s and 50 plus respectively) and the proportion of men who knew they were naturally immune increased up the age range (1.3%, 4.4%, 4.6%, 10.4% and 22.2% respectively). This suggests interventions intended to increase Hepatitis B vaccination uptake would be most efficient if directed towards younger men.

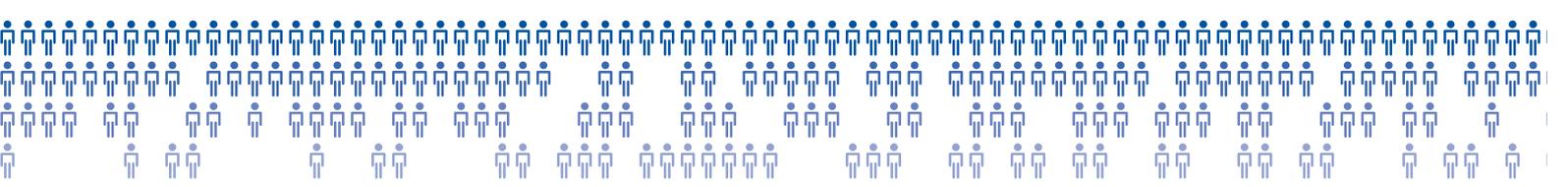
As with some other variables, it was the middle education group who stood out from those with either lower or higher education. Fewer men in the middle group had been vaccinated (30.1%) than the other two. We found no evidence for an association between occupation and vaccination.

- Over half the men (56%) are not benefiting from Hepatitis B vaccinations, and this was higher among men outside rather than in Dublin, and among younger rather than older men.

This suggests that in order to reduce inequalities in Hepatitis B vaccination, interventions reducing need related to vaccinations should prioritise men living outside Dublin, and younger rather than older men.

5.4 *Recency of check-up for sexually transmitted infections*

All sexually active men are liable to come into contact with sexually transmitted infections, the probability of doing so being related to the volume of sexual partners men have. The frequency with which men who pick up STIs go for an STI screening will determine the average length of time they have their infection untreated, and subsequently how many other men they will pass their infection on to. In a cross-sectional survey, the recency with which men had an STI screen can be used as a population parameter. In the current survey men were asked: ***When was the last time you had a check-up for sexually transmitted infections (STI's)?*** (missing = 90). They were asked to indicate either never or one of five time bands. The proportion indicating each answer is shown in the table below, which also shows the proportions for men with different numbers of sexual partners.



When was the last time you had a check-up for sexually transmitted infections (STIs)?	% of total sample (n=1 200)	% by number of sexual partners in the last year					
		none (n=34)	one (n=204)	2,3 or 4 (n=251)	5 to 12 (n=309)	13 to 29 (n=125)	30+ (n=110)
I've never had a check-up	34.0	58.8	44.6	39.4	33.0	19.2	13.6
More than five years ago	6.2	2.9	10.6	6.8	3.9	7.2	3.6
More than a year ago but less than five years	22.0	23.5	23.5	17.9	22.7	22.4	25.5
Within the last year but not in the last month	28.3	8.8	16.2	26.3	30.4	40.8	40.9
Within the last month	9.6	5.9	5.4	9.6	10	10.4	16.4

Figure 5.4: Recency of check-up for sexually transmitted infections by number of sexual partners

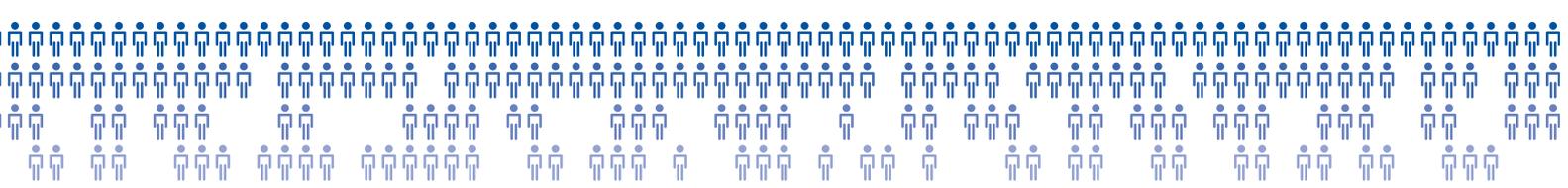
Overall, 66.0% of men had experience of an STI check-up. (Of the 34.0% who had never had a check-up, only 5.6% had no sexual partners in the last year). Ever having had a check-up was increasingly common among men with larger numbers of sexual partners: 41.2% of those with no sexual partners in the last year had ever had one compared with 86.4% of men with 30 or more partners. However, this means that 13.6% of men with 30 or more sexual partners in the last year had never been for a STI check-up.

Over a third (37.9%) had been for a check-up within the last year, and again this rose steadily from 14.7% of those with no sexual partners in the last year through 21.6% of those with one partner, 35.9% of those with two to four, 40.4% of those with five to twelve, 51.2% of those with thirteen to 29 partners and 57.1% of those with 30 or more. We cannot tell from this question whether men were attending with symptomatic infections acquired as a result of higher numbers of partners, or whether men with higher numbers of partners are more likely to engage in preventative STI screening.

Men living in Dublin were significantly more likely to have had an STI check-up in the last year (42.0% had) compared with men who lived elsewhere in Ireland (34.4% had). We found no evidence for an association between STI check-up behaviour and either age, education or employment.

- Most men (57%) with more than one sexual partners in the last year had not been for an STI screening.

While men with large numbers of partners were more likely to attend, it is also likely they had picked up an STI and therefore had greater need for attendance. These findings suggest considerable work could be directed at increasing the frequency with which men attend for STI screening, and that this work could target all men with multiple partners. Needs related to STI screenings could include knowledge of STIs and screening services,



confidence in attending, awareness of when attendance is most pressing (ie. after multiple partner change), the existence of geographically accessible screening services which clearly value gay and bisexual attenders and which are sensitive to their sexual lifestyles and sexual health needs.

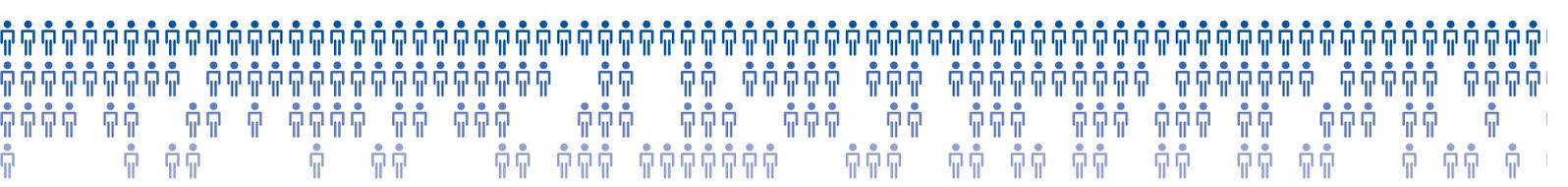
5.5 Recreational drug use

It is widely recognised that effective HIV prevention and sexual health work engages with the reality of men's lives and works with where they are at. We include drug use here in the sample description as drugs are often part of gay men's lives and we are describing the men that HIV prevention engages and works with.

Men were asked: *In the last year, which drugs have you used recreationally?* and were given a list of thirteen drugs to tick (including alcohol). The list was headed with the option 'I haven't used any recreational drugs'. This was ticked by 12.3% (n=1 269, missing 21). The following table shows the proportion of men who indicated having taken each of the drugs in the last year. For comparison, the findings of an identical question from England's 1999 Gay Men's Sex Survey are also given.

In the last year, which drugs have you used recreationally? (* indicates significantly higher prevalence)	% of total sample (n = 1 269) (missing 21)	% by residence		England Gay Men's Sex Survey 1999 (Weatherburn et al. 2000, n=9 007)
		Dublin (n=671)	Elsewhere (n=598)	
alcohol	79.7	81.2	77.9	82.4
poppers	38.6	40.4	36.6	48.4
cannabis	32.5	* 35.8	28.8	35.5
ecstasy	25.1	* 28.2	21.7	19.2
cocaine	14.0	* 17.3	10.4	15.0
speed	12.4	13.9	10.7	19.8
acid/LSD	5.2	5.5	4.8	6.6
ketamine	4.7	5.2	4.2	5.0
Viagra	4.1	4.2	4.0	3.6
GHB/GBH	2.5	2.4	2.7	3.4
crack cocaine	2.5	2.2	2.8	1.6
heroin	2.0	2.1	2.0	0.9
steroids	1.8	1.3	2.3	1.4
other	1.5	1.2	1.8	1.9

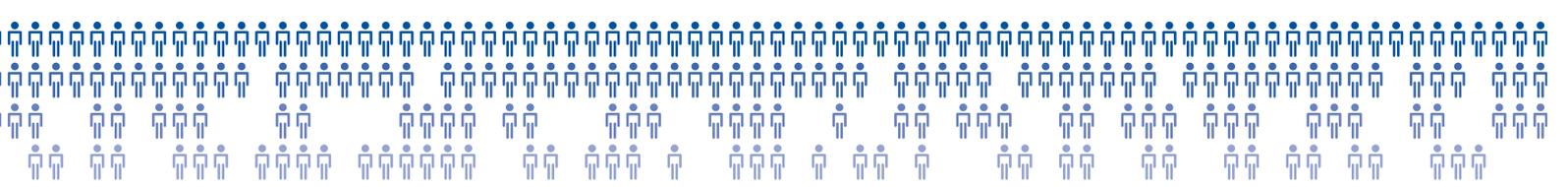
Figure 5.5: Drugs used



Excluding alcohol, Viagra and steroids, 55% of men had used at least one of the above drugs in the last year. The prevalence of individual drugs used by gay men in Ireland is very similar to that in England. Perhaps unsurprisingly given its legality and availability, alcohol is the most popular drug with four out of five men having used it in the last year. Poppers (Amyl/Butyl Nitrate) is the next most common drug in both countries (although in these data they are less common in Ireland than in England), with cannabis the third most popular. Use of three drugs was significantly more common among men living in Dublin than men living elsewhere: cannabis, ecstasy and cocaine. All other drugs were equally common among men in the Dublin and elsewhere, suggesting recreational drugs are not solely a large city habit.

- Recreational drug use among gay and bisexual men in Ireland is common.

As well as being part of the context in which HIV prevention and sexual health promotion work takes place, these data also suggest that problems with recreational drug use may not be uncommon. However, the survey did not ask about drugs problems directly and these data point to the need for a detailed investigation into drug use and related problems among gay and bisexual men in Ireland.



6. HIV prevention needs

HIV prevention needs can be thought of as an aim of intervention that is not already met. The indicators of need used in the survey were determined by what the aims of GHN interventions are. Through their work, GHN hopes to ensure that men are knowledgeable about HIV, that they have access to condoms and lubricants and have the skills and confidence to use them, that they are not socially excluded and enjoy the support of a social network, etc. The indicators of need are therefore attempting to assess the extent to which these aims are not true for respondents.

6.1 Sexual assertiveness

In order to have control over sex and safer sex men must have the interpersonal skills to negotiate sex. This includes being sufficiently assertive to say no to unwanted or risky sex. Men were asked to agree or disagree with a statement about sexual assertiveness.

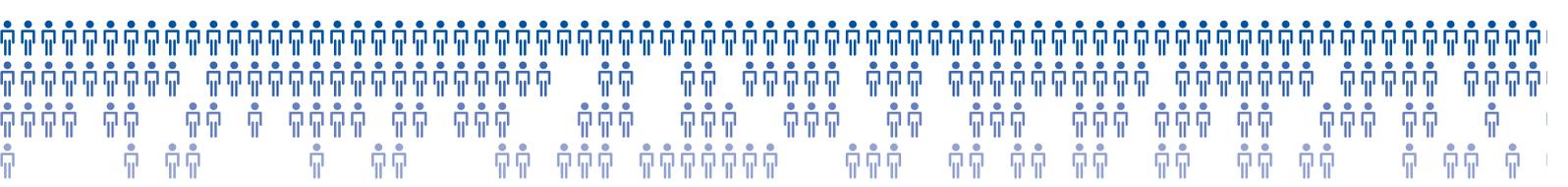
'Indicate whether you disagree or agree with the following statements by circling a number from 1 to 5 ' (N= 1 147 missing 143)	disagree					agree
	1	2	3	4	5	
'I find it easy to say 'no' to sex I don't want'	16.7	7.4	13.0	12.1	50.7	

Figure 6.1: Indicator of need for sexual assertiveness

Overall, 24.1% disagreed with the statement, indicating unmet HIV prevention need around sexual assertiveness. The majority of those men disagreed strongly, indicating that their unmet need is severe. Assertiveness is a quality that it is not easy to impart to men - it is not increased by a leaflet for example, although it can be realistically increased with assertiveness training in groups (Hickson & Boxford, 1999). This means this level of lack of sexual assertiveness in the population will require considerable resources to address.

- Sexual assertiveness is an unmet HIV prevention need for a quarter of men.

Indicating unmet need with regard to sexual assertiveness was significantly more common among older men (those aged 50 or over, see Section 6.7.2 below). This suggests that an intervention which aims to increase assertiveness may be of particular advantage to older men.



6.2 Access to condoms

Condoms are widely available from chemists, shops and dispensers in bars and clubs in cities, but are less commonly available in other areas. Free condoms may be supplied to an individual by health boards and STI clinics if "they are supplied to that person for the purpose of preventing HIV or any other sexually transmitted disease", Health (Family Planning Act) Regulation 1992, (S.I. no.312 of 1992)". The National AIDS Strategy Committee in *AIDS Strategy 2000* recommended that "health boards throughout the country address the issue of condom availability to NGOs for distribution free of charge" (NASC, 2000, p41).

It is an aim of HIV prevention activities that all gay and bisexual men have access to condoms.

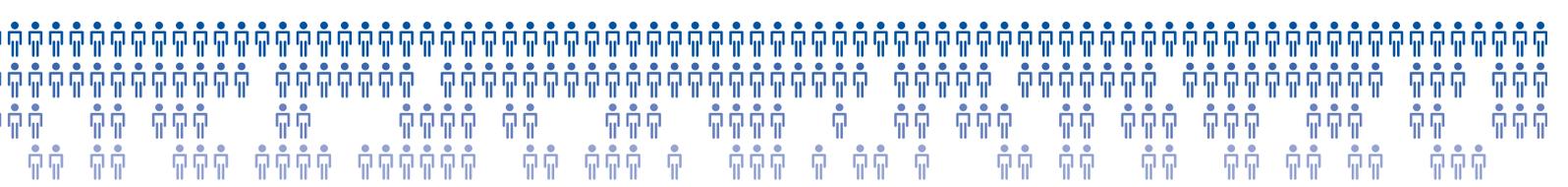
'Indicate whether you disagree or agree with the following statements by circling a number from 1 to 5 ' (N= 1 131 missing 159)	disagree				agree
	1	2	3	4	5
'I sometimes have a problem getting hold of condoms'	78.0	7.1	6.6	3.2	5.1

Figure 6.2: Indicator of need for access to condoms

Access to condoms is high. Overall, only 8.3% of men indicated problems getting hold of them. This suggests that the majority of need around access to condoms is being met with the interventions currently in place. Access to condoms was not associated with sexual assertiveness.

- One in twelve men has unmet need around access to condoms.

This need was significantly more commonly unmet outside Dublin than among men living in Dublin (see Section 6.7.1).



6.3 Condom use confidence

Confidence in using condoms has been shown to be associated with lower levels of condom failure (Golombok, Harding and Sheldon, 2000). Feeling confident and relaxed about using condoms may also make it more likely men will use them, fear of failure being a disincentive to do so. HIV prevention aims for men to be able to use condoms and to be comfortable doing so. An indicator of HIV prevention need is therefore men not being confident about condom use.

'Indicate whether you disagree or agree with the following statements by circling a number from 1 to 5 ' (N= 1 137 missing 153)	disagree					agree
	1	2	3	4	5	
'I feel confident about using condoms myself'	18.0	5.4	12.0	8.8	55.8	

Figure 6.3: Indicator of need for confidence in condom use

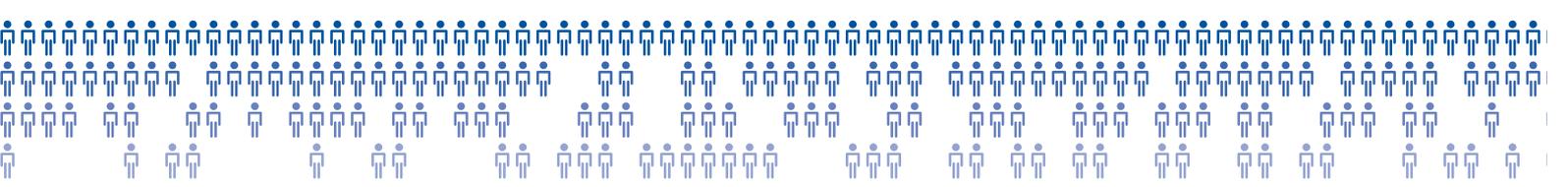
Overall, 23.4% of men indicated unmet need around condom confidence, the majority of them indicating severe need. While access to condoms appears a problem for few men, lack of confidence in using them is far more widespread. As with assertiveness, skills in using condoms are not amenable to simple interventions and probably require more than, for example, a leaflet to acquire. Confidence in using condoms was associated with both access to them and general sexual assertiveness. Men who had problems accessing condoms were less likely to feel confident about their use, as were men who found it difficult to say 'no' to unwanted sex.

- Confidence in using condoms was a far more commonly unmet need than access to condoms.

This need was equally unmet across all the demographic variables that we looked at (age, HV testing history, education, employment and residence).

6.4 Social support

The Prevention and Education sub-Committee of the National AIDS Strategy Committee has recently recommended that "further integration into mainstream programmes of responses to gay disadvantage . . . would be of great benefit to HIV prevention programmes" (NASC, 2000, p.42). Social isolation can both be a cause of mental ill-health and can make physical illness more likely by reducing the probability people will have their health needs met by their social networks. In the context of HIV prevention and sexual health promotion, social networks have historically been a central source of knowledge and awareness about both sexual hazards and health services.



'Indicate whether you disagree or agree with the following statements by circling a number from 1 to 5 ' (N= 1 148 missing 142)	disagree					agree
	1	2	3	4	5	
'I sometimes feel lonely'	19.7	13.8	25.5	17.0	24.0	

Figure 6.4: Indicator of need for social support

Overall, 41% agreed that they sometimes felt lonely. This is less than the 63% of men who agreed with the same statement in England (Weatherburn et al., 2000). Loneliness was not associated with access to condoms, confidence in their use or general sexual assertiveness.

- Social support and integration is a commonly unmet HIV prevention need across all groups.

Social integration and support have been identified as key determinants of ill health by the World Health Organisation across a range of diseases. They have concluded that "in all areas of personal and institutional life, practices should be avoided that cast others as socially inferior or less valuable" (WHO, 1998, p.19). Given the discriminatory context in which all gay and bisexual men live their lives, and the extent of social isolation demonstrated in this survey, building community infrastructures may be a particularly fruitful area for health promotion with this group.

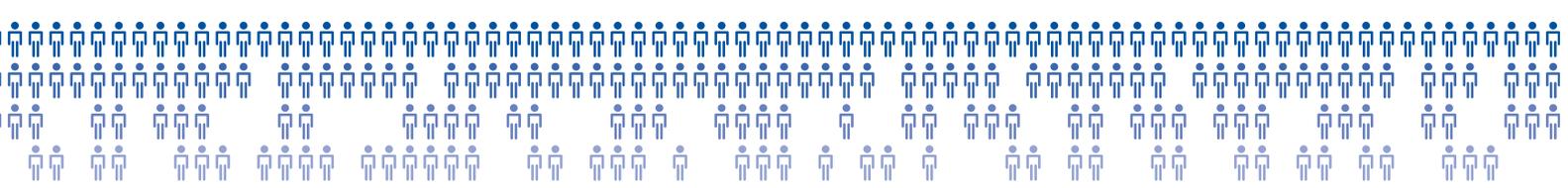
6.5 Self-worth

The consequences of discriminatory practices include not only social isolation but also other social determinants of ill health such as stress and feelings of low self-worth.

'Indicate whether you disagree or agree with the following statements by circling a number from 1 to 5 ' (N= 1 124 missing 166)	disagree					agree
	1	2	3	4	5	
'I wish I wasn't attracted to men'	68.4	9.8	9.9	4.3	7.7	

Figure 6.5: Indicator of need for self-worth

Given these men were recruited on the gay scene we might expect them to be more confident about their sexuality than other homosexually active men. Regretting homosexual desire was not associated with access to condoms, confidence in their use or general sexual assertiveness. It was associated with being lonely. Of those men who agreed they wish they were not attracted to men 56% indicated they were sometimes lonely compared with 39% of those who had no such regret ($p < .05$). Conversely, 8% of those who



were not lonely regretted their desire compared with 16% of those who were sometimes lonely. These data can tell us nothing about a causal relationship between these two needs, simply that they are likely to be found in the same men. We suspect they are each supporting of the other (men who regret their desire are less likely to form a supportive social network and men who are lonely are more likely to regret their desire) and that both are generated by living in a discriminatory climate.

- One in ten men (12.0%) agreed that they wish they were not attracted to men.

Regretting their attraction to men was significantly more common among men with lower levels of formal education (see Section 6.7.3) who may have fewer resources with which to challenge the discrimination they experience on a day to day basis.

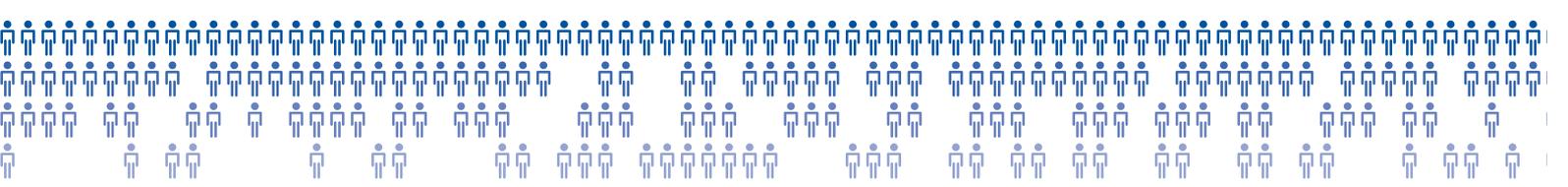
6.6 HIV knowledge

The relationship between knowledge about HIV and sexual behaviour is complex. It is often stated that 'knowledge' about HIV among gay men is high (or very high), and that lack of knowledge accounts for very little 'unsafe sex'. However, this may simply mean men know how to recite the 'safer sex rules', and this is different from being educated about HIV infection. The current survey gave men ten items of information about HIV and asked men whether they already 'knew this', they were 'not sure' or they 'didn't know' this was the case. The question was designed in this way (rather than a mixture of true/false statements) so that men would not be misled. The following table shows the proportions giving each response and the proportion who left the answer blank.

The proportion of men who indicated they knew each item varied. Although most men knew HIV infection is not always apparent, one in twenty (5.8%) did not know that 'men can have HIV without knowing it'. The least known fact was that 'not all people with HIV infection benefit from anti-HIV drugs'. A third of men (31.7%) did not know this simple fact.

- Knowledge about HIV, its prevention and treatment is variable.

Several knowledge items significantly varied across demographic groups, and where they did they were more likely to be unmet among men living outside rather than inside Dublin (Section 6.7.1), younger rather than older men (Section 6.7.2), those with lower levels of formal education (Section 6.7.3), unemployed men (Section 6.7.4) and those who had never tested for HIV (Section 6.7.5).

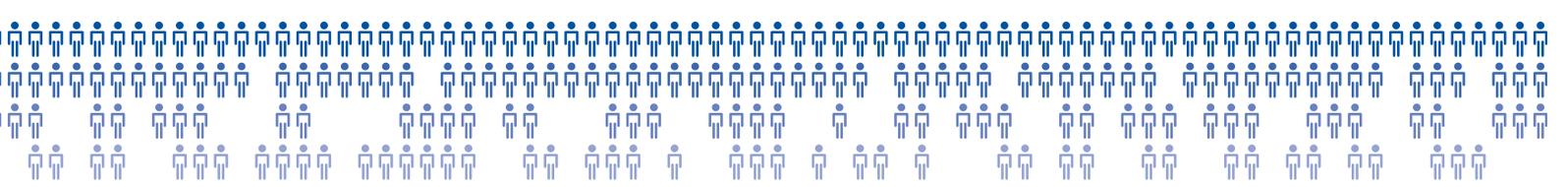


'All of the following statements are true, did you know this already?' (N=1 215, missing 75 men who answered none of the knowledge items)	% Responses			% Left this item blank
	Knew this	Not sure	Didn't know	
Men can have HIV without knowing it	94.2	3.1	2.2	0.5
Drugs cannot get rid of HIV infection once someone has it	91.5	4.9	1.9	1.6
An HIV negative man can pick up HIV by fucking an HIV positive man without a condom	88.2	7	2.4	2.4
Condoms are very good at preventing HIV being transmitted when HIV negative and positive men fuck together	85.8	9.7	1.8	2.7
Condoms are less likely to break if you use a water - based lubricant	83.7	9.1	4.6	2.6
When fucking an HIV negative man without a condom, an HIV positive man is more likely to pass on HIV infection if he does ejaculate (cum) in his partner	80.7	11.4	4.8	3.1
Using oil-based lubricants with condoms increases the chances of condoms breaking	78.8	10.6	7.8	2.8
Even if he does not ejaculate (cum), an HIV positive man can pass on HIV infection through fucking an HIV negative man	78.3	12.8	6.4	2.6
An HIV negative man is more likely to pick up HIV by getting fucked by an HIV positive man than by fucking him	77.6	14.2	5.7	2.6
Not all people with HIV infection benefit from anti-HIV drugs	68.3	18.8	10.6	2.2

Figure 6.6: Indicators of need for knowledge

6.7 Demographic differences in need

This section looks at how the preceding indicators of need varied across the demographic groups. In the following tables, the proportion of men in need is shown for each group. Where there is a statistically significant ($p < .05$) difference, the group with the highest level of unmet need has been shaded. This means a group who shows more need relative to other groups across a number of indicators will appear in the table as a shaded column.



6.7.1 Residence

The table below shows how the indicators of need differed between men living in Dublin and those living elsewhere.

Four of the indicators of knowledge varied by residence as did one other indicator and all five showed more need outside Dublin. Men living outside Dublin were significantly more likely to express problems with access to condoms than men living in Dublin. They were also less likely to know about the benefits of water-based lubricant and the relative dangers of ejaculation in the body during UAI.

- HIV prevention needs are more commonly unmet outside of Dublin.

At a national level, interventions are more pressingly needed outside Dublin.

Indicators of need (* knowledge items show % who did not already know this or were not sure)	% in need by residence	
	Dublin (n=655)	Elsewhere (n=560)
I [don't] find it easy to say 'no' to sex I don't want	23.6	24.9
I sometimes have a problem getting hold of condoms	6.1	* 10.9
I [don't] feel confident about using condoms myself	22.7	24.3
I sometimes feel lonely	38.9	43.7
I wish I wasn't attracted to men	11.5	12.5
Men can have HIV without knowing it	4.7	7.1
Drugs cannot get rid of HIV infection once someone has it	7.8	9.3
An HIV negative man can pick up HIV by fucking	11.1	12.5
A negative man is more likely to pick up HIV getting fucked	20.8	24.3
A positive man can pass on HIV without ejaculating	18.6	* 25.4
A positive man is more likely to pass HIV if he ejaculates	16.8	* 22.1
Condoms are very good at preventing HIV	12.8	15.9
Condoms break less if you use a water-based lubricant	14.4	* 18.6
Oil-based lubricants increase condoms breaking	19.4	23.4
Not all people with HIV infection benefit from anti-HIV drugs	30.8	32.7

Figure 6.7.1: Variation in needs by residence

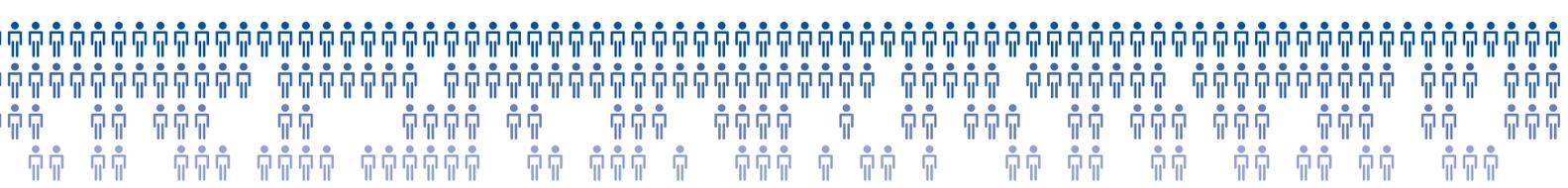
6.7.2 Age

The table below shows how the indicators of need differed across the age range.

Five indicators varied significantly by age, usually indicating younger men to be in more need. However, it is also interesting to note that several indicators of need rise again among the over 50s. This pattern of need across age has also been observed in England (Hickson et al, 1999; Weatherburn et al., 2000).

Indicators of need (* knowledge items show % who did not already know this or were not sure)	% in need by age				
	<19 (n=94)	20s (n=558)	30s (n=379)	40s (n=124)	50+ (n=30)
I [don't] find it easy to say 'no' to sex I don't want	24.4	24.7	20.7	27.7	* 48.0
I sometimes have a problem getting hold of condoms	15.2	8.7	6.6	6.2	3.8
I [don't] feel confident about using condoms myself	23.1	21.6	22.0	33.9	29.6
I sometimes feel lonely	47.3	38.5	42.7	46.2	37.9
I wish I wasn't attracted to men	17.6	12.1	11.3	6.3	7.4
Men can have HIV without knowing it	* 12.8	4.5	5.3	4.0	6.7
Drugs cannot get rid of HIV infection once someone has it	3.2	7.0	10.8	8.1	6.7
An HIV negative man can pick up HIV by fucking	18.1	11.1	11.3	8.1	16.7
By negative man is more likely to pick up HIV getting fucked	26.6	24.6	19.0	16.9	23.3
A positive man can pass on HIV without ejaculating	29.8	21.3	17.9	22.6	33.3
A positive man is more likely to pass HIV if he ejaculates	* 30.9	19.2	17.2	14.5	20.0
Condoms are very good at preventing HIV	18.1	14.5	11.9	11.3	20.0
Condoms break less if you use a water - based lubricant	* 24.5	19.0	11.9	9.7	13.3
Oil-based lubricants increase condoms breaking	28.7	21.7	18.2	18.5	23.3
Not all people with HIV infection benefit from anti-HIV drugs	* 38.3	34.1	27.7	23.4	* 36.7

Figure 6.7.2: Variation in needs across the age range

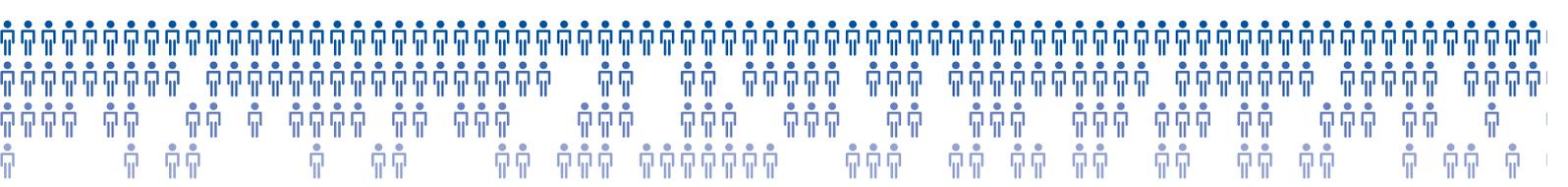


Interestingly, it was older men, those over 50, who were most likely to indicate they had difficulty saying 'no' to unwanted sex. Problems with condom access and homosexual regret appear to be more common amongst younger men, although neither of these differences was statistically significant.

While almost all men knew it is possible to have HIV infection without knowing it, more than one-in-ten (12.8%) of young gay men (those under 20) did not know this. This finding underlines the need for on-going basic education about HIV infection. The biology of HIV is not self-evident and young men need basic education to equip them to deal with this major hazard in their lives.

- Most indicators suggest greater unmet need among younger men, although older men show more unmet need around sexual assertiveness.

An HIV prevention programme should therefore disproportionately benefit younger men, possibly with some tailored interventions for older men.



6.7.3 Education

The table below shows how the indicators of need differed across the three education groups.

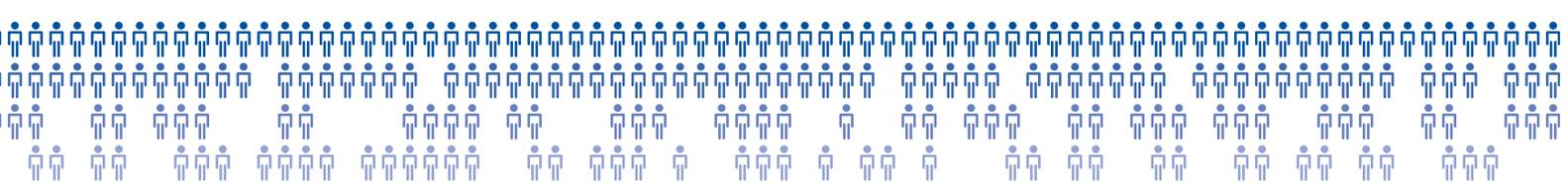
Indicators of need (*knowledge items show % who did not already know this or were not sure)	% in need by education		
	low (n=152)	medium (n=237)	high (n=739)
I [don't] find it easy to say 'no' to sex I don't want	30.8	26.2	22.0
I sometimes have a problem getting hold of condoms	10.4	9.6	7.0
I [don't] feel confident about using condoms myself	30.4	26.0	21.7
I sometimes feel lonely	49.6	42.9	39.0
I wish I wasn't attracted to men	* 18.7	11.1	10.7
Men can have HIV without knowing it	* 11.2	5.9	3.7
Drugs cannot get rid of HIV infection once someone has it	* 12.5	9.7	6.0
An HIV negative man can pick up HIV by fucking	* 17.8	14.3	8.9
A negative man is more likely to pick up HIV getting fucked	* 28.9	26.6	18.5
A positive man can pass on HIV without ejaculating	* 27.0	24.5	19.1
A positive man is more likely to pass HIV if he ejaculates	* 28.9	21.9	15.8
Condoms are very good at preventing HIV	* 23.0	11.8	12.0
Condoms break less if you use a water-based lubricant	* 21.7	16.0	13.4
Oil-based lubricants increase condoms breaking	* 32.2	24.1	17.2
Not all people with HIV infection benefit from anti-HIV drugs	36.2	33.8	29.5

Figure 6.7.3: Variation in needs by education

Ten of the fifteen indicators showed significantly greater unmet need among men with lower education compared to men with higher education, and the other five indicators showed trends in the same direction. Men with lower education were more likely to regret their sexual attraction to men, as well as (perhaps less surprisingly) being less likely to know many of the basic facts about the biology of HIV transmission.

- Men with lower levels of formal education consistently show more unmet need than men with higher education.

Clearly, any HIV prevention programme should be designed to disproportionately benefit men with lower levels of education.



6.7.4 Employment

The table below shows how the indicators of need differed across the three employment groups.

Indicators of need (*knowledge items show % who did not already know this or were not sure)	% in need by employment		
	full-time employed (n=869)	full-time student (n=116)	unemployed (n=77)
I [don't] find it easy to say 'no' to sex I don't want	22.5	27.6	31.8
I sometimes have a problem getting hold of condoms	7.5	11.2	14.5
I [don't] feel confident about using condoms myself	22.8	25.0	24.6
I sometimes feel lonely	39.7	42.1	45.6
I wish I wasn't attracted to men	10.8	14.2	17.5
Men can have HIV without knowing it	4.8	6.0	* 14.3
Drugs cannot get rid of HIV infection once someone has it	8.5	2.6	* 14.3
An HIV negative man can pick up HIV by fucking	9.9	13.8	* 27.3
A negative man is more likely to pick up HIV getting fucked	21.2	19.0	* 35.1
A positive man can pass on HIV without ejaculating	19.9	20.7	* 36.4
A positive man is more likely to pass HIV if he ejaculates	18.9	17.2	29.9
Condoms are very good at preventing HIV	13.5	11.2	* 28.6
Condoms break less if you use a water-based lubricant	15.4	11.2	* 26.0
Oil-based lubricants increase condoms breaking	19.8	18.1	29.9
Not all people with HIV infection benefit from anti-HIV drugs	30.0	30.2	42.9

Figure 6.7.4: Variation in needs by occupation

Seven indicators varied by employment. All were knowledge indicators showing greater unmet need among unemployed men compared with those in full-time employment or education. Large proportions of men were ignorant of some of the basic facts of the biology of HIV transmission. Since unemployment is strongly associated with lower levels of education, these findings should not be surprising. However, among only those men with higher education, those who were unemployed were significantly less likely to know several of the items, so it appears there are two mechanisms in operation.

- Men who are unemployed are often have more unmet HIV prevention need than those in employment.

This suggests HIV prevention programs should include interventions targeted at unemployed men. This should also contribute to the objective of ensuring men with lower levels of education encounter interventions and vice versa.

6.7.5 HIV testing history

The table below shows how the indicators of need differed across the three testing history groups.

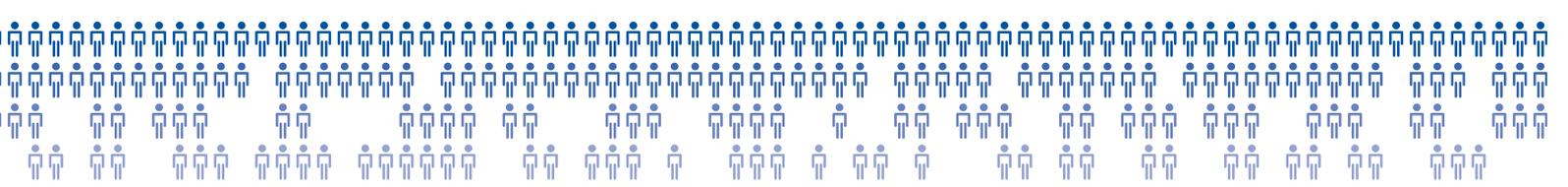
Indicators of need (* knowledge items show % who did not already know this or were not sure)	HIV testing history		
	never tested (n=514)	last test negative (n=707)	tested positive (n=38)
I [don't] find it easy to say 'no' to sex I don't want	25.0	23.2	20.0
I sometimes have a problem getting hold of condoms	8.4	7.3	16.2
I [don't] feel confident about using condoms myself	25.1	22.2	19.4
I sometimes feel lonely	38.4	42.7	48.6
I wish I wasn't attracted to men	13.3	10.8	14.7
Men can have HIV without knowing it	* 8.5	4.0	5.6
Drugs cannot get rid of HIV infection once someone has it	10.7	7.0	8.3
An HIV negative man can pick up HIV by fucking	11.8	11.3	13.9
A negative man is more likely to pick up HIV getting fucked	* 28.9	17.8	13.9
A positive man can pass on HIV without ejaculating	* 27.3	18.2	16.7
A positive man is more likely to pass HIV if he ejaculates	* 25.2	15.2	13.9
Condoms are very good at preventing HIV	14.7	14.0	8.3
Condoms break less if you use a water-based lubricant	* 20.7	12.7	16.7
Oil-based lubricants increase condoms breaking	* 27.3	16.9	11.1
Not all people with HIV infection benefit from anti-HIV drugs	* 38.2	27.6	25

Figure 6.7.5: Variation in needs by HIV testing history

Seven of the knowledge indicators showed differences across testing history and for all seven it was men who had never tested who were in greatest need of information. The process of testing is a time when men may increase their knowledge or it could be that knowledgeable men are more likely to test. Either way:

- In terms of knowledge, men who had never tested for HIV were usually in more need than those who had tested.

This suggests the strong need for educational interventions outside the clinic setting both for those men who choose not to test, and to increase the knowledge men have about the testing process itself which instigates testing behaviours.



7. Use of health promotion settings

The previous chapters concluded that an HIV prevention programme for gay men should prioritise different HIV prevention needs for different groups of men. In order to increase the likelihood that interventions are disproportionately encountered by priority target groups, it is helpful to know about the places men go where they may encounter them. Obviously, the places in which the sample was recruited will influence these findings.

7.1 Overall use of settings

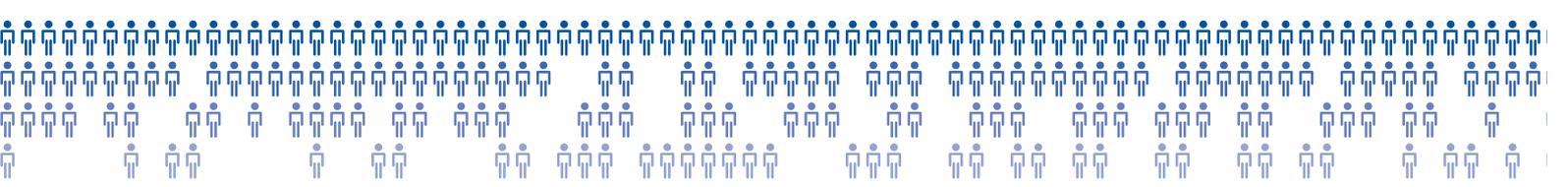
Men were asked to indicate which of twelve settings they had used in the last year. The settings were chosen on the basis that they are places in which HIV prevention interventions could occur.

In the last year have you...?	% of total sample (N=1 290)
Been to a gay pub or club	80.7
Read <i>Gay Community News</i>	80.6
Read any other gay press	63.8
Been to your GP (family doctor)	50.2
Been to a gay social group	26.8
Been to a gay community centre	25.4
Been to the drop-in clinic (GMHP)	19.0
Been to a sexual health (STI) clinic	18.7
Used an AIDS organisation	10.9
Phoned a Gay Helpline	7.1
Been to a bisexual group	4.1
Phoned a HIV/AIDS Helpline	2.6

Figure 7.1: Use of health promotion settings in total sample

The most commonly used setting where HIV prevention interventions could occur were gay pubs and clubs with four out of five men using them in the last year. That not all men use this setting confirms the need for multi-intervention prevention programmes which utilise a variety of settings, even for an out, gay-identified population of homosexually active men. The gay press, in particular *Gay Community News*, is seen by as many men as visit bars and clubs. Interventions in the press will be seen by a large proportion of men.

- Interventions that take place in gay community settings will be encountered by large proportions of gay men.



There are twelve lesbian, gay and bisexual helplines in the Republic of Ireland and two in Northern Ireland, of which the largest is Dublin Gay Switchboard, which takes approximately 4 000 calls per year. In 1998, these switchboards between them took approximately 14 000. Overall, 8.4% of respondents had phoned either a gay or HIV helpline in the last year with gay helplines being used by more men (7.1%) than HIV helplines (2.6%). Over half (56%) of those who had used an HIV helpline had also used a gay helpline.

7.2 Demographic differences in use of settings

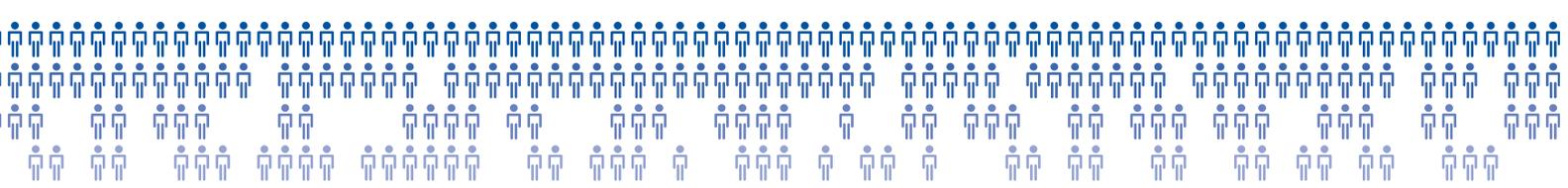
7.2.1 Type of area

To look at differences in use of settings by residence we have looked at the type of place men said they lived (see Section 3.2). Those indicating 'village' or 'rural area' were grouped together and compared to those indicating 'city' or 'town'. The following table shows the proportion of men in each group who used each of the settings in the preceding year.

In the last year have you...?	% of total sample (N=1 290)	% by type of area lived in		
		city (n=1 007)	town (n=150)	village / rural area (n=124)
Been to a gay pub or club	80.7	* 83.2	68.7	75.0
Read <i>Gay Community News</i>	80.6	* 83.4	72.0	69.4
Read any other gay press	63.8	* 66.8	48.7	58.9
Been to your GP (family doctor)	50.2	51.0	46.0	49.2
Been to a gay social group	26.8	27.4	24.7	25.0
Been to a gay community centre	25.4	* 27.7	19.3	15.3
Been to the drop-in clinic (GMHP)	19.0	* 21.4	12.0	8.1
Been to a sexual health (STI) clinic	18.7	* 20.3	14.0	12.1
Used an AIDS organisation	10.9	11.6	7.3	9.7
Phoned a Gay Helpline	7.1	6.2	10.0	* 11.3
Been to a bisexual group	4.1	4.1	2.7	6.5
Phoned a HIV/AIDS Helpline	2.6	2.7	2.0	3.2

Figure 7.2.1: Use of health promotion settings by type of area lived in

Use of six settings varied by residence. Five were more likely to be used by men who lived in a city compared with men who lived elsewhere. Not surprisingly, the GMHP Drop-in Clinic and the gay community centre which are located in Dublin were visited by more of the men living in cities than elsewhere (and more again of only those men who live in Dublin: 28.0% used the Drop-in, 30.7% used the community centre). However,



the figures also suggest a sizable minority of men living outside Dublin are willing to travel there to use these settings. Men in cities were more likely to use gay pubs and clubs. As this is where gay community newspapers are distributed, being less likely to use the pubs also results in being less likely to see the gay press. Only one setting was more commonly used by men living away from larger conurbations. Gay helplines (but not HIV/AIDS helplines) were more commonly used by men in villages and rural areas.

- Men living outside cities are less likely to use gay community settings in which many HIV prevention interventions occur.

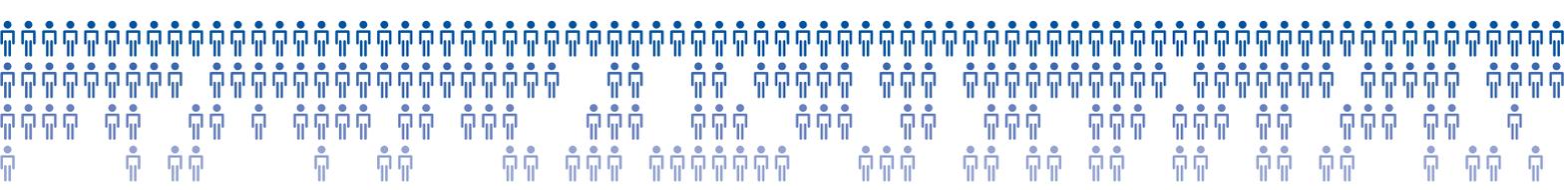
This suggests HIV prevention programmes in rural and semi-rural areas may have to use a larger diversity of settings for interventions to cover the same proportion of the population. This conclusion and implication underlines the observation that HIV prevention activity is more expensive (per man serviced) in areas with less gay community infrastructure and a smaller or non-existent commercial scene.

7.2.2 Age

The following table presents the proportions of each age group who indicated they had used each setting in the previous year.

In the last year have you...?	% of total sample (N=1 290)	% by age group				
		< 19 (n=98)	20s (n=593)	30s (n=399)	40s (n=135)	50+ (n=31)
Been to a gay pub or club	80.7	79.6	81.3	84.2	73.3	83.9
Read <i>Gay Community News</i>	80.6	<u>64.3</u>	82.5	81.5	82.2	83.9
Read any other gay press	63.8	58.2	63.9	68.9	57.8	54.8
Been to your GP (family doctor)	50.2	41.8	48.4	54.6	49.6	71.0
Been to a gay social group	26.8	20.4	24.8	30.3	31.1	29.0
Been to a gay community centre	25.4	<u>21.4</u>	<u>19.6</u>	32.6	31.1	35.5
Been to the drop-in clinic (GMHP)	19.0	14.3	19.4	19.8	20.7	19.4
Been to a sexual health (STI) clinic	18.7	9.2	19.2	20.3	19.3	22.6
Used an AIDS organisation	10.9	9.2	11.0	11.8	10.4	6.5
Phoned a Gay Helpline	7.1	11.2	7.1	7.5	5.2	0.0
Been to a bisexual group	4.1	2.0	4.4	3.8	4.4	6.5
Phoned a HIV/AIDS Helpline	2.6	2.0	3.2	2.3	2.2	0.0

Figure 7.2: Use of health promotion settings by age group



We found evidence for use of three settings varying by age. Younger men (i.e. those under 20 years) were less likely to read *Gay Community News* than other age groups. Use of a GP and use of the community centre increased with age. Although not statistically significant, it is interesting to note that using a gay helpline became less common with increasing age - none of the 31 older men in the 50+ age group had used one.

- Interventions which are intended to disproportionately benefit older men (such as assertiveness training) may profitably recruit men in GPs and in the gay community centre.

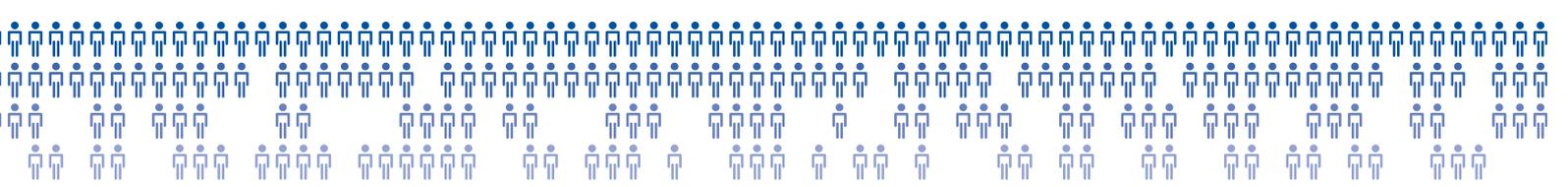
7.2.3 Education and employment

Going to gay pubs and clubs, reading *GCN*, visiting AIDS organisations or using an AIDS / HIV helpline varied by employment (table not shown). Men who were unemployed were less likely to go to pubs and clubs (68.7%) than those who were employed full-time (82.0%) or were full-time students (81.3%) while those who were employed full-time were more likely to read *Gay Community News* (82.6%) than those in full-time education (74.8%) or unemployed (73.5%).

Men who were unemployed were particularly likely to have been to an AIDS organisation in the last year (19.3%) compared to men in full-time employment (9.9%) or education (6.5%). One explanation for this might be that unemployed men are more likely to volunteer at an AIDS organisation and that is why they are more likely to have been there. However, unemployed men were also more likely to have phoned an HIV/AIDS helpline (7.2%) compared to employed men (2.3%) or students (1.6%), suggesting their need is HIV related. This difference was not due to HIV positive men being both more likely to be unemployed and more likely to use an AIDS organisation. The association was apparent among those men who had not tested positive.

- Unemployed men are less likely to use pubs and clubs and to read the gay press than others, but were more likely to have used AIDS organisations and helplines.

The Prevention and Education sub-Committee of the National AIDS Strategy Committee concluded that "there is a need to continue HIV prevention and sexual health promotion work in the gay community" (NASC, 2000, p.42). This preceding data suggests that gay community social settings are frequently used by a large proportion of gay men and are places in which a wide variety of interventions can be implemented. However, an HIV prevention programme which occurs only on the gay scene and in the gay press will disproportionately benefit those in least need (employed, well educated men). Therefore, other settings for contacting men should also be used. Helplines are an important setting for interventions with unemployed men.



8. Coverage measures for five small media interventions

This chapter reports on a final set of questions which asked men whether they recognised five small media resources produced by GHN.

8.1 Qualities of interventions

All HIV prevention interventions share a number of basic qualities. These include their feasibility, cost, accessibility, acceptability, the extent to which they are needed, their effectiveness and efficiency. Survey methods are not the method of choice for most evaluation purposes. However, they are useful for basic measures of recognition, which can be taken as an indicator of accessibility. The question being asked here is *What proportion of the target group for the intervention encountered it?* We also address the question *Do some groups encounter the intervention more than others?* with regard to residence, age, education and employment. The average (mean) overall national recognition for ten English leaflets released between 1997 and 2000 was 17%, with a range of 8% to 40% (Weatherburn et al, 2000). In 1988 a remarkable 82% of men surveyed said they had read the Gay Health Action leaflet called "Safe Sex Card".

8.2 The materials

All five of the interventions were produced by the Gay Health Network. The year and quantity printed is shown below.

Leaflet/card name	Print date	Print number
Play Safe Sexy Booklet	1999	25 000
Play Safe Sexy Cards	1999	20 000
HIV Testing Leaflet	1998	10 000
Hepatitis B Leaflet	1997	10 000
Healthy, Hot and Horny Booklet	1995	40 000

Figure 8.2: The small media for which coverage was measured

In Dublin the leaflets were initially distributed by hand in saunas, pubs and clubs and through gay social groups and HIV agencies. They were also available in STI clinics in Dublin. Later, racks were also used in commercial venues. All five leaflets are still distributed during outreach interventions and as hand-outs during events. In the rest of the country and the North distribution has been through local gay, health or AIDS organisations including Southern Gay Health Project in Cork, AIDS Help West in Galway, Red Ribbon Project in Limerick, Foyle Friend in Derry and Rainbow Project in Belfast. The settings used for distribution include the services themselves, by hand during outreach and from racks in venues.

8.3 Overall coverage

The final page of the questionnaire reproduced the covers of five leaflets/cards and asked men to indicate one of five options in the table below. As this was the final part of the self-completion survey, these questions have the largest amount of missing data in the survey (13% of men did not answer these). The table groups the four recognition options together then shows the proportion indicating each among those who recognised the material.

Overall coverage	Play safe sexy booklet (n=1 129)	Play safe sexy cards (n=1 125)	HIV testing leaflet (n=1 126)	Hepatitis B leaflet (n=1 124)	Healthy hot and horny booklet (n=1 124)
No, I've never seen it	31.3	47.4	45.2	58.5	69.4
Yes, some recognition	68.7	52.6	54.8	41.5	30.6
I recognise it but have never looked at it or read it in detail	13.0	23.0	25.4	23.2	21.8
I've looked at a copy but not read it in detail	17.3	18.6	21.9	16.7	18.3
I've read most of it	32.0	29.6	30.1	35	31.4
I've got my own copy of it	37.8	28.9	22.5	25.1	28.5

Figure 8.3: Coverage measures for five small media interventions

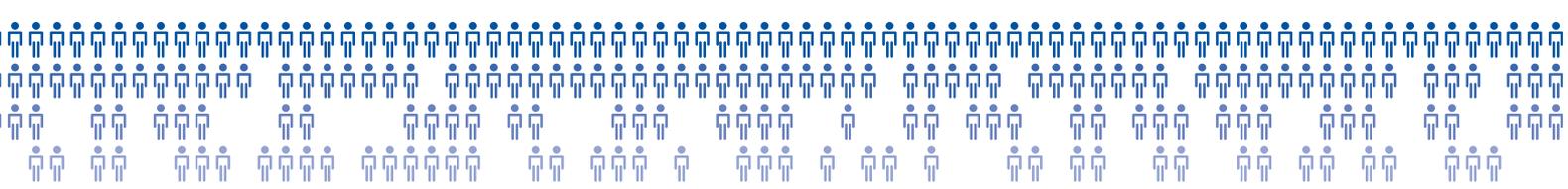
There is no clear relationship between the number of copies printed, their date and the level of recognition found. Overall recognition of the five leaflets/cards was between 31% and 69%. For four of the leaflets, almost a quarter of the men who recognised them said they had not looked at them. The Play Safe Sexy Booklet was most widely recognised and among those who did recognise it, the largest proportions had engaged with it.

- On average, half the men had seen each leaflet, of which 79% engaged with them.

This indicates both the strength and the limitations of small media interventions.

8.4 Demographic differences in coverage

There were differences in recognition by where men lived. The Hepatitis B leaflet was equally likely to be recognised by men living in Dublin as men living elsewhere. However, the other four were more likely to be recognised by men in Dublin: the Healthy, Hot and Horny Booklet (35.0% in Dublin, 25.2% outside); the HIV Testing Leaflet (64.1% in Dublin, 43.5% outside); the Play Safe Sexy Booklet (80.6% in Dublin, 54.4% outside); and the Play Safe Sexy Cards (62.3% in Dublin, 40.9% outside). Without more detailed analysis of the ways in which the leaflets were distributed, we can say little else about this data, but



that these interventions appear to most benefit men in Dublin, although large proportions of men living elsewhere also encounter them.

Recognition significantly varied across the age range for four of the interventions (the Play Safe Sexy Booklet was universally highly recognised). Recognition peaked in the 20s and 30s and then declined again (see Figure 8.4).

- So far, the distribution of these leaflets has most benefited men in their 20s and 30s.

This suggests further distribution of these resources might profitably attend to settings disproportionately used by men under 20.

We found no evidence that recognition of the leaflets and cards varied by education group or occupation. This is a reassuring finding as we might expect the priority groups, unemployed men and those with less education, to be less likely to encounter these leaflets, given they are less likely to use some of the settings in which they are distributed and their text-based method.

- Men who had tested positive were most likely to have seen each of the leaflets and cards, those who had never tested were least likely to have seen them.

This finding underlines the importance of small media interventions being relevant and acceptable to men with diagnosed HIV as well as those without. In order to have control over their involvement in sero-discordant unprotected intercourse men with HIV need a number of things. These are the same range of things that men without HIV need, although the extent to which they are met will vary (see Section 6.7.5). That men with HIV have HIV prevention needs also and that these needs are compounded rather than alleviated by HIV diagnosis has recently been acknowledged and is increasingly being addressed (Summerside and Davis, 2001).

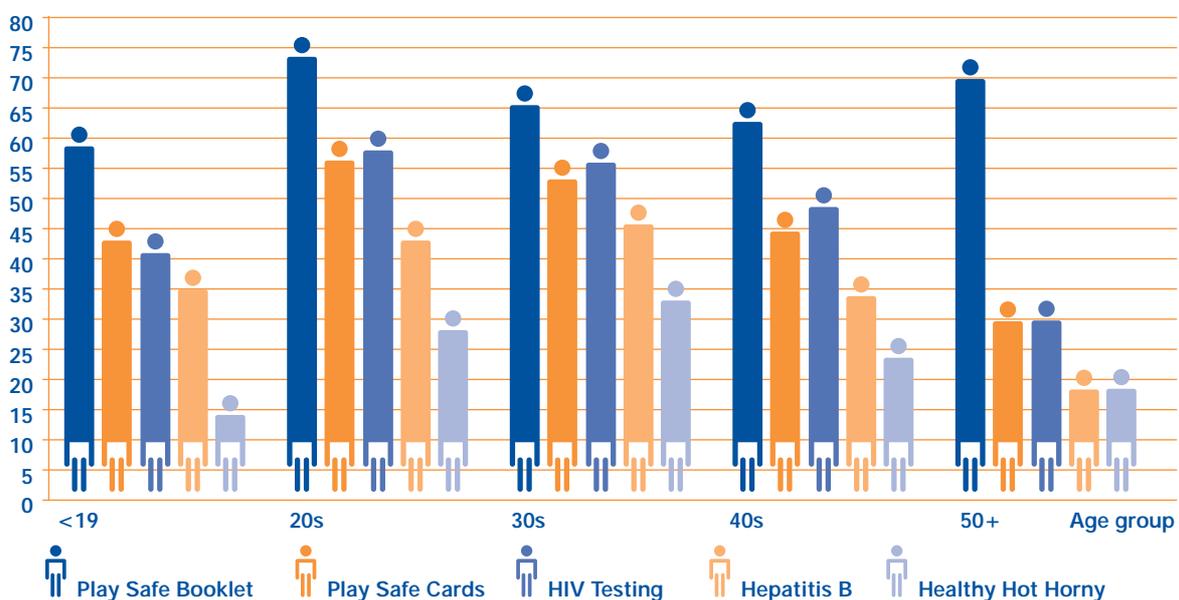
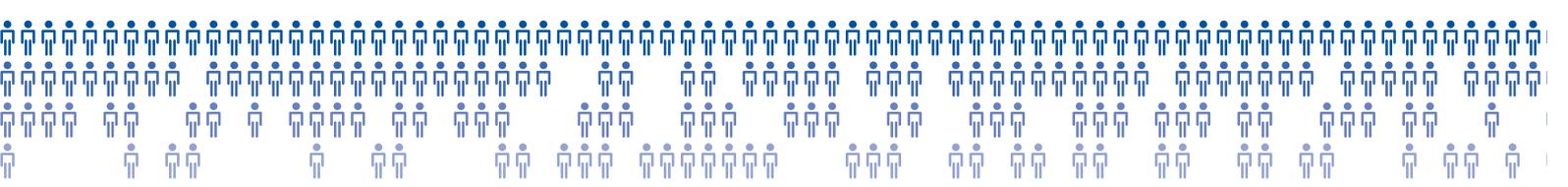


Figure 8.4: Recognition by age



9 Summary of conclusions and implications for planning

9.1 The sample

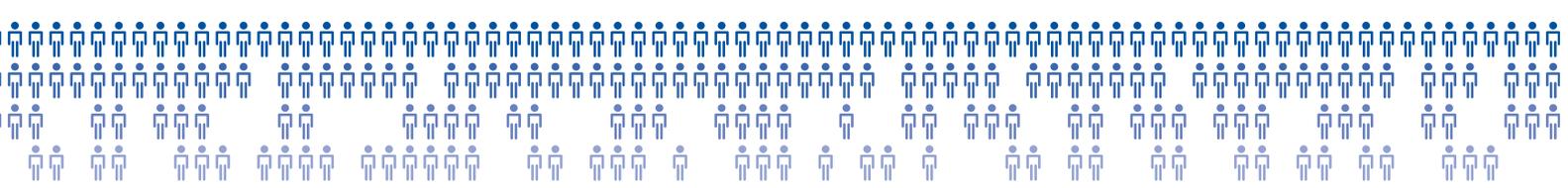
The sample is predominantly men who have sex with men only, and who identify as gay. Half live in Dublin while the rest are resident across the Republic and Northern Ireland. They are mainly in their 20s and 30s, over half had higher education and the majority were employed full-time. Half had a current regular male sexual partner and half of those had been together over two years. The sample live in a variety of household structures, with half living either alone or with a male partner only.

It is impossible to judge how representative this sample is of all homosexually active men. However, it is a description of the population with which health promoters, such as GHN, work. It is reasonable to assume that compared to all homosexually active men in Ireland the sample is: more likely to identify as gay; more 'out' about their sexuality; less likely to have sex with women as well as men. Given that the sample was recruited at gay Pride events and on the gay scene, compared to all gay men (or men who have sex only with men) in Ireland, it may also be reasonable to assume the sample to be younger and more sexually active.

9.2 HIV testing

- Sixty per cent had ever tested for HIV and overall, 3.0% had tested HIV positive (or 5.1% of those who had ever tested)
- Up to a further 3% may have undiagnosed HIV infections
- Testing for HIV is more common in Dublin than elsewhere
- Prevalence of diagnosed infection peaked among men aged 35 to 45 suggesting most men acquiring HIV are under 40
- HIV testing history is not the same as men's current belief in their HIV status, although they are strongly related.

The scale of the HIV epidemic among gay and bisexual men in Ireland is not declining. The data would suggest that in addition to the 3% with diagnosed HIV infection it is likely that, at present, up to a further 3% may have undiagnosed HIV infection. It is essential to step up funding for HIV prevention with gay and bisexual men if national levels of incidence are to be tackled.

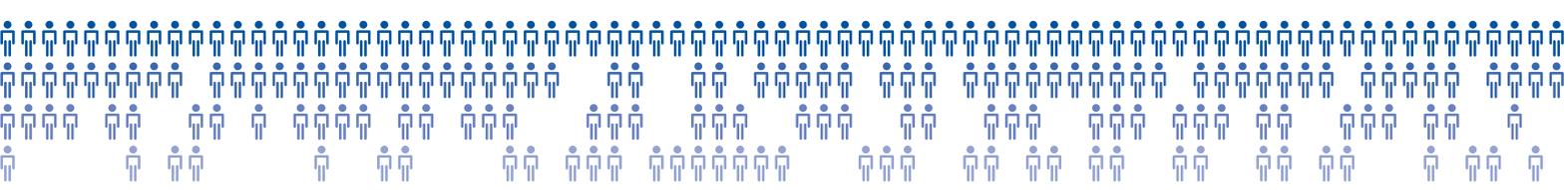


9.3 Health-related behaviour

- The average (median) number of sexual partners in the last year was five, with men in the middle education group and those who had tested HIV positive averaging more partners than other groups
- Almost all men had met a new sexual partner in the last year
- Bars and clubs are by far the most common place to meet new sexual partners with two thirds of men meeting a partner there: almost a third met new partners only in bars and clubs
- Men who had never tested for HIV or had tested negative were most likely to have unprotected anal intercourse (UAI) with a man they knew at the time was HIV negative
- Those who knew they were HIV positive were most likely to have UAI with a man they knew was positive
- At least some men having UAI are doing so intentionally and with regard to both their own and their partners HIV status. Thus, harm reduction strategies or an element of negotiated safety is practiced by some men
- However, the majority of men who had UAI either had not tested themselves, or did not know if their partner had the same status as themselves
- Although men who had never tested were less likely to have UAI, they were by definition unable to know if they were doing so with a man of the same HIV status as themselves
- We found no evidence of unknown or known discordant UAI being more common among any demographic group or by HIV testing history.

As men with HIV are in the minority, unknown UAI among this group is more likely to be sero-discordant than for men who do not have HIV. Therefore, HIV prevention programmes should prioritise the needs of men with diagnosed HIV infection in order to have maximum impact on incidence.

Although different sexual behaviours vary in different directions within the demographic categories used in the study, we found little evidence for overall variation in sexual HIV exposure. With no over-riding patterns in sexual HIV exposure evident from the study, targeting specific sexual behaviours may not be effective as HIV prevention strategies. This suggests that HIV prevention may best be planned on the basis of unmet need rather than on likelihood of involvement in exposure.



- Over a year period, one in eight condom users experienced some condom failure and most condom failure was experienced by younger men.

This suggests prioritising the condom failure needs of younger men rather than older men, as unmet need in this area is likely to be more hazardous than among older men, as younger men have more AI.

- Over half the men (56%) are not benefiting from Hepatitis B vaccinations, and this was higher among men outside rather than within Dublin, and among younger rather than older men.

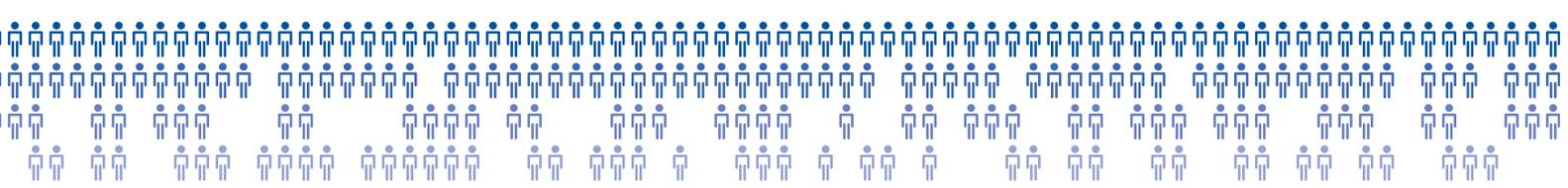
This suggests that in order to reduce inequalities in Hepatitis B vaccination, interventions reducing need related to vaccinations should prioritise men living outside Dublin, and younger rather than older men.

- Most men (57%) with more than one sexual partner in the last year had not been for an STI screening
- Men with large numbers of partners were more likely to attend for an STI screening; it is also likely they had picked up a STI and therefore had greater need for attendance.

These findings suggest considerable work could be directed at increasing the frequency with which men attend for STI screening, and that this work could target all men with multiple partners. Needs related to STI screenings could include knowledge of STIs and screening services, confidence in attending, awareness of when attendance is most pressing (i.e. after multiple partner change), the existence of geographically accessible screening services which clearly value gay and bisexual attenders and which are sensitive to their sexual lifestyles and sexual health needs.

- Recreational drug use among gay and bisexual men in Ireland is common.

As well as being part of the context in which HIV prevention and sexual health promotion work takes place, these responses also suggest that problems with recreational drug use may not be uncommon. However, the survey did not ask about drugs problems directly and these data point to the need for a detailed investigation into drug use and related problems among gay and bisexual men in Ireland.



9.4 HIV prevention needs

HIV prevention needs can be thought of as an aim of an intervention that is not already met. In this study the indicators of need were those around which GHN design HIV prevention interventions. These are:

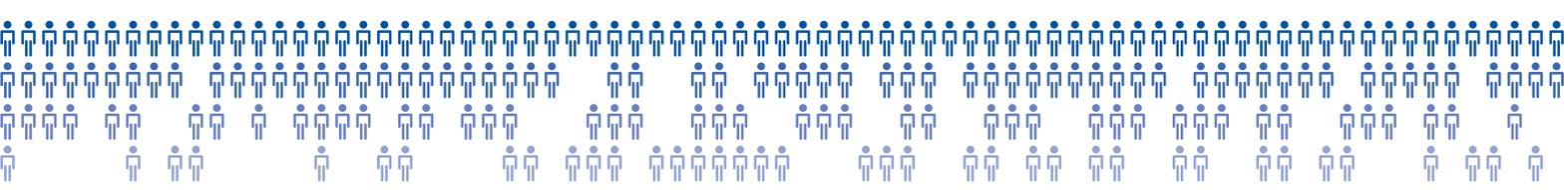
- To ensure that men are knowledgeable about HIV
- That men have access to condoms and lubricant and have the skills and confidence to use them
- That men are not socially excluded and enjoy the support of a social network
The indicators of need are therefore attempting to assess the extent to which these aims are not true for respondents
- Sexual assertiveness is an unmet HIV prevention need for a quarter of men
- One in twelve men has unmet need around access to condoms, but confidence in using condoms is a far more commonly unmet need than access to condoms
- Social support and integration is a commonly unmet HIV prevention need across all groups and one in ten men (12.0%) agreed that they wish they were not attracted to men
- Knowledge about HIV, its prevention and treatment is variable.

Assertiveness is a quality that it is not easy to impart to men - it is not increased by a leaflet for example, although it can be realistically increased with assertiveness training in groups. This means that it will require considerable resources to address the lack of social assertiveness in the gay population.

In the context of HIV prevention and sexual health promotion, social networks have historically been a central source of knowledge and awareness about both sexual hazards and health services. Given the discriminatory context in which all gay and bisexual men live their lives, and the extent of social isolation demonstrated in this survey, building community infrastructures may be a particularly fruitful area for health promotion with this group.

Looking at HIV Prevention needs by demographic variables, the following needs emerge:

- HIV prevention needs are more commonly unmet outside of Dublin
- Most indicators suggest greater unmet need among younger men, although older men show more unmet need around sexual assertiveness
- Men with lower levels of formal education consistently show more unmet need than men with higher education and men who are unemployed are often have more unmet HIV prevention need than those in employment



- In terms of knowledge, men who had never tested for HIV were usually in more need than those who had tested.

At a national level, interventions are more pressingly needed outside Dublin. It is apparent that HIV prevention programmes should disproportionately benefit younger men, men with lower levels of education and unemployed men. There is also a strong need for educational interventions outside the clinic setting for those men who choose not to test, which will increase the knowledge men have about the testing process itself, which in turn instigates testing behaviours. Some tailored interventions may also be required for older men.

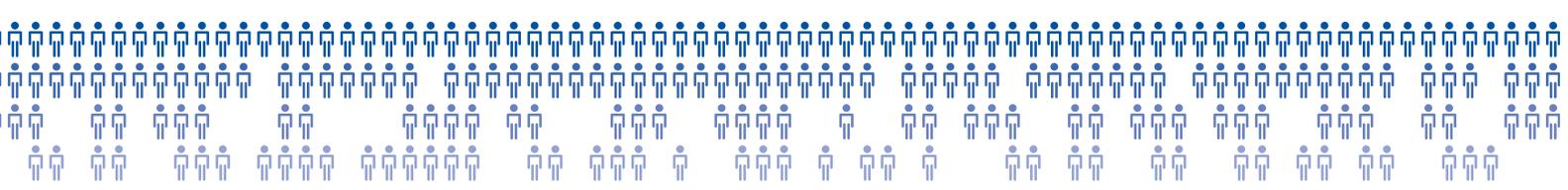
These findings confirm the *NASC AIDS Strategy 2000* report recommendation that 'further integration into mainstream programmes of responses to gay disadvantage, particular those aimed at gay men experiencing multiple disadvantages, would be of great benefit to HIV prevention programmes'. The findings confirm a further recommendation that "younger gay men need to be targeted in order to promote healthy sexual choices" (NASC, 2000, p42).

9.5 Use of settings in which interventions may occur

In order to increase the likelihood that HIV prevention interventions are disproportionately encountered by priority target groups, it is helpful to know about the places men go where they may encounter these interventions.

- Interventions that take place in gay community settings will be encountered by large proportions of gay men
- Men living outside cities are less likely to use gay community settings in which many HIV prevention interventions occur
- Interventions which are intended to disproportionately benefit older men (such as assertiveness training) may profitably recruit men in GPs and in the gay community centres
- Unemployed men are less likely to use pubs and clubs and to read the gay press than others, but were more likely to have used AIDS organisations and helplines.

This study suggests that gay community social settings are frequently used by a large proportion of gay men and are places in which a wide variety of interventions can be implemented. HIV prevention programmes in rural and semi-rural areas may have to use a larger diversity of settings for interventions to cover the same proportion of the population. This conclusion and implication underlines the observation that HIV prevention activity is more expensive (per man serviced) in areas with less gay community infrastructure and a smaller or non-existent commercial scene. However, an HIV prevention programme which occurs only on the gay scene and in the gay press will disproportionately benefit those in least need (employed, well educated men). Therefore, other settings for contacting men should also be used.

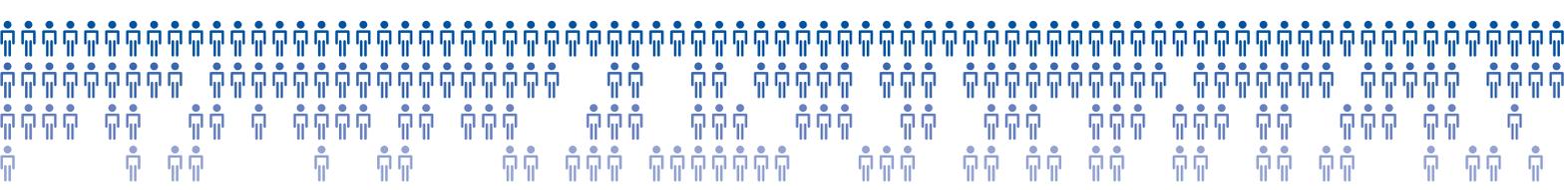


9.6 Coverage of small media interventions

This study also aimed to generate data which would contribute to an evaluation of GHN interventions to date, and which would inform future interventions.

- On average, half the men had seen each of five GHN leaflets, of which 79% engaged with them
- So far, the distribution of these leaflets has most benefited men in their 20s and 30s
- Men who had tested positive were most likely to have seen each of the leaflets and cards, those who had never tested were least likely to have seen them.

The findings on the coverage of small media interventions support the claim that gay community organisations are well placed to reach a large proportion of gay men and reinforce the recommendation from the NASC that "funding for appropriate information materials for the gay community needs to be continued" (NASC, 2000, p.42).



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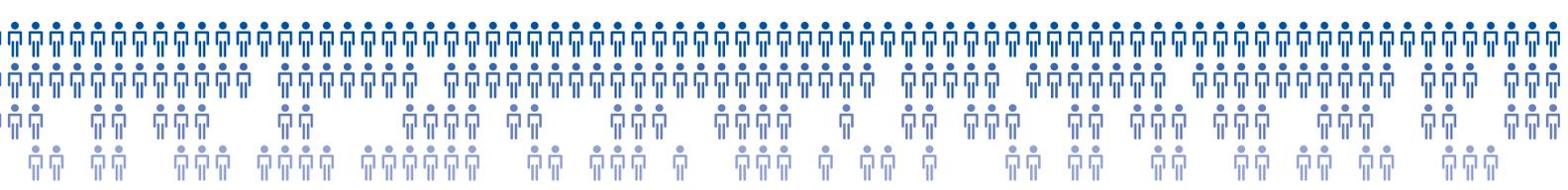
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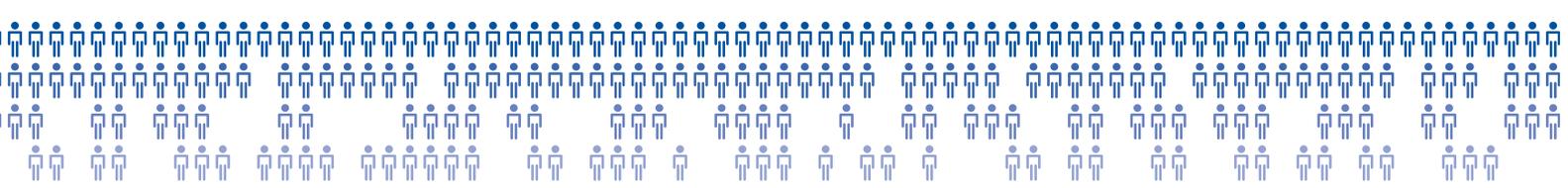
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Appendix

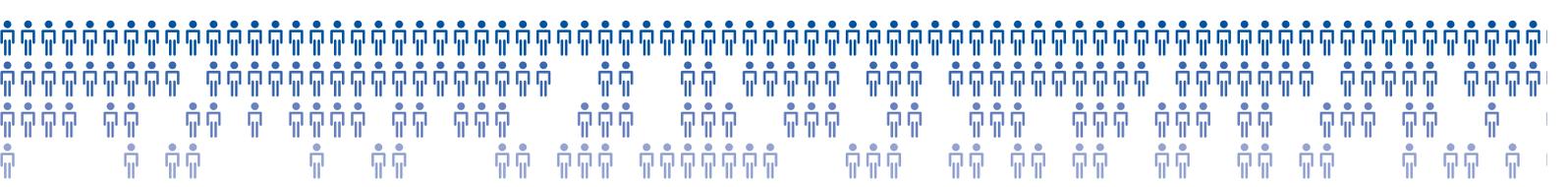
Local sub-samples data

The following tables give key measurements from the survey for groups of men living in each of five health boards in the Republic of Ireland, and in Northern Ireland. An asterisk (*) indicates that the difference in the measure across the six areas is unlikely to be by chance (probability less than one in twenty, or 5%). For the indicators of need which significantly vary, the two areas with the highest levels of need are shaded.

Health Board / Authority	Eastern Region Health Authority	Mid-Western Health Board	South-Eastern Health Board	Southern Health Board	Western Health Board	Northern Ireland
Sample size	712	44	33	98	77	233
Demographics						
% gay identified	87	80	79	81	88	87
Mean age (yrs)	29.8	28.7	29.6	30.3	30.1	29.4
% educated to 3rd level *	71	59	55	56	72	50
% unemployed *	5	9	3	6	3	12
% currently partnered	49	61	47	39	51	57
% living alone	29	27	18	37	39	30
HIV testing						
% ever tested *	65	58	52	50	54	50
% tested positive <i>(of those who had ever tested)</i>	5	0	0	0	5	7
Health behaviours						
Median male partners yr	5	6	7	4.5	3	5
% anal intercourse yr <i>(of those who had sex)</i>	80	85	66	76	80	86
% unprotected AI yr <i>(who had anal intercourse)</i>	50	46	65	52	65	59
% HIV discordant or unknown UAI yr	33	32	36	32	40	40
% condom failure yr <i>(of condom users)</i>	13	8	14	11	15	14
% susceptible to Hep B *	53	46	72	70	69	63
% STI check-up in year	42	36	24	30	31	35



Health Board / Authority	Eastern Region Area Health Board	Mid-Western Health Board	South-Eastern Health Board	Southern Health Board	Western Health Board	Northern Ireland
Sample size	712	44	33	98	77	233
HIV prevention need <i>(knowledge items show % who did not already know this or were not sure)</i>						
[Not] easy to say 'no' to sex I don't want	24	17	14	25	24	27
Sometimes have problem getting hold of condoms*	6	9	11	8	17	10
[Not] confident about using condoms myself *	23	11	14	36	21	25
I sometimes feel lonely	39	50	48	41	43	41
I wish I wasn't attracted to men *	11	26	7	16	17	9
Men can HIV without knowing it	5	8	10	5	0	8
Can pick up HIV by fucking	11	10	13	13	11	10
More likely to pick up HIV getting fucked	21	31	23	19	24	23
Condoms are very good at preventing HIV	13	15	13	14	14	15
Condoms break less with water lubricant *	14	33	7	19	17	15
Oil lubricants increase condoms breaking	20	39	20	24	20	18
Can pass on HIV without ejaculating	19	28	30	22	23	22
More likely to pass HIV if ejaculates	17	18	17	21	17	23
Drugs cannot get rid of HIV infection	8	10	7	9	7	8
Not all people benefit from anti-HIV drugs *	32	46	33	44	21	26



Health Board / Authority	Eastern Region Area Health Board	Mid-Western Health Board	South-Eastern Health Board	Southern Health Board	Western Health Board	Northern Ireland
Sample size	712	44	33	98	77	233
Settings (% who used the following settings in the last year)						
Gay pub or club *	84	77	91	80	82	74
<i>Gay Community News</i> *	89	77	82	77	78	60
Other gay press	66	71	76	62	68	58
GP (family doctor)	50	57	58	45	44	52
Gay social group	26	32	30	28	25	28
Gay community centre *	31	14	21	20	13	21
Drop-in clinic (GMHP) *	28	7	6	9	7	7
Sexual health (STI) clinic	19	18	12	15	13	22
AIDS organisation	11	9	6	9	8	11
Gay Helpline	6	14	6	6	7	7
Been to a bisexual group	4	5	0	4	3	5
HIV/AIDS Helpline	2	7	3	1	1	4
Recognition of small media (% recognised on promoted recall)						
Play Safe Sexy Booklet *	81	61	85	55	68	41
Play Safe Sexy Cards *	62	55	48	44	46	32
HIV Testing Leaflet *	64	46	48	45	48	35
Hepatitis B Leaflet	43	45	44	50	36	34
Healthy Hot & Horny *	34	34	15	29	40	18