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ARTICLE

PERSPECTIVES on Sexual and Reproductive Health

Engaging hard-to-reach men-who-have-sex-with-men with sexual health screening: Qualitative interviews in an Australian sex-on-premises-venue and sexual health service

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Abstract

Context: Compared with the general population in Australia, men-who-have-sex-with-men (MSM) have higher rates of HIV and sexually transmissible infections (STIs). Despite widespread advice to test regularly, a minority of these men remain "hard to reach." We undertook qualitative interviews with a group of such men in Sydney to better understand their views and experiences in relation to sexual health screening.

Methods: We conducted semi-structured interviews with men engaging with HIV/STI screening services at a sex-on-premises-venue and the local Sexual Health Service in Greater Western Sydney. We analyzed these data for content and themes.

Results: Sexual behaviors and identities were diverse, often discordant and compartmentalized from everyday lives. Overall, reported HIV/STI knowledge was poor and men did not see themselves at risk of HIV/STIs regardless of sexual behavior. Men took calculated risks and balanced with pleasure and escapism. Reasons for avoidance of testing included fear, unwillingness to disclose behavior, privacy concerns, and perceived low risk. Men viewed sexual health care as distinct from general health care. Service delivery preferences varied by service venue. Participants highlighted convenience, confidentiality, and trust as critical factors for a testing service.

Conclusion: A variety of testing options are needed to engage hard-to-reach MSM. Opportunities to enhance testing may include expanding health messaging, demystifying testing, and delinking sexual identity from sexual behavior and risk, thus promoting advantages of testing and establishing testing as standard of care.

INTRODUCTION

In Australia, populations at higher risk of acquiring sexually transmissible infections (STIs) and HIV than the general community are targeted for testing.[1,2] Men-who-have-sex-with-men (MSM) have experienced rising notifications of chlamydia, gonorrhea, and syphilis for over 10 years and bear the burden of HIV infection in Australia.[3,4] The notifications of HIV and STIs in MSM exceed those in heterosexuals by a factor of 3 (HIV and gonorrhea)[5,6] and up to 10 (syphilis).[7] Frequent, regular screening is key to timely diagnosis and treatment,

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preventing negative sequelae and onward transmission, and reducing the overall STI community burden.[1,8] Furthermore, STI coinfection has been demonstrated to increase the risk of HIV acquisition and transmission.[9–11] Prompt HIV diagnosis may expedite progress to an undetectable viral load and potential "untransmissibility".[12,13]

MSM are not a homogenous cultural or demographic group and they report a diversity of risk practices, sexual identities, and screening behaviors.[14] Not all MSM identify as gay or homosexual.[15] Therefore to address the sexual health needs of MSM, a range of screening options and health promotion approaches is required. Sex-on-premises-venues (SOPVs) facilitate casual, often anonymous, sex in an affordable and convenient environment. Although not commercial sex-work premises, these venues (also known as sex clubs, saunas, and backrooms) provide men with a dark environment to accommodate anonymity and remove a focus on appearance-based "cruising," while increasing the availability and variety of partners and access to sex practices not easily accessed elsewhere, including group sex and condomless sex. SOPVs clients have reported this combination of anonymity and safety (afforded by being in a "public" space) as appealing.[16]

SOPVs clients include men who rarely or never engage with the gay-identified health services or community venues where health promotion for MSM have typically been concentrated.[15,17–23] Consequently, MSM attending SOPVs have long been identified as being at particular risk for STIs and HIV. International studies report SOPV clients at high risk of HIV/STI are less likely to access testing and this has also been demonstrated in the Australian context.[15,17–23] These studies indicate that many men attending SOPVs do not use condoms consistently, if at all, and do not participate in regular HIV/STI testing. This may be the result of lower levels of knowledge of Sexual Health Service availability and poorer sexual health literacy compared with other MSM.[15,24,25] Past strategies to facilitate screening for SOPV patrons have been limited to outreach HIV/STI screening services. In Australia, these have typically been time-limited research projects or short-term outreach services from local Sexual Health Services.[23] Little data exist to elucidate what these men understand about HIV, STIs and testing, what they want in a screening service, and how these perspectives and preferences may differ to men who are willing and able to access traditional clinic-based services.

Although we have population level data about MSM and their HIV/STI risk, the individual voices and the experiences of these men are missing. In this study, we took a qualitative approach to listen to the voices of men who attended a SOPV in Greater Western Sydney or an established Sexual Health Service, based within a public community health facility.

We aimed to deepen our understanding of how men regard their sexual behavior and their HIV/STI risk, their views on sex, and how sexual identity might impact their sexual health and health seeking behaviors. Through thematic analysis, we synthesized these data to generate new insights into the sexual health screening needs and preferences of this distinctive group of men and identify potential opportunities for improvement. These data are unique because they provide grounded evidence of the needs of a population who remain under-served and hidden from mainstream HIV prevention approaches, despite the many advances in supporting gay-identified men in the year prior to achieving marriage equality in Australia.[26]

METHOD

Design

This analysis forms part of a mixed-methods doctoral project investigating the sexual health needs of MSM attending SOPVs. The Western Sydney Local Health District Human Research Ethics Committee approved this study (LNR/15/WMEAD/306). We have described the design of the broader study in detail elsewhere.[2] In this manuscript we describe the qualitative component, which comprised semi-structured interviews with men attending a SOPV and a Sexual Health Service for asymptomatic STI/HIV screening.

Settings

From November 2015 to November 2016, Catriona Ooi interviewed men who engaged with an outreach sexual health clinic delivered within a suburban Sydney SOPV. The male SOPV outreach offered HIV/STI screening only. Services were conducted over the lunchtime period, for 4 h, two to three consecutive days per month. A sexual health clinician from the local Sexual Health Service and a community organization MSM peer educator staffed the service. We describe the outreach service and findings elsewhere.[2] The publicly funded Sexual Health Service was located 3.4 km away from the SOPV and operated weekdays, providing comprehensive STI and HIV care for at-risk populations inclusive of MSM. Services include free HIV/STI screening.[1,2] We chose this SOPV and Sexual Health Service because they were the sole operators of their type in the local area and geographically close to the study team.

Participant recruitment

During the SOPV outreach service, the peer educator invited men in the SOPV to undergo HIV/STI screening, via a loudspeaker system and individual engagement. Only men who underwent screening and reported sex with other men were eligible. At completion of screening, Catriona Ooi invited men to participate in a semi-structured interview. Catriona Ooi recruited all SOPV interview participants. Sexual Health Service clinical staff invited and recruited all MSM attending the local Sexual Health Service for screening during recruitment periods (the week following the SOPV clinic). Sexual Health Service participants who consented to an interview but were unable to participate directly after screening were offered a telephone interview, conducted within 1 week of the clinic visit. We offered all participants a copy of their signed consent form and a participant information sheet.

Data collection and analysis

All participants provided written and oral consent. Men were able to opt out at any time. Catriona Ooi conducted and recorded all interviews and used the same 15–20 min semi-structured guide, which aimed to capture men's views, understandings, and preferences regarding screening, risk HIV/STI knowledge, and ongoing testing needs (Table 1). We collected data for 12 months to coincide with the duration of the SOPV outreach service. Catriona Ooi checked that the participants enrolled at the SOPV and Sexual Health Service screening populations were discrete. Catriona Ooi conducted the fieldwork, led the analysis and writing, and conducted reflexive memoing and note-taking throughout data collection and analysis. We conducted face-to-face interviews in a private setting. A professional transcribing service transcribed verbatim de-identified audio recordings. Catriona Ooi checked transcripts against the original recordings for accuracy and coded transcripts line-by-line in NVIVO, following an iterative process of theme generation. We were guided by the steps involved in reflexive thematic analysis to support the generation of themes responsive to the primary areas of interest, and identify unexpected patterns and variations in the data.[27] Catriona Ooi and Christy E. Newman grouped codes into categories which included testing, sexual behavior, relationships, separate lives, sexual identity, judgment, fear, risk, safety, and sexual health knowledge. We report three themes which were generated to capture the dominant ways men described the place of sex and sexual health in their lives and to understand the key issues and factors that shape engagement with sexual health care, particularly sexual health testing.

RESULTS

We conducted interviews with 32 men attending the SOPV and 48 men attending the Sexual Health Service. Most Sexual Health Service participants ($n = 38$, 79%) engaged in face-to-face interviews, the remainder by phone. We summarize participant characteristics in Table 2. We describe demographic, behavioral, and screening behavior information elsewhere.[2] Most men attending the Sexual Health Service self-identified as gay or homosexual, while nearly half of the men interviewed at the SOPV had a long-term female partner, were married to women, or widowed.[2] Most of the men attending the SOPV were not engaged in the gay/homosexual community, did not self-identify as gay or homosexual, reported they had no gay friends, and did not know anyone who was HIV positive.

TABLE 1 Sex-on-premises and sexual health service participant semi-structured interview questions

- Can you tell me a bit about yourself?
- What do you know about infections that are sexually transmitted? What about HIV?
- Can you tell me about why you came in for testing for these infections today?
- What was your experience of testing like today? What did it feel like to have tests conducted in this space?
- If you have been tested for these infections before, was today any different? How so?
- Are there other places you would be happy to go for testing?
- How often would you get tested here? At those other places?
- How often do you think you should test for HIV/STI?
- What do you think would help you go for testing more often?
- Is there anything you would like to add that you feel we have not covered?

Abbreviation: STIs, sexually transmissible infections.

Separating sex from daily life

The first theme captures the meanings that men ascribed to the SOPV, as a space that permitted a separation of their sex lives from their everyday lives, particularly elements of life that involved family, work, and other partners. Most men viewed attending the SOPV as an escape, a place to let down their defenses. One 27 year old heterosexually identified man described the SOPV as "my getaway from the real world, if that makes any sense". But this escape required compartmentalization of the SOPV experience. SOPV participants often strongly described this separation. One 56 year old self-identified heterosexual man who was married to a woman explained how he viewed the SOPV, describing the venue as "a little box in my life that no-one else knows about."

TABLE 2 Sex-on premises-venue and sexual health service participant demographics

Demographic characteristic	SOPV *n/N* (%)	Sexual health service *n/N* (%)
Age (years)		
Mean	48	36
Median	47	33
Range	24–78	19–64
Born in Australia	20/32 (63)	27/48 (56)
English at home	27/32 (84)	42/48 (88)
Aboriginal and Torres Strait Islander	1/32 (3)	1/48 (2)
Interview mode		
Face-to-face	32/32 (100)	38/48 (79)
Telephone	0	10/48 (21)
Behavior		
Ever had sex with a female	26/32 (81)	15/48 (31)
Married/widowed/long term female partner	15/32 (47)	5/48 (10)
Previous screening		
No previous HIV screen	9/32 (28)	1/48 (2)
No previous STI screen	15/32 (47)	1/48 (2)

Abbreviations: *n*, number of participants with variable per site; *N*, total number of participants per site; SOPV, sex-on-premises-venue; STI, sexually transmissible infection; (%), percentage of participants with variable per site.

This sense of the SOPV as other-worldly or an escape appeared to afford men a respite from domestic and professional responsibilities and men described an environment of liberty and freedom, allowing relaxation without fear of reprisals or judgment. One SOPV participant described the SOPV as a unique space for feeling connected to other MSM:

> When we are together, we have a different conversation. When gay men are together or men of the same sexual interest, we have a different conversation. And you come here for one thing. There's nothing to hide. (58 years old, gay-identified).

Men also discussed understanding and respecting the choice of other men to separate their sexual and everyday lives in that space. For SOPV participants, confidentiality and privacy among the staff and patrons contributed to creating this enabling environment. Men implicitly understood the desire for discretion and confidentiality, a "hear no evil, see no evil, speak no evil sort of, sort of thing," negating the need for explicit discussion with other SOPV attendees or staff. One gay-identified 38 year old man observed "an unwritten rule that you don't really speak about things like that in an environment like this, you know. What happens here tends to stay here."

Other participants described the sex they accessed in the SOPV as fulfilling a primarily physical need or providing release. Casual sex with other men was described as an efficient, convenient route to achieve this:

> I find later in life attracted to easy places to get sexual relief. However, I find it not easy as you get older to relate to women but easier with men. Gives you physical relief. (78 years old, widowed).

Heterosexually identifying men tended to feel the need to justify this behavior:

> I was married for quite a few years. Divorced in 2000… All healthy. Yeah, just a healthy hetero. I'm 99.99 hetero. And that's it, you know. I do not think anyone's 100% hetero or gay, or whatever. It's just all part of your genes. (59 years old, heterosexually-identified).

Some men, particularly those who did not identify as gay, associated sex with other men in the SOPV with feelings of guilt or regret. These men appeared to feel compelled to justify their choice of sexual partners and/or sex venue, often describing themselves as unable to find the sex they desired at home. Guilt weighed heavily on some as evidenced by their volunteered explanations. One married 59 year old SOPV participant felt compelled to "blame" his unknowing wife, thus divesting the responsibility of his behavior: "I don't have sex (with my wife). We haven't done so for about nine years. That's not my fault. That's her fault. So, I've gotta go and get it elsewhere."

Other men drew on beliefs about morality and sexuality in justifying the separation of their home and sex lives. Another married man attending the SOPV described sex with men as a separate existence:

> (It's) like you have got two lives. In one life, I'm like pretty much perfect in one life. Not perfect as in perfect but morality and all that, and what I do, and everything, and the way people look up to me. And in the secret life it's, it's a bit seedy, really. (57 years old, married to a woman).

The compartmentalization that other men could hold between a "straight" life at home and sex with men at the SOPV appeared confusing for some gay-identifying men:

> But there are these married guys who, who have sex with men; they do not class themselves as gay and it therefore becomes very, very complicated because, when you ask someone, "Are you gay?" "Oh no." And I think, "Well I've just had sex with you." (50 years old, did not identify).

Attenuating sexual risk

The second theme describes the meanings men ascribed to the potential risk of HIV/STI, which most men described as a balance between pursuing the pleasure of sex and minimizing the risk of infection. One 50 year old Sexual Health Service participant who did not identify explained his motivations for testing, "there's freedom and there's responsibility, and I think there's a lot of responsibility (that comes) with our freedom to have sex, to make sure that we're protecting the community."

Despite this, many men believed that sexual partners could not be trusted to feel similarly, describing them as "not clean," and seeing themselves as carrying the burden of responsibility in managing sexual risk. While this notion of "being clean" was commonly expressed, meaning varied. For some, "being clean" just involved good personal hygiene or tidiness. But for most, there was an assumed link between observed hygiene practices and a risk of HIV/STI which influenced the sexual risks that men were willing to take. For example, men described being asked or asking "how clean are you?" or "how safe are you," depending on the situation or the partner involved. Men across both sites described having made judgments about sexual risk "depending upon each person." However, the prevailing opinion was that sex with a married man or a small group of regular sex partners was safer than sex with gay-identified men or anonymous partners.

Although we identified a variety of assumptions about the risk associated with particular people and sex practices, men agreed condoms were protective for HIV and STIs when having anal sex. However, most did not use condoms consistently due to concerns about erectile loss and reduced pleasure, intoxication, or because they believed their sexual practices were low risk. Most men believed others were engaged in

riskier practices such as having a more "sexually active lifestyle" or having multiple sexual partners. One 24 year old participant engaged to a woman described himself as different from others who attended the SOPV, saying that "I'm not like a sex-freaker."

Risk assessment was also shaped by feelings of trust. There was a common belief expressed that HIV/STI risk lowered when you "knew someone," although it was unclear how men determined this. One 36 year old gay-identified man attending the Sexual Health Service described mitigating risk by attending screening and using condoms with new sex partners until feeling comfortable enough with them to have unprotected sex: "I always use condoms before I have sex with anyone. I've always got tested as well. Just, you know, before I'm comfortable being with them in any sort of sexual way." Body fluids, including saliva and blood, were often mentioned and seen as potentially infectious. Practices such as oral sex, digital penetration, and genital rubbing were assessed as low to no risk.

We found most participants described their understanding of HIV and STI risk and symptoms as limited. One 65 year old gay-identified man, when asked about his HIV/STI knowledge and that of his friends, admitted "it's very poor." However, Sexual Health Service participants, who were younger or gay-identifying, generally reported they had better levels of HIV/STI knowledge than the SOPV clients, who were often older and heterosexually-identifying. There were many myths which participants described as truths, such as STIs and HIV always being associated with symptoms. For example, a 39 year old participant married to a woman stated, "I probably would let it off thinking I feel fine, nothing wrong with me. I'll wait 'til I get a symptom." Other commonly stated myths included that oral sex has no risk, HIV is always fatal, and men married to women are not at risk of HIV or STIs. Few understood the difference between HIV and AIDS or the role of HIV post-exposure prophylaxis (PEP) or HIV pre-exposure prophylaxis (PrEP).

Sexual health knowledge was typically garnered from word of mouth, the internet and television. For example, one married SOPV participant, when asked what he knew about HIV or STIs, replied:

> Nothing. I mean apart from what you hear. What you hear at, on the radio and on the telly about people with HIV and stuff like that. I did, I knew a guy that had gonorrhea when I was 17, so 40-plus years ago. (59 years old, married to a woman).

Most men reported that if they were looking for information, they would search online, however none were able to name any specific sites. A few Sexual Health Service participants explained they would seek information from the staff, which is to be expected in a group who had already demonstrated some degree of engagement with sexual health care services.

Avoiding and engaging with testing

Participants in this study had engaged with an HIV/STI testing service so we do not capture the views of men who have never tested. Despite this, their accounts reveal how trepidation and avoidance characterize this group and influence testing behaviors.

Some men described having felt very nervous about testing because of "the fear of having a positive result and I guess the judgment and stigma that could come from it." However, after exploring these fears in more depth, we identified a range of additional and more nuanced issues, including being unsure about where to access testing, fear of disclosing sexual practices, and anxiety while awaiting results. These were common barriers regardless of testing site or sexual identity and resulted in men delaying testing for significant periods of time despite personal risk. One man described his first visit to the Sexual Health Service using highly emotive language:

> I freaked out. I did not know what it was gonna be like at the clinic. I was terrified. Oh yeah, you have also got that feeling, well you are being punished… It's kind of that, you know, you are doing something that's wrong and now you are being punished. And you go to the doctor, and the doctor's gonna say, "Well, it's your fault." (50 years old, did not identify).

Most men who expressed a reluctance to test expressed this entanglement of embarrassment, guilt, and shame. These powerfully negative feelings overshadowed motivations to test and resulted in either a delay or an active refusal to test altogether, regardless of the benefits testing may bring. Some men found the final impetus often came in the form of genital symptoms or strong encouragement from people whose opinion they valued, particularly peers. For others, the courage to test required building their trust in a specific service, understanding the testing process, or becoming familiar with health promotion messaging. For example, some men described observing the presence of the testing service at the SOPV for months before they felt comfortable enough to participate.

Despite initial concerns, most men expressed relief after the initial test and surprise at the simplicity of the testing procedure and the frank and non-judgmental discussion and openness of the process involved:

> Before you get tested, you are kind of like jittery but I think that's like a pre-flight jitters type of thing. So, like before I walk in, I'm a bit, you know, "Oh no!" But then, as I get into it, as I speak to the, the, like the clinic workers and stuff, they are quite nice. And by the end of it you are like, "Okay," you know. I feel a lot more calmer. But it is a very pre-flight jitters thing. (29 years old, gay-identified).

When we asked what would make first time testing easier, men suggested simpler access to testing and results, positive messaging to normalize testing, peer-led testing, and more testing locations. When asked what would make regular testing easier, men identified convenience and privacy as primary factors. As one Sexual Health Service participant explained 'that's it, convenience, really" (48 years old, married to a woman).

Given the intimacy of sexual activity and mens' confidentiality concerns it is unsurprising that almost all men viewed sexual health as distinct from other health matters. Most chose to access sexual health care separately from general health care. A 57 year old participant married to a woman discussed his primary care physician: "because he's (the general practitioner), it feels like he's personal. Yeah. So that's part of that other life bleeding into…. He's like the, the friend you go and see for, you know, when you've got a normal infection." The primary reasons given for preferring to test at a Sexual Health Service included privacy and confidentiality, specialist knowledge, the formality of the process, the friendliness and non-judgmental attitude of the staff, and comprehensive testing. Contrary to this, SOPV participants preferred the informality of the process, the walk-in nature of testing, and the privacy of the site. However, most men assumed that others attending the SOPV did not test regularly and suggested that the sense of obligation to safeguard their peers was not shared. Few were aware of peer led testing services and when described, reported a fear of being seen resulting in inadvertent disclosure of their sexual practices.

Men reported a sense of satisfaction once screening was completed but this sometimes involved a movement from fear to righteousness, believing they were now" doing the right thing" compared with those who continued to avoid testing. This theme of personal responsibility was often offered as the primary reason to continue getting tested. For example, one 36 year old gay-identified man said "if I get something, if I leave it (getting tested) for six months or a year, the amount of people that I would, could possibly like hurt in that space of time it's greatly decreased when I do it (get tested) every three months." Both Sexual Health Service and SOPV participants alluded to the alliance between personal and public health, particularly the idea of testing representing the deliberate safeguarding of partners and family. One participant suggested that testing represented:

> Doing the right thing about, finally doing the right thing and it's like, it's like some things you have gotta do in life, and it just seemed like it was one thing that you had to do. Doing the right thing for everybody that I know. Me and family, and, and future people I may meet as well. (57 years old married to a woman).

DISCUSSION

This analysis offers insight into the views and experiences of MSM attending HIV/STI screening at a SOPV and a Sexual Health Service in Western Sydney and reveals some of the issues which affect engagement with mainstream HIV/STI prevention and care services. We examined issues discussed by the participants such as sexual identity and sexual behavior and consider how these views appeared to influence and shape attitudes to testing and understanding of health needs. Attitudes to sex with men and disclosure of sexual behaviors associated with accessing appropriate sexual health care remain key barriers to screening in this population, despite advances in engaging gay-identified men with HIV/STI prevention activities. The intersection of views, practices, and experiences highlights the complexity of providing services to these men that address their health needs and are delivered in an acceptable and accessible manner.

While sexual encounters for both groups were considered private, the behavior of SOPV participants was often secret, totally separated from day-to-day life. Men compartmentalized this dimension of their life. However, this freedom came at a price for some. Feelings of guilt and shame were commonly described, and men were sometimes tearful and remorseful, indicating a desire to change their behavior but feeling unable or unwilling to do so. Men reported appreciating the acceptance and discretion they experienced at the SOPV despite sometimes criticizing the behavior of others, indicating a lack of sympathy or an inability to comprehend the apparent contradiction of others in separating their sexual, family and professional lives, and the complexities of these choices. These tensions between the public and private self were negotiated throughout the interviews and were influential in men's assessment of their own sexual risk and safety, shaping their views of sexual health care needs and health-seeking behaviors.

While there is an acknowledgement in the literature that sexual behavior and sexual identity do not always align, there is less understanding of this in the general community.[28–30] Mainstream Australia generally views sexuality as binary (gay or straight); public understanding and acceptance are somewhat limited to these two poles of the sexuality spectrum. Many still argue that sexual behavior equates to sexual orientation. However, this does not adequately capture the complexity of human sexuality, which is a major factor in understanding how people make sense of risk and engage with care.[31,32]

Our findings highlight differences in attitudes to sex and sexual health care between those men who did or did not identify as gay or homosexual. Sexual identity was an important factor across all the themes we explored, influencing access to care, sexual behavior, and psychological wellbeing. Most non-gay-identifying MSM participants indicated fear of disclosure and judgment as particular barriers to care-seeking.

Many of those participants who identified as heterosexual, or who had long term female partners, explained that they were troubled by their desire to have sex with other men. These men felt their sense of wellbeing and belonging in their everyday lives was threaten by guilt and shame and fear of disclosure and judgment. Cultural, religious, societal, and familial views shape our understandings of self and can influence what each individual believes is acceptable and "right" or "wrong," falling outside of notions of their role in society.[31,33]

These complex factors resulted in a reticence to disclose intimate sexual practices to health staff, thus impacting access to appropriate care. Research has shown that non-gay MSM are less likely to report HIV/STI testing than gay-identifying MSM, however there is little data available regarding the sexual behaviors and sexual health needs of this group.[2,24] In a sample of MSM from Scotland, Wales, Northern Ireland and the Republic of Ireland, Mcaloney-Kocaman and colleagues[34] reported that non-gay MSM were less likely to be engaged in the gay scene or identify with the gay community and therefore did

not engage with safer sex and testing interventions traditionally aimed at gay men. The authors postulated that this "identity-driven" health promotion is, in part, contributing to ongoing neglect of a population at risk. The semiotic snare of "identity-driven" health care highlights the complexities of targeting and designing services for these men. Scrimshaw and colleagues[35] found that "non-disclosing behaviorally bisexual men may be unresponsive to materials (e.g. pamphlets, websites) that explicitly state that they are designed for gay or bisexual men." Further, Newman and colleagues[36] have acknowledged the "process of 'branding' … services as inclusive in an attempt to make both people living with HIV and GLBT people feel welcomed … can potentially have the unintended effect of making some other groups of people … including heterosexually identified men, feel excluded." Our findings echoed these notions.

Despite the complexities, understanding these barriers is necessary to develop effective approaches to sexual health care for all MSM. However, "MSM" as a catch-all term to address behavior, by default, appears to have evolved to encompass identity, a nominal description of self-identified homosexuality.[31,37] Engagement of all MSM, regardless of sexual identity is essential to improve access to sexual health care and various strategies have been employed. Community led programmes have been shown to be effective, and Numer discusses the potential role of community leaders who are advantaged by understanding "gay identity."[38] Involvement of key community stakeholders in messaging has long been integral to MSM health promotion in Australia, but a more nuanced approach may be challenging given the heterogeneity of this group.

Younger men and men who identified as gay were generally more engaged with health messaging and with the gay/homosexually identifying community. We found these men were more aware of their sexual health needs. Non-gay MSM, regardless of risk, may not engage with this messaging. Several of the non-gay SOPV participants drew a distinction between "me" (as no/low risk of HIV/STI) and "them" (as high risk because of assumed sexual practices). These "others" were the men these participants believed should be most concerned about HIV/STI. Men assessed their own sexual risk based upon their HIV/STI knowledge, personal methods of risk mitigation and assumptions made about their sexual partners. These elements are all essential for understanding and strengthening motivation for testing.

And yet, when asked about testing, men often reported one motivating factor to be a sense of responsibility to sexual partners and friends and family. Men felt alone in this regard, believing this "responsibilization" not typically felt by others. This is consistent with the literature. In a qualitative study of concerns about HIV treatment as prevention,[39–41] Australian participants considered themselves to be "moral and responsible, and 'others' as reckless and risky."[42] This sentiment may offer insight to inform future health promotion for this group of men, by engaging men through language which promotes this sense of the heroism and altruism of regular testing. Promoting the advantages of HIV/STI testing and emphasizing the potential to protect others may enhance men's motivation to test. Men were reassured by services they trusted, reminding us of the value of establishing and maintaining a consistent message and presence, for building familiarity and willingness to test. By addressing sexual health issues as standard-of-care alongside regular health checks, clinicians can open channels for dialog and disclosure. Health providers and services need to be mindful of de-linking sexual identity with sexual risk to avoid making assumptions based upon presentation.

Interviews demonstrated a variety of health care settings is needed, based upon privacy and convenience, and encompassing speed, efficiency, and flexible access. While SOPV participants preferred to test at the SOPV and men who tested at the Sexual Health Service preferred to test at that location, all men valued discretion. Although some viewed general practice as easy and convenient, most preferred to access their sexual health needs separately, because of concerns about confidentiality and privacy, particularly in smaller communities, non-urban areas and within ethnic groups.[16,42,43] We conducted this study in an urban setting where dedicated Sexual Health Services are available. Outside of urban and metro areas in Australia, Sexual Health Services may be geographically distant for many MSM.[44] This demonstrates the need for both dedicated Sexual Health Services and expertise within mainstream primary care.

These data highlight some of the complex and intersecting factors influencing sexual health testing in MSM in Western Sydney. Further research is needed in this area, to further explore the needs of this diverse group, including men living in rural and remote geographical areas, men accessing other services, men who have never accessed testing and men from a broad range of diverse cultural and language backgrounds.

Limitations

Despite relatively large numbers of participants in this study for a qualitative design, the findings are limited by the fact that qualitative methodology is not intended to be generalizable. Participants self-selected to participate after attending either one SOPV or one Sexual Health Service in Western Sydney and there may be perspectives missing from those men who declined. Recruiting from these sites, where testing was provided, may have introduced some social desirability bias regarding the expression of preferences and experiences. Interviews and screening were conducted in English only and those who were not proficient in English may have self-selected out of the study. Finally, the positionality of the interviewer as a woman of color could be deemed beneficial in demarcating her position as a non-sexualized professional in a highly sexualized environment, but this also had the potential to cause discomfort among SOPV and Sexual Health Service clients. Issues relating to the insider/outsider status of those who deliver these services are therefore important to recognize and minimize, to ensure both staff and clients feel they can belong in that space, even if the gender and /or cultural dynamics are complex. We sought to minimize the limiting impacts of the interviewer's perceived gender and cultural background by involving a peer worker who identified as a gay man and creating a separate and private space to conduct the study.

CONCLUSIONS

This unique data set highlights how views of sex and sexual identity can shape notions of risk and health needs thereby influencing health seeking behaviors and HIV/STI screening motivation. Through amplifying mens' voices, we have drawn attention to the complexities and challenges in understanding and engaging hard-to-reach MSM to identify opportunities and possible areas of future work to encourage and promote testing for this population in developed countries such as Australia, particularly those MSM who identify as heterosexual. This study highlights the voices of MSM themselves regarding the issues and factors that should inform service provision and health promotion for this hard to reach and largely invisible population. As long as heteronormativity remains dominant across Australian communities, the complexities of engaging this hard-to-reach group of MSM will remain.

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Catriona Ooi and Christy E. Newman planned this project. Catriona Ooi collected data, analyzed, and reported the work described in the article. Christy E. Newman and David A. Lewis advised, commented and reviewed outcomes. Catriona Ooi is responsible for the overall findings. This research did not receive any specific funding.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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