

double trouble?

the health needs of culturally diverse
men who have sex with men



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acknowledgments

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executive summary

key findings

identity, discrimination and vulnerability

- Experiences of discrimination and exclusion contribute to distress and risk-taking, but these are concentrated rather than spread out evenly across the whole population of CALD MSM.
- The concentration of vulnerability occurs during temporary periods of intensity or ‘time in crisis’ characterised by distress and risk-taking, feelings of anomie, and a bleak evaluation of the future.
- For most CALD MSM these periods are time-limited, but some will ‘get stuck’ and need support.

sexual practices and spaces

- For CALD MSM the risks and harms may be quite different from mainstream MSM. In our case study of Asian MSM, research shows lower risk-taking with casual partners, higher risk in relationships, significantly lower numbers ever having tested for HIV, and a major need for sexual negotiation skills to avoid the harm of unwanted sex.

negotiations of identity, family and community

- Connection to family and community are protective factors that can be maintained through tacit and staged tactics for integrating same sex relationships into family and community life.
- The sudden loss of connection to family and community support, on the other hand, can precipitate ‘time in crisis’ during which risk-taking may occur. This loss may be due to rejection by the family after “coming out” or being “outed”, or due to migration as a refugee or international student.
- The importance of support from family and community intensifies the harm caused by discrimination and exclusion, by reducing opportunities to find this support from other MSM.

navigating the health system

- The major barriers to service access are upfront cost, complexity of the system, reliance on word of mouth to advertise services, and lack of trust in privacy and confidentiality of services.

recommendations

state and sector-wide

- Coordinated campaigns are needed to (1) reduce sexual prejudice (homophobia) in ethnic communities and families and (2) reduce ethnic prejudice (sexual racism) in the gay community.
- Innovative public health frameworks such as the vulnerable populations approach and social cognitive theory should be combined with “social public health” methods of enquiry to better understand the needs and lived experience of culturally diverse men who have sex with men.
- Peer education and empowerment models of education are the most appropriate methods for addressing the social and situational factors that lead to risk-taking among CALD MSM.
- Training and opportunities to discuss broader understandings of “evidence based practice” will help the sector adopt and incorporate qualitative research and working knowledge in rigorous ways.
- Work is needed to reduce the relatively high rate of CALD MSM who have never tested for HIV.

recommendations (continued)

research

- Research is needed to quantify and explain the disproportionate rate of HIV infection among CALD MSM compared to Australian-born MSM.
- Researchers should consider deliberately oversampling MSM from CALD backgrounds to ensure that comparisons with Anglo-Australian MSM can be made and differences in their needs be identified.
- Targeted research is needed to fill gaps in our knowledge and test common assumptions as identified by the consultation.
- Research is needed into the experience and health needs for CALD MSM from non-South East Asian backgrounds, particularly African, Middle Eastern, and South Asian cultures, and refugees.
- It is essential to ask direct questions about visa status in epidemiological survey instruments.

community response

- Development of a training package to help clinical and community workers understand and respond effectively to the interaction of identity and discrimination among CALD MSM.
- Culturally responsive health promotion is needed, focusing on the social and contextual risk factors for HIV acquisition and poor sexual health and wellbeing among CALD MSM with particular attention to sexual negotiation, spoken agreements in primary relationships, and avoiding unwanted sex.
- Depictions of the stories, faces and bodies of men from CALD backgrounds should be included in community-based health promotion campaigns around HIV and sexual health, particularly those concerned with sexual adventurism.
- A plain language resource should be produced for CALD MSM community members responding to the particular health and social support needs identified in this chapter and elsewhere.
- Groups like Gay Asian Proud which provide social connectedness and culturally responsive peer-based health education should be further resourced and strengthened.

clinical services

- Clinicians and counsellors should ask CALD MSM about social and contextual risk factors, not just individual sexual behaviour, knowledge about HIV/STI, and STI screening.
- Clinical and community workers should take time during service orientation and intake interviews to build their CALD MSM clients' awareness of and trust in privacy and confidentiality.
- Clinical and community services should be advertised more widely, including outside the gay press and through online channels used by CALD MSM, in order to bridge the gaps in social networks across which 'word of mouth' cannot reach.
- Both service providers and community members should be made aware of free and low-cost opportunities to access sexual health care, including clinics that will bulk bill Medicare or overseas student health cover (OSHC) insurers.

introduction

background

Multicultural Health and Support Service (MHSS) convened a working group to organise a consultative forum on the topic of culturally and linguistically diverse (CALD) men who have sex with men (MSM).

Concern has often been expressed in the HIV/AIDS service sector around the experience and health needs of men in this group, in part because there is not a lot of research on the topic.

We decided to hold a consultative forum to assemble all the different pieces of knowledge held by people working in different services. As the available knowledge is fragmentary and incomplete, we developed a framework to evaluate the results and identify gaps.

methods

- We developed a group facilitation and reporting framework loosely based on the matrix of recognised and demanded health needs conceptualised by Alzougool, Chang & Gray (2008).
- The forum heard presentations by two service providers with direct experience of working with CALD MSM, and a presentation about the relevant epidemiology, as well as a personal perspective from an emerging writer who is CALD MSM himself.
- A select literature review was developed and the working group used it to choose four key themes and focus questions for each one.
- The second part of the forum divided the audience into four focus groups looking at the different key themes and focus questions, and these discussions were recorded.
- A report back session helped identify common themes across the four groups.
- A small number of key informant interviews were conducted to fill gaps identified in the knowledge elicited during the consultative forum, and to provide case studies.
- Transcripts of the interviews and discussion groups were analysed according to the principles of grounded theory (Corbin & Strauss, 2007).

key themes and focus questions

A breakout group was held for each of these themes to answer the related focus question(s):

- 1) **Sexual racism, internalised racism and homophobia**
Do they increase vulnerability to HIV infection and poor sexual health?
- 2) **Sexual practices and spaces**
Where and how do CALD MSM find and have sex?
- 3) **Negotiations of identity, family and community**
*How do CALD MSM manage who knows about their sexual attraction?
Where do they get health and emotional support?*
- 4) **Obstacles to health and barriers to service access**
Are there obstacles to health and service access for CALD MSM?

outcomes

- The Working Group met six times between January and August 2009.
- A preliminary literature review was developed and circulated internally, and a final version is presented in this report.
- A consultative forum was held on 30 July 2009 from 9AM-12PM in the seminar room at the Australian research Centre in Sex Health and Society, with about 45 participants including visitors from interstate.

In addition to this report:

- A plain language resource will be developed to offer practical guidance to service providers around the four key themes considered at the forum.
- MHSS will develop a training package for service providers around culturally responsive care for CALD MSM.
- MHSS will explore options to publish findings from the consultation in peer reviewed journals, to increase their accessibility and acceptability to practitioners trained in health sciences.
- A follow-up consultation will be held as part of the Diversity in Health conference auspiced by the Centre for Culture, Ethnicity and Health in June 2010.

limitations

This was not a primary research project – it was research into ‘what do we know and how do we know it’ as a sector. Relatively little is known about CALD MSM. This report discusses extensively the literature relating to the most-researched group, MSM from South-East Asian backgrounds, because we felt the lack of research into MSM from other ethnic groups was not a good reason to exclude what we do know. However, the findings of research into Asian MSM should not be generalised to other groups, as there are cultural differences that may have a direct impact upon the practices reported here. The findings are presented because they illustrate important questions to consider in planning and implementing culturally-responsive health promotion and clinical service provision.

identifiers

Where someone has made a contribution we particularly wanted to acknowledge, we have asked for their permission to credit them by name. Consultation participants were advised that the forum and discussion groups were being recorded and transcribed for this report and asked to advise the facilitator so the recording could be paused if they wanted to speak off the record; however, nobody made this request.

Since specifying someone’s particular occupation could identify them, quotes are identified with the participants’ disciplinary background: community member (CALD MSM), community worker, clinical worker, social researcher. Separate identifiers for community and clinical workers have been used because disciplinary background emerged as significant in the thematic analysis. It is acknowledged that these are not exclusive categories, of course: many of the community workers and social researchers present were also CALD MSM themselves, and where this was relevant it has been noted.

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glossary

AGMC

Australian GLBTIQ Multicultural Council

“coming out”

explicitly disclosing same sex attraction or gay/bisexual identification to others

BBV

blood-borne virus (such as HIV or hepatitis B/C)

CALD

culturally and linguistically diverse

evidence-based practice

the philosophy of basing health practice on rigorous published research from as high as possible on a hierarchy of evidence sources; the randomised controlled trial is at the top

GCPS

Gay Community Periodic Survey undertaken at periodic intervals by the National Centre in HIV Social Research

HIV

human immuno-deficiency virus

homonegativity

a more conceptually-sound alternative to “homophobia”, referring to sexual stigma against gay/bisexual people

homophily

seeking sameness and avoiding difference in friends and partners (“birds of a feather”)

MHSS

Multicultural Health and Support Service, a program of the Centre for Culture, Ethnicity and Health

MSHC

Melbourne Sexual Health Centre

MSM

Men who have Sex with Men

n= (number)

the number of participants in a study

OSHC

Overseas Student Health Cover – insurance all international students must purchase here

PLHIV/PLWHA

Person/People Living with HIV (or HIV/AIDS)

population

a conceptual grouping of individuals according to some shared attribute for epidemiological purposes, which may not exist as a social group or community in the ‘real world’

risk

the probability of an event occurring, such as HIV infection; sometimes used to refer to practices where that probability is increased

SEA

South East Asian

SOPV

sex on premises venue, such as a sauna or sex club where MSM may meet to have sex on site

SSAY

same sex attracted youth

STI

sexually transmitted infection

VAC/GMHC

Victorian AIDS Council/Gay Men’s Health Centre

vulnerability

“risk of risks” -- a social factor applying to a population leading to more of its members encountering or tending towards risk

I identity, discrimination and vulnerability

How do the experiences of sexual racism and internalised homophobia create vulnerability to poor sexual and mental health outcomes for CALD MSM?

overview

Culturally and linguistically diverse (CALD) men who have sex with men (MSM) experience discrimination from other MSM in relation to their ethnicity and from their family and community in relation to their sexuality. Although they share the same human capacity for adaptation as anyone else, the added complexity of dealing with discrimination and exclusion is a challenge and a cause of stress, and it can result in feelings of shame and silencing of self-expression and social activity. Social exclusion decreases access to support from friends and community, and limits opportunities for social learning; in its acute forms it can precipitate intense emotional crisis, distress and anomie, which may occasion risk taking. Community and clinical workers need to consider these aspects of the lived experience of CALD MSM when planning and providing services and support – but the recognition of these needs may be hampered by the focus on intentionality and debates about ‘who is to blame’ for racism.

findings

what do we know?

discrimination and exclusion

CALD MSM experience racial discrimination on the gay ‘scene’ (commercial social and sex on premises venues and community organisations) and online. Discrimination is often based on stereotypes about gender, associated with their cultures of origin and physical appearance; although it frequently takes the form of sexual rejection, community participants also encountered men who were attracted to them because they match a given stereotype.

Asvin Phorugam, health educator and coordinator of the peer education program at the Victorian AIDS Council/Gay Men’s Health Centre, presented the forum with two case studies typical of the one-on-one support needs presented by participants in the Gay Asian Proud (GAP) project he facilitates. Both were professionally-employed men in their thirties who had lived in Australia for more than a decade and reported living with intense and at-times debilitating anger

about experiences of discrimination and being stereotyped by other gay men.

Experiences of exclusion and discrimination have been extensively reported in health literature and community forums, but it is important not to discount them just because they are not ‘new’ findings.

The question of blame sometimes overrides the discussion of social exclusion. Exclusion can occur unthinkingly and through ignorance, without any specific intention to discriminate or exclude. The difficulty of proving that discrimination was intended should not be used to discount its impact or deny the reality of that experience for CALD MSM.

The modern reality of discrimination and exclusion is that it is subtle and covert, designed to “fly beneath the radar”. This has prompted social psychologists Sue et al (2007) to develop the concept of “racial microaggressions” to describe everyday slights that are racial or ethnically-based “put-downs”.

shame and silence

Shame about same sex attraction and sexual practice can exert strong influence on CALD MSM in different areas of their lives. It can decrease disclosure of male to male sexual activity to doctors, reducing the relevance of risk counselling and sexual health testing they receive.

Behavioural research shows that shame, understood as internalised homonegativity, reduces disclosure of serostatus and increases unprotected anal intercourse with casual partners. Rigorous qualitative research has shown that shame, conceived as “self-attributive” responses to discrimination, is significantly associated with unsafe sex.

Personal and political strategies developed in Western cultures to resist shame, such as gay pride and coming out, can force CALD MSM from collectivist cultures to “choose” between their sexual and ethnic identities.

Shame can reduce discussion of sexual experiences and relationships gone wrong with other gay men, decreasing opportunities for social learning. It translates readily into fear of HIV, which can manifest in excessive health-seeking behaviour by the “worried well” patient who obsesses about HIV infection following low-risk sexual contact and does not enjoy his sex life for that reason.

One participant suggested shame creates a “quick fix” mentality about sexual contact, in which brevity and privacy (being “discreet”) matter (rather than discussion or negotiation).

If you feel proud of who you are, you can publicly affirm yourselves, say “I am gay and I’ve had a partner for five years”, but if you can do that, then sexual urges overcome you and you go for a quick fix. (Community member)

In some cultures shame may also be attached to receptive anal sex as a marker of being gay or like a woman.

what are we assuming?

nature of “evidence”

In the past decade there has been a strong push to adopt “evidence-based practice” in health promotion planning and service delivery. There was an assumption made in a number of breakout group discussions that CALD MSM needs and experiences are not reflected in the “evidence base”:

“We know from our clinical experience that a barrier exists, but we don’t see this reflected

in the evidence base... Anecdotally, there’s no doubt there are barriers to CALD MSM accessing services – but how do you get evidence that’s due to internalised racism? (Clinical worker)

We don’t know the prevalence of sexual racism and homophobia; we know anecdotally that some cultures have strong family values that may lead to homophobia, but this has not been quantified and reported in the evidence base. (Community worker)

In an irony, this belief is not based on any systematic review of all the available knowledge. It combines a number of related assumptions, namely that:

- “Evidence” means published quantitative research, compared to informal working knowledge and (sometimes) qualitative social research, which are called “anecdotal”;
- Risk and vulnerability will make themselves visible in a quantitative measure such as the rate of new HIV notifications among CALD MSM; and
- The rationale for action (funded program work, service improvement, and further research) must always be evidence-based.

As a combination, these assumptions can produce inertia, or reluctance to initiate change, and a continual questioning of the rationale behind program work for CALD MSM.

sexual behaviour and risk-taking

In a number of breakout groups, participants stated that CALD MSM are broadly similar in behaviour and risk-taking to the general population. Apart from Asian MSM in Australia, there is not much research to support or depart from this assumption. Chapter Two takes advantage of the comparative wealth of research about Asian MSM to compare them with the mainstream population of MSM, finding they report lower risk behaviour and higher condom use on average. However, it is also important to consider the range and distribution of risk-taking and protective factors, as we discuss in Chapter 5, and their social meaning and context (see Kippax & Race, 2003) which vary considerably between, and within, mainstream and minority cultures.

mechanism of vulnerability

There was extensive discussion about the nature of the mechanism through which CALD MSM experiences of discrimination might increase their vulnerability to HIV infection. A couple of

“folk hypotheses” emerged:

(1) lower self-esteem and ability to negotiate condom use

I think the general link that I use at work is that sexual racism – or any form of being oppressed as a minority – leads to low self-esteem, lower community attachment and therefore that compromises your access to services/support and poorer decision-making. (Community worker)

(2) exploitation in relationships with older White men

But I do think there is an assumption, particularly from services, if I see a young Asian man come into the centre with an older Caucasian bloke, straight away I make assumptions there and it’s about exploitation on the part of the older Caucasian man. Unfairly perhaps, and not always, and that’s my assumption that the power disparity is felt more by the younger, non-English speaking or non-Caucasian partner. (Clinical worker)

These accounts provoked a very productive discussion in the breakout group, providing an opportunity to elicit and examine the stereotypes underpinning working knowledge about CALD MSM. In relation to the second account, one participant, a social researcher and CALD MSM himself, pointed out:

In the culture where I come from, my friends do desire older Caucasian men, but it’s not because they respect them as ‘elders’, it’s an imagination of you having someone who is a father figure... – “Sugar daddy?” – Not so much, because sometimes they may themselves be financially independent, but they do see in that kind of figure something a younger Caucasian or younger man cannot provide. – “And an older Asian man wouldn’t?” – For an older Asian man, it’s either they are married, most of them are, or they are not very comfortable with their sexuality. So for Caucasian men they find it easier because they can connect sexually.

The quote above calls attention to the benefits and social learning CALD MSM in such relationships may seek and derive, and to the need to balance broader concerns about racism and power with respect for the local meanings and importance of relationships within the lives of CALD MSM.

Either way, there’s a dynamic between Asian and Caucasian guys. Whether that’s racism... if Asian guys prefer older Caucasian men, what’s wrong with older Caucasian men? I don’t think that’s racism – there’s a dynamic and we could draw links between that and vulnerability, but don’t call it racism. (Community worker)

That said, cross-cultural relationships can present quite concrete issues where the potential for vulnerability is clear:

It’s about dependency equals ‘lifeline’. You have a young person from overseas with very limited knowledge and social connection around local ideas on all sorts of things, and that younger person becomes dependent on an older person, (for) social networks, friendships, healthcare, where to go for whatever. (Community worker)

Discussing the ‘problem’ of cross-cultural, older/younger relationships can obscure the reality that power dynamics exist in every relationship, and the broader question of whether health and social services can identify and respond appropriately to CALD MSM experiencing difficulties around them. Discussion in this and other breakout groups identified the problem that very little is known about CALD men who prefer sex and relationships with other men from their own culture.

The first folk hypothesis (above) about self-esteem and negotiation, offers a rough sketch of the generally-assumed relationship between discrimination and vulnerability to HIV infection.

In American research, internalised homonegativity (shame and self-stigma about same sex attraction & practice) has been shown to predict unsafe sex and lower serostatus disclosure (Ross & Rosser, 1996); experiences of racist discrimination predict unsafe sex in Latin-American MSM (Diaz & Ayala, 2001); and the type of response to discrimination (specifically, self-attributive responses) was associated with reporting unsafe sex in Asian & Pacific Islander MSM (Wilson & Yoshikawa, 2004).

However, research into Asian MSM in Australia has reported higher use of condoms, fewer men having anal intercourse with casual partners (Mao et al 2003), and higher self-efficacy for condom use and avoiding risk situations with casual partners (Mao, Van de Ven & McCormick 2004). Discussion in the breakout group identified the need to look at the interpersonal, social and cultural context of risk-taking:

Well, but self-esteem, then it just becomes about the individual, doesn’t it, rather than social constructs and everything that goes with that: it’s blaming the individual and their poor self-esteem. (Clinical worker)

This raised a related question about how social change can be initiated. One participant expressed a real scepticism about the possibility of initiating change, suggesting interventions to enhance the individual resilience of CALD MSM

are a more realistic objective, at least in the short term:

Addressing it at that level (depictions of Asian men in campaign materials) is almost tokenistic, in that people's preferences around what is sexual is so much bigger than a couple of ads in the press. A different approach is working with the community around building resilience to sexual racism. (Community worker)

Another participant saw the impetus for social change coming from "victims":

The reality is that when we see the politicising of most groups, it is the victims – or the people that experience that power disparity – that are generally the ones that spearhead change and, rightly or wrongly, drag society behind them, I think, be that women, or gay men, or whatever. (Clinical worker)

This quote gives a reasonable summary of how social change movements have worked in Western countries. This model may be less culturally appropriate and accessible for those CALD MSM who come from collectivist cultural backgrounds where same sex attraction is a private/individual matter rather than a social/political issue.

Equally, the assumption that CALD MSM have lower self-esteem underestimates within-group differences produced by personal adaptability (Sue & Sue, 1990) and resistance strategies (Wilson & Yoshikawa, 2004). These are important both as protective factors and as markers of social contexts where risks are taken.

hard to reach

Is that one of our assumptions – that we can't reach non-gay identifying MSM?
 – That's an assumption I've come across.
 – They've been called 'harder to reach'.
 – That's right, because they'll run away from anything gay. (Exchange between four participants)

The assumption that CALD MSM are "hard to reach" is sometimes used to explain the lack of "evidence" (see above) of problems and unmet needs experienced by this group. CALD MSM who identify as bisexual or heterosexual are said to be particularly hard to reach. In an essay titled "Who's on whose margins?" the Australian social researcher Michael Hurley (2009) points out the dangers of using this concept unreflexively. It can be used to mask the failure of educators and researchers to offer something relevant to the lives of our target communities.

For example, Hurley describes how researchers thought Indigenous Australians were "hard to reach", without realising that Indigenous people did not see their ATSI heritage as something they might report in a question asking about 'ethnicity', as the researchers expected. He notes "Their status as 'hard to reach' had been an artefact of research practices rather than a characteristic of them as a population" (Hurley 2009).

what don't we know?

is it just preference, just racism, or sexual racism?

A forum participant queried about the definition of sexual racism, asking how it was any different from "just" racism. This mirrors another objection raised against sexual racism by people who insist their refusal to consider non-white sexual partners is "just" personal preference.

Both of these statements naturalise their objects (racism/preference), which is to say they treat them as universal constants of human psychology, rather than social practices that vary enormously in their underlying purpose and meaning (Young-Bruehl, 1996). The content of sexual racism may be culturally-specific gender stereotypes, such as the feminisation of Asian men or the hypermasculinity attributed to Black men, or it may consist in a strong desire for sameness in a partner (known in the trade as "homophily"). As one participant pointed out:

I think if you compare it between different CALD groups – or between Indigenous Australians and gay Asian men – the dynamic of the sexual racism is different. Is that to do with the cultures themselves, or is it still "just" sexual racism? Is it about partner preferences and decisions, relating to vulnerability, or is it cultural factors, like assumptions and different values being held by those cultures? (Community worker)

where are CALD MSM located?

The breakout group noted that CALD MSM may not follow the pattern observed in some mainstream gay/bisexual men of living in (or near) inner city 'gay enclaves' (Prestage et al, 2008). In another breakout group, Rob Lake from Positive Life New South Wales noted it is possible to identify "low caseload clinics" in the outer suburbs where CALD MSM may access health services. "Low caseload" refers to clinics that diagnose or treat only a small number of HIV cases each year.

relationships between CALD MSM

Both in the literature and the consultation, there has been a lot of discussion about sexual encounters and relationships between CALD MSM and White men, but there is much less known about CALD MSM who prefer sex and relationships with other CALD MSM (particularly from their own cultural group). There is a stereotype that CALD MSM have sex in “closed sexual networks” with lower STI prevalence, but there is not a lot of evidence to support this belief, which will be discussed in greater length in Chapter Two.

Friends, up until now, they’ve gone out with mostly Asian men, but um, there’s more diversity now. Like, a few of them are starting to date, you know, white guys, Caucasian men. [...] I sometimes have the perception that the white guys have slept around a lot more than any other Asian guy – so in a sense they probably have a better chance of having a disease. (CALD MSM, in-depth interview)

There are people who hang around... like Vietnamese kids, who hang around together that don’t really know many other people apart from themselves and they have no presence. (Peter, respondent in Ridge, Hee & Minichiello, 1999:53)

are HIV notification rates disproportionate?

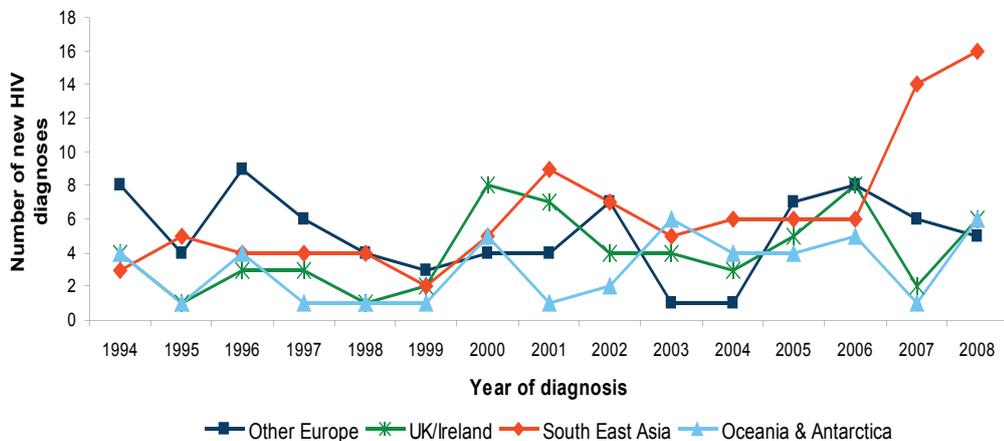
In the HIV sector in Victoria there is a constant focus on surveillance of new HIV diagnoses, and it was clear that some consultation participants had this outcome in mind when they queried whether there is “evidence” of unmet health needs in CALD MSM. Traditionally the focus has been on trends/changes in HIV diagnosis rates over time, with increasing trends taken as evidence of unmet

health promotion needs. Carol el-Hayek from the Burnet Institute presented data at the forum (see figure below) showing quite a substantial increase in HIV infections diagnosed in MSM born in South East Asia – from 6 in 2006 to 16 in 2008.

The increase is cause for concern. It is not possible to say whether it reflects an increased rate of infection in this population, or a change in the size of the population due to patterns of migration. As we discuss in Chapter Five, the question about residency status asked on the notification form is ambiguous, and the number of international students living in Victoria has doubled since 2001 (AEI, 2008). Further research is required to find out what is going on.

However, there is another question that hasn’t been asked before: **are rates of HIV infection among CALD MSM disproportionate to their population size?** Taking Southeast Asian-born MSM, they account for slightly more than 10% of total HIV diagnoses among MSM, despite coming from an ethnic background making up only 3% of the total Victorian population (el-Hayek, personal communication; ABS Census, 2006). This translates into substantially different rates of infection per 100,000 population. Again, it might be this reflects differences in the age structure of the Australian-born and Southeast Asian-born populations of MSM, but there are no data on the latter to enable age standardisation of rates.

The proportionality question arises only because notification rates have been used as the main indicator of vulnerability in CALD MSM, and is much less important if other forms of knowledge are allowed to contribute to that discussion. Nonetheless, we recommend further research to explore possible causes of or explanations for this troubling disparity.



Regions of birth for HIV positive diagnoses in MSM born overseas

Source: Carol el-Hayek, Burnet Institute, presentation to Double Trouble Consultation Forum (31 July 2009). Reprinted with permission from the Victorian Government Department of Health.

where are African and Middle Eastern MSM?

The need to study and respond to the experiences and indeed the existence of MSM in Africa has only recently become a priority on the international research and policy agenda, with statements on the issue from Peter Piot, former director of UNAIDS, and advocacy at the International AIDS Conference in Mexico. There has been global news reporting of court-sentenced and extrajudicial torture and execution

of men accused of homosexual practice in the Middle East, particularly Iraq and Saudi Arabia. However, the research and policy agenda in Australia has yet to catch up, despite recent immigration from these regions, including applications for asylum based on the anticipation or past experience of homophobic persecution. The needs and experiences of African and Middle Eastern MSM in Australia remain largely unknown.

conclusion

Sexual and ethnic prejudice and their expression in discrimination and social exclusion exert a powerful influence on the wellbeing of CALD MSM. Coming out, making friends, finding partners and engaging with the scene can be a challenging experience for men of any ethnic background, but for CALD MSM, engaging with prejudices in both the gay and their ethnic communities adds another layer of stress and complexity that Anglo-Australian gay/bisexual men do not have to deal with. Shame and silence, and “getting stuck” in periods of identity crisis, can isolate CALD MSM from clinical services and social support. There is a need for ongoing discussion within the health and community sectors about racism and the practical and power dimensions of cross-cultural encounters – whether clinical or romantic. As a sector we also need an expanded conception of what counts as evidence, including qualitative research and working knowledge.

This chapter presents the findings of the consultation alongside brief summaries of how these issues are discussed in the literature. Showing how identity and discrimination contribute in a causal sense to increased vulnerability requires taking an imaginative leap, guided by relevant theoretical frameworks in public health and health behavioural research. The result is a “best guess” hypothesis about how the experiences of discrimination and exclusion may lead to HIV infection for some individuals and not others. For clarity this discussion can be found in Chapter Five of this report, where it draws together themes and issues emerging in later chapters.

recommendations

- Coordinated campaigns to (1) reduce sexual prejudice (homophobia) in ethnic communities and families and (2) reduce ethnic prejudice (sexual racism) in the gay community.
- Development of a training package to help clinical and community workers understand and respond effectively to the interaction of identity and discrimination among CALD MSM.
- Training and opportunities to discuss broader understandings of “evidence based practice” that can accommodate qualitative research and working knowledge in rigorous ways.
- Targeted research is needed to fill gaps in our knowledge and test our assumptions as identified by the consultation.
- Research is needed to quantify and explain the disproportionate rate of HIV infection among CALD MSM compared to Australian-born MSM.

2 sexual practices and spaces

Where and how do culturally diverse MSM find partners and have sex?

overview

Australian social research into HIV risk has focused closely on individual sexual behaviours/practices, and this can obscure the more social and contextual reasons why some CALD MSM take risks leading to HIV infection. On the standard behavioural marker of risk – “unprotected anal intercourse with casual partners” (UAIC) – some groups of CALD MSM report *half* the exposure of the mainstream MSM population. In the context of primary relationships, the same groups were much less likely to have spoken agreements about anal sex within and outside the relationship, or to have ever tested. This chapter presents the findings of the consultation forum, discusses some very large assumptions that are made about the sexual practices of CALD MSM here and overseas, and concludes with a case study of research into Asian MSM in Australia.

findings

what do we know?

The sexual practice of CALD MSM is broadly comparable to the mainstream population, and MSM from some backgrounds report lower risk and higher protective factors on average. (See Case Study below for a comparison of a selected group and the general population).

Some CALD MSM have no problem finding sexual spaces (such as SOPV) and clinical services (such as the sexual health centre), and present to clinicians and nurse outreach with the same kind of issues as non-CALD MSM.

From my experience working in an SOPV, plenty of international students do come through, so they know how to find them and use them. I've seen no obstacle for them to find sex. They know where the beats are, exactly the same as locals. Their ability to navigate the scene using the net is the same as anyone in Melbourne. (Clinical worker)

Some CALD MSM report feeling social exclusion and related difficulty in finding partners for sex

and relationships, and coping this issue can take priority over sexual health-seeking.

In (support group) lately we haven't dealt a lot with the issue of sexual health, mainly because the issue of finding a sexual partner dominates discussion. Sexual space is also an issue, because some of our participants feel they do not have a place to go to – they are aware of saunas, beats, chatrooms, but at the same time, their experience of exclusion leaves them feeling they do not have a space. Being really frank, they say the reason we come here is a) we want support b) to find potential partners. (Community member and social researcher)

One clear difference between CALD MSM and White Australian MSM is the latter do not have to deal with the issue of race in everyday life. The influence of racial difference cuts across identity formation, sexual negotiation, making friends and finding partners.

Finding sexual and relationship partners exceeds sexual health maintenance as a life priority for some CALD MSM. There are three

related aspects, involving disclosure of sexual attraction, overcoming social exclusion, and learning skills for ‘picking up’ in social settings.

How do I tell people that I’m a gay man and I find them attractive and I want to go out on a date, when I’m not out at work and I’m not out in my community and I’m not out at university? This element of silence: I feel silenced because I’m aware of everything that’s going on, but I’m just not part of it. (Community worker)

I’d also be interested to know more about CALD communities’ perception of their ability to meet someone at work and establish a relationship at work, or meet someone in a tute if you’re a student, or those kind of situations – in a bar, in a more traditional old fashioned... (Clinical worker)

Sexual encounters between men don’t necessarily conflict with traditional cultural norms around getting married and starting a family until language around ‘gay’ comes into play.

what are we assuming?

closed sexual networks

Responding to a question about men who are ‘hard to reach’, one participant jumped right in:

We don’t know much about Asian-Asian attractions or Indian-Indian or any kind of same-race attractions, because the focus so much is on interracial. So what happens if there are two international male students from whichever countries that come, fall in love and do not identify with the wider gay culture – (interjection: they become invisible!) – that’s right, they don’t associate with (local) Asian cultures either, so where are they? They’re nowhere and they’re not a target of health promotion. (Community worker)

This account was immediately challenged by another participant, a clinical worker:

- But they may not need to be because they don’t have STI.
- Well that we don’t know... (Community worker)
- Well if they’re shagging each other they’re not gonna be.

As another participant then pointed out, behavioural research among CALD MSM has found higher rates of sex with women and non-homosexual identification than mainstream men in similar studies, as well as comparable rates of open (non-monogamous) relationships among CALD MSM respondents. This would seem to contradict the view that CALD MSM have sex in closed sexual networks.

sexual history “over there” and in Australia

At the consultation, many participants assumed that CALD MSM experience their arrival in Australia as an occasion of increased sexual freedom:

Arriving in Australia gives them the chance to be more sexually adventurous than they ever have been... for our MSM it tends to be a place where they can increase their number of partners, so we see plenty of those sorts of things, and there aren’t the same constraints as at home, so there are more opportunities to have sex in Melbourne than other places. (Clinical worker)

This view was strongly challenged by a social researcher who was CALD MSM himself:

I just really hate to see this conversation going to that duality of “they came here because they don’t know anything (about sex) and they want to explore” when the reality is, there has been a lot of work done in Asian countries (around HIV and sexuality). I do not find myself explaining a lot to students who arrive here, because they already knew this stuff – they already knew about HIV before arriving and look, kudos to them and the organisations in their home countries for making it visible. Their main question is ‘I want to go out, where’s the best place where I won’t experience racism’. (Social researcher)

At the International Congress on AIDS in the Asia-Pacific held in August 2009, a session about prevention for MSM in developed Asian nations heard that key behavioural trends included (1) high rates of partner exchange, facilitated by the internet; (2) group sex; (3) the use of amphetamine-type stimulants (ATS) during sexual encounters.

Research into male-to-male sexual practice in developing countries has reported widespread use of beats (sex in public spaces such as toilets) despite intense repressive surveillance by police and private security guards.

While age of sex onset may be delayed in Australia until after the age of consent, the illegality of homosexual sex means there is no age of consent and sexual debut may occur much earlier. It is not safe to assume that international students and migrants do not have sex in their home countries before arriving here, or that CALD MSM perceive Australia as a place of sexual liberation compared to their home countries.

culturally responsive health promotion

A major question discussed in the breakout group was what different cultures define and recognise as “sexual” activity. The concept “men who have sex with men” is assumed to avoid the

complexities around identification, but it may just introduce new problems around the definition of sex.

You'll have 16-17 guys living in one house, or even in one, two and three-bedroom apartments; you'll have mattresses spread across the floor, you won't necessarily sleep in the same bed each night, you won't necessarily sleep with the same person. Some homosexual activity is occurring that people don't necessarily identify as homosexual, and we've had a few e-mails and one face-to-face consultation, where students didn't know when they were having sex and what wasn't sex... (Clinical worker)

Some participants saw culturally responsive education as a matter of avoiding offending people:

And then all these people come on board and say 'well how do you present this in a way that's not taboo for their culture' but then how can you produce such a generic pamphlet that somehow gets that message across without offending anyone? (Clinical worker)

There's a lot of perception about offending people, though, and in the end, when everyone's got their clothes off, it's the same thing. (Clinical worker)

As an alternative to messages based on identity (or the general phrase "sexually active") one participant suggested the need to be really explicit about the bodily mechanics of sexual practice:

I think the challenge for us... is going to be shifting away from that issue of identity, because it's going to be more of a barrier for us... In terms of messaging, we need to shift from "gay and bisexual men should have testing", to "if you are having anal sex, or oral sex..." and being really explicit about the actual practice, and saying what is sex and what is risk, and really moving away from identity. (Community worker)

A practitioner of culturally-responsive peer education gently questioned these approaches:

It's a different strategy to what we use in (support group), because we've found if we do a lecture or information session to our guys, most likely they will just tune out. So we're doing it in very informal ways – we meet up, we go out, we have lunch, we have coffees, and that's when the education works. So there is that cultural element that I think plays a factor in the way our guys learn about sexual practices and where to go out. It's not condescending but it's involving and that works for us. (Community worker)

The approach taken by MHSS and VAC/GMHC Peer Education groups like Gay Asian Proud involves letting clients raise their own needs and

issues in a mixed social and educational formats, often involving food. Often, the needs a client presents with are different from the needs the State Government funds our services to meet. Culturally responsive care involves a negotiation process to meet the needs the client presents with as well as needs they may not recognise or request be met.

nature of harm

In BBV/STI health promotion it is often taken for granted that the harm we are seeking to prevent is infection with a BBV or STI – yet in culturally responsive health promotion practice, we know that avoiding BBV/STI is a much lower priority for members of CALD communities than it is for our sector, and effective education around BBV/STI is often best delivered in the context of meeting other needs prioritised by our target population, or addressing more significant and immediate harms. A recurring theme in the CALD MSM consultation was the need for skills education around sexual negotiation with a view to preventing a harm of unwanted sex. The following quote demonstrates its significance:

Even around the beat culture, we've had instances with students who... have, I mean, they have been raped – because they didn't experience what they thought they were going to negotiate. This was a case presentation to our counselling service. And when they worked it through, they'd found out probably the perception would just have been quite different between the two partners. And in most of those cases that was (with partners) from a similar culture, but the negotiation hadn't been strong, so they had been raped. (Clinical worker)

In the guys who compartmentalise their lives, politeness can put them at risk. A (youth group) participant was getting dressed and preparing to leave a sauna when a much older man hit on him, and he went ahead with sex because he felt embarrassed to say no thanks. (Clinical worker)

Addressing the harm of unwanted sex, by improving negotiation skills, has obvious follow-on benefits for negotiating condom use. It also suggests the need to ask about experiences of unwanted sex in any screening of CALD MSM.

what don't we know?

partners of CALD MSM

A participant in the group identified a focus on relationships between White Australian and CALD MSM and a major gap in our knowledge around relationships between CALD MSM and other CALD MSM.

sex work

Student service providers report some anecdotal discussion of sex work by female international students, but there has not been any research to quantify how common this practice might be among CALD MSM, or what particular needs may arise for CALD MSM engaging in sex work.

CALD MSM who are not international students

The discussion of sexual practices and spaces at the consultation forum focused heavily on the needs and experiences of international students, and it was noted this may occur because they form a clearly identifiable cohort. Much less is known about the impact of Australian-born CALD MSM from second and third generations in migrant and refugee families.

case study – Asian MSM in Australia

MHSS has two key populations, Asian and African communities in Victoria, but there is almost no literature at all regarding MSM from African or Middle Eastern backgrounds in Australia, nor on CALD MSM in Melbourne/Victoria.

This section presents a literature review of a select group of CALD MSM – men from Asian ancestry and cultures of origin – examining similarities and differences between their sexual practice and the wider gay/bisexual community in Sydney, Australia.

In the absence of research into CALD MSM from other cultural backgrounds, it is important not to assume this case study is representative of their needs and experiences.

A rough comparison between Asian MSM and the wider gay/bisexual community in Sydney is possible because an Asian Gay Community Periodic Survey (GCPS) was conducted there in 1998 and 2002 using questions and recruitment strategies based on the Sydney Gay Community Periodic Survey (Mao et al, 2003; Hull et al, 2003).

The differences fall into the category of “interesting if real”, since it is possible they result from recruitment differences between the two studies. Overall, the comparison suggests that Asian MSM had a lower risk profile on average than the whole gay/bisexual community. This interpretation is supported by a further study undertaken by the same investigators, comparing Asian and Caucasian men’s answers to the same questionnaire (Mao, Van de Ven & McCormick, 2004). The comparison also identifies some key areas in which Asian MSM may be more vulnerable. (See over.)

The key dimensions of the comparison are:

- (1) sexual identification;
- (2) safe sex with casual partners;
- (3) relationships;
- (4) sexual contexts;
- (5) particular risk factors;
- (6) sexual negotiation;
- (7) sexual health.

1) sexual identification

Respondents in the Asian survey were twice as likely to report bisexual identification and practice compared to men in the whole community sample, although it may be the difference is a result of variations in recruitment approaches and channels used by the two studies compared here.

	Asian GCPS	Sydney GCPS
Identifying as 'bisexual' or 'heterosexual'	11.38% ¹	7.5% ³
Sex with one or more women in the past 6 months	11.2% ²	5.6% ⁴

Sources: ¹ Mao et al (2003:14); ² Mao et al (2003:9); ³ Hull et al (2003:49) table fig. 9; ⁴ Hull et al (2003:48) table fig. 6.

2) safe sex with casual partners

Asian MSM showed half the rate of casual anal intercourse (total) and slightly more than half the rate of *unprotected* casual anal intercourse as the whole-community survey.

	Asian GCPS	Sydney GCPS
Men who did not have anal intercourse with casual partners	39.6%	19%
Always used condoms for casual anal sex	51.6%	46.8%
Sometimes did not use condoms for casual anal sex	18.8%	34.2%

Sources: Mao et al (2003:31); Hull et al (2003:31).

Asian men also reported slightly lower numbers of total partners compared to the whole community.

	Asian GCPS	Sydney GCPS
Number of male partners in the previous six months		
None	5.3%	11.8%
One	12.3%	16.7%
2-10	57.9%	39.4%
11-50	18.2%	24.3%
50+	6.4%	7.8%

Sources: Mao et al (2003:24); Hull et al (2003:21).

3) relationships

A slightly lower percentage of Asian MSM had regular partners or both casual and regular partners.

	Asian GCPS	Sydney GCPS
Men who reported having regular partners	56.4%	63%
Men who had both casual and regular partners	30.8%	34.6%

Sources: Mao et al (2003:10); Hull et al (2003:21).

In an 'open relationship', either partner or both partners may have sex with other partners. A participant in the consultation forum reported a scenario where older Caucasian men 'brought' younger CALD male partners to a clinic for sexual health testing. The participant reported that sometimes, later down the track, STI infections were detected in one or both partners, which the participant interpreted as evidence of a breakdown in monogamy on the older partner's part.

3) relationships (cont)

In community dialogue about cross-cultural relationships, stereotype attributes Caucasian men with higher ‘sex drive’ – wanting more sex, more adventurous sex, and sex with a greater variety of partners – and this is seen as a potential source of relationship conflict and loss of face for CALD (especially Asian) partners (see Chou, 2000).

It is therefore interesting to note how few Asian MSM reported that only their partners had sex outside the relationship. The age and ethnicity of partners was not asked about on the survey. It is possible that partners having casual sex was underreported due to the stigma surrounding this in community discourse.

	Asian GCPS
My partner has casual sex but I do not	3.1%
I have casual sex but my partner does not	24.1%
Both of us have casual sex	34.4%

Sources: Mao et al (2003:10).

There is a process described as “negotiated safety” available for couples who wish to have sex without condoms within their relationship (Kippax et al, 1993). It involves both partners getting HIV tests twice, three months apart, during which time they continue using condoms, in order to “close the window” period of antibody testing and definitively establish their serostatus before having sex without condoms.

The process also requires the couple to have an explicit discussion and conclude an agreement about sex outside the relationship, such as whether sex is permitted at all, what kinds of sex are permitted, and that condoms should be used and the other party be notified in the event that any of the other agreements are not followed.

Problems can arise when the communication process is not followed, since STI caught from a secondary partner may be transmitted to a regular partner during unprotected sex. Research has identified common flaws in the agreements, such as the reliance on indirect communication and assumptions, or agreements being incomplete (ie. failing to consider some likely possibility).

Compared to respondents on the whole-community survey, Asian MSM were significantly less likely to have negotiated a spoken agreement about anal sex within and outside the relationship.

	Asian GCPS	Sydney GCPS
No spoken agreement about anal sex <i>within</i> the relationship	33.9%	21.3%
No spoken agreement about anal sex <i>outside</i> the relationship	43.9%	29.1%

Sources: Mao et al (2003:30); Hull et al (2003:30).

4) sexual contexts

As described in the findings of this report, there was some discussion about whether CALD MSM feel excluded from social and sexual contexts used by MSM generally to find friends and partners. In this case study, the ways Asian men in Sydney found partners were broadly similar to the ways used by men in the whole community sample; however, Asian MSM were one quarter less likely to use gay bars to meet sexual partners.

	Asian GCPS	Sydney GCPS
Any use of gay bars to find sexual partners	62.6%	78%

Sources: Mao et al (2003:18); Hull et al (2003:33) (aggregates respondents who ‘often’ or ‘occasionally’ used gay bars).

5) particular risk factors

On the Asian GCPS (Mao et al, 2003) the practice of what Kippax, Crawford et al (1999) describe as ‘esoteric sex’ was quite high, and it had increased since the previous survey in the same study (Van de Ven, Mao & Prestage 2004; Prestage et al 2000). Esoteric or “adventurous” sex refers to practices such as bondage, sadomasochism, ‘watersports’ (urolognia), fisting, group sex and sex on drugs. In an analysis of data from both surveys of Asian MSM, increased engagement in esoteric sex predicted increased HIV risk (Van de Ven, Mao & Prestage, 2004:5).

On other ‘standard’ measures of HIV risk, Asian MSM reported less risk practices. Unprotected sex with casual partners was markedly lower (see (2) above). Another major difference was use of recreational drugs, with Asian men reporting rates of use less than half those found in the whole-community survey (Mao et al, 2003:33; Hull et al, 2003:39). Only 2 Asian men reported injecting any drug in both 1999 and 2002 (Mao et al, 2003:33) compared to about 5% of the Sydney GCPS (Hull et al, 2003:39).

6) cultural differences in sexual negotiation

A separate project undertaken by the authors of the Asian Gay Community Periodic Survey recruited Asian (n=199) and Caucasian (n=201) participants to complete the same questionnaire, which included items about individualism-collectivism and social-cognitive factors influencing condom use (Mao, Van de Ven & McCormick, 2004).

As in the comparison above, there were broad similarities between Asian and Caucasian respondents. For both groups, having more gay friends was associated with higher sexual risk, and higher self-efficacy for avoiding risky situations was associated with lower sexual risk. It also confirmed many of the differences found between the Asian and Sydney GCPS studies, with Asian men reporting lower casual risk taking and higher self-efficacy around condom use with casual partners on average.

	Asian	Caucasian
Any unprotected anal sex with regular partners	50.0%	48.9%
Any unprotected anal sex with casual partners	19.1%	34.4%

Sources: Mao, Van de Ven and McCormick (2004:60).

However, the average does not apply to every member of the population, and it is also necessary to consider the range and distribution of variation within the population. The study identified one factor which predicted variation in risk levels between Asian MSM. Lower self-efficacy around condom use with casual partners predicted higher risk behaviour, and the study concludes this should be a priority for HIV prevention education with this population.

7) sexual health testing

There was a striking difference in the number of Asian men who had **never** tested.

	Asian GCPS	Sydney GCPS
Men who had never tested	22.8%	6.4%

Sources: Mao et al (2003:20); Hull et al (2003:14).

The reasons Asian men gave for not having an HIV test included:

- Don’t want to know the result (39.2%)
- I am at low risk and don’t need to test (37.3%)
- Don’t know where to go for a test (13.7%)
- Don’t want government to know (12.7%)
- Fear of stigma/discrimination (11.8%)
- Cost (2.9%) or Other (4.9%)

Neither length of residence in Australia nor ethnic background was related to respondents not knowing their HIV status (Mao et al, 2003:21).

conclusion

This chapter identifies some quite major assumptions being made by workers in both the clinical and community sectors about the sexual practices of CALD MSM in Australia and overseas. One is the notion that CALD MSM and/or international students have sex “in closed networks”. Another is the idea that recent migrants have no sexual experience before arriving in Australia, and perceive this country as a paradise of sexual liberation. A third is the idea that culturally responsive sexual health care is primarily concerned with avoiding offending people. Finally, there is an assumption that CALD MSM share the same priority we place upon avoiding BBV/STI infection, compared to other harms they face like unwanted sex.

All of these assumptions could have an impact upon how we plan and implement work with CALD MSM, or conceptualise their needs within work targeting the community as a whole. While there is a kernel of truth in every one, there is a danger of applying them inflexibly to stereotype CALD MSM, and more work needs to be done to replace these assumptions with targeted and sensitive social research.

This chapter presents a case study comparing a select group of CALD MSM, specifically Asian MSM, with the whole community in two large behavioural surveys conducted in Sydney in the early 2000s. Some quite large differences emerged and are highlighted in that case study, subject to the disclaimer that they should be treated as “interesting if real”. They pose something of a paradox – in Victoria, it seems that HIV infection rates are disproportionate and rising in a group that has elsewhere reported lower risk practices. The discussion in Chapter Five of this report takes that apparent paradox as a starting-off point, using the ‘vulnerable populations’ approach to show why the distribution of risk exposure within a population matters as much as the overall aggregate of risk expressed in HIV infection rates.

recommendations

- Work is needed to reduce the relatively high rate of CALD MSM who have never tested for HIV.
- Culturally responsive health promotion is needed, focusing on the social and contextual risk factors for HIV acquisition and poor sexual health and wellbeing among CALD MSM with particular attention to sexual negotiation, spoken agreements in primary relationships, and avoiding unwanted sex.
- Depictions of the stories, faces and bodies of men from CALD backgrounds should be included in community-based health promotion campaigns around HIV and sexual health, particularly those concerned with sexual adventurism.
- Researchers should consider deliberately oversampling MSM from CALD backgrounds to ensure that comparisons with Anglo-Australian MSM can be made and differences in their needs be identified.
- Clinicians and counsellors should ask CALD MSM about social and contextual risk factors, not just individual sexual behaviour, knowledge about HIV/STI, and STI screening.

3 negotiations of identity, family and community

How do CALD MSM manage who knows about their sexual attraction?
Where do they get health information and emotional support?

overview

Part of the “double trouble” CALD MSM experience comes from the challenge of negotiating the integration of same sex attraction into family and community life. (The other part is the experience of discrimination and exclusion CALD MSM experience as ethnic minorities in the gay community, as discussed in Chapter One of this report.) Research into “identity conflict” shows it is often caused by external factors of the situation, forcing CALD MSM to choose between identities, rather than by any inherent incompatibility between same sex attraction and ethnic family and community life. The unquestioned expectation that CALD MSM will “come out” can force them to choose, when more tacit or staged approaches, such as “coming home”, may work better.

findings

what do we know?

Loss of support from and connection with family and ethnic community can precipitate the kind of crisis that is a major context for sexual risk-taking and unhealthy relationships. Combined with the experience of discrimination in the Gay community, it can lead CALD MSM to form a very bleak evaluation of the future.

I feel like I've thrown away my whole future, my study plans, my job plans, my part in the family to be part of the gay community which so far I've found is unable to even begin to replace what I've lost. (Pallotta-Chiarolli, 1998:8).

There is a need to engage with ethnic communities, both in person and through the media, to de-stigmatise homosexuality and provide support and accurate health information to CALD MSM and their parents and families.

Increasing the visibility of same sex attracted people in happy and healthy relationships is a challenge, since ethnic media currently adopt a very negative frame in their coverage of homosexuality.

One of the dilemmas that we've found in the past is sometimes ethnic media will take on the 'AIDS story' but won't take on the relationships stories

or family stories; they're kind of reinforcing that anything to do with same sex attraction is about disease. (Social researcher)

The most effective way to raise awareness of an issue in CALD communities is through interpersonal communication.

It's about having the personal (interaction) – parents in a lot of communities go 'I don't want to read about this in Arabic, for example; I want to meet someone who is a mother of (a gay child). (Social researcher)

In some communities, an individual's disclosure of same sex attraction or HIV positive status may reflect negatively upon the extended family. Failing to consider and carefully manage this possibility may be taken to imply the individual does not value these family relationships.

Shame, loss of face, respect... especially for your families. It's different if it was just you on your own and you had no family. I would be much more out if I didn't have my... if my parents were dead, say for instance. You know... if I didn't have a huge extended family that work in the health sector. So it's really, I have to be discreet, not because of me, but because of my family. And that's maybe not such a connection for maybe Caucasian men, I think – maybe, maybe! (Clinical worker)

There is limited awareness of these issues in the Gay community, and the prejudice against men who do not “come out” may cause distress to CALD MSM as well as creating difficulties in relationships with partners who do not recognise the sensitivities involved.

Family attitudes towards same sex attraction can change, along with society, over time. For some MSM, quite long-held habits of keeping their personal life private from the family may no longer be necessary or even functional.

Sometimes it’s about these kids’ perception of how their parents would react, as opposed to how their parents actually would react. I’ve just had a (late 40s) man come out to his family – South American, he came out as gay and HIV-positive at the same time, and he’s Christian so he had all that stuff as well! He has been at the bottom of the barrel (emotionally) for about four years, really sick, (until he) finally came out: the difference in him since then! His family have been very supportive and accepting of him – he has been shocked by how they’ve accepted him. (Clinical worker)

Sixteen years ago when I came to Australia, we never talked about safe sex; we were never concerned about that. When you talk about safe sex, it seemed like you were talking about disease, and people don’t see the doctor when they don’t feel they have a problem. Their priorities when they came here were employment, money, accommodation, study. Also, in Asian culture, when we talk about safe sex, that used to mean you were going for commercial sex – and that’s not acceptable, not good, so that’s why people didn’t want to talk about that. After many years living here, people have a more open mind to talk about that, the concept is changing and the culture is changing – that’s why people can talk about safe sex (now). (Community worker)

Research by the Refugee Health Research Centre at La Trobe University has described the sexual health information needs of refugee young people, who wanted their parents to develop a better understanding of sexual health so they could be more supportive (McMichael & Gifford, 2009). Our community participants echoed this:

My parents’ main thing was, my mum basically, she was focusing on all the negatives and the STDs and you know, sexual practices, and everything. Because she gets online, and she gets all the negative stuff, and she freaks out and she rings me. I say ‘Mum, where are you getting all this information from? I can send you pamphlets or anything like that!’ (Community member)

what are we assuming?

is coming out the answer?

In a book titled *Tongzhi: Politics of Same-Sex Eroticism in Chinese Societies*, Professor Chou Wah-Shan describes “coming out” as a social practice adapted and appropriate for the individualism of Western culture that can seem confrontational and self-centred in more collectivist Chinese cultures. The word *tongzhi* means ‘comrade’, a term appropriated from nationalist discourse by Chinese GLBT activists.

The strength of Prof Chou’s work lies in the depth and sensitivity of his interview research and field work with Chinese and Caucasian MSM across a range of different Chinese city cultures, particularly the comparison of post-colonial Hong Kong, the city-state of Taiwan, and mainland Chinese cities.

Prof Chou sometimes caricatures Western gay liberation and identity politics as being “confrontational”, underestimating the space they create for negotiation and ambivalence; however, this reflects a comparison that makes sense within the values of his reference point, Chinese culture, and it has a lot of salience for CALD MSM from cultures where family is the primary source of identity.

Based on his research, Prof Chou suggests “coming home” as a culturally appropriate alternative to “coming out”.

Despite the immense pressures *tongzhi* face, smooth integration of a positive *tongzhi* identity into the familial context is not unheard of. “Coming home” is a negotiative process of bringing one’s sexuality into the family-kin network, not by singling out same-sex eroticism as a site for conceptual discussion but by constructing a same-sex relationship in terms of family-kin categories. The *tongzhi* would establish such a relationship with his/her parents by mundane practices like shopping or playing mahjong together. Dinner has often been quoted as a crucial cultural marker for breaking the insider-outsider distinction. The *tongzhi* may then use quasi-kin categories like half sisters/brothers to integrate her/his partner into the family. (Chou, 2001:36)

losing my religion

Something that I’ve found, just as a gay man and in conversations with other gay men whether Caucasian or from other cultures: the intersection of religion (and sexuality) is a huge determinant in our wellbeing, and the kinds of conversations we have... because spirit means an awful lot, and that gives you community

belonging sometimes. So the tension is between, am I Muslim/am I gay, how do I negotiate that – and I want to still practice, but I have this (same sex) desire? It's kind of a pink elephant in the room! (Community member)

In gay community discourse, religion is often cited as one of the great sources of homophobic prejudice, and as consensus has built around this position it has led to the view that homosexuality and religious belief are incompatible, creating pressure on people who are both religious and same-sex attracted to disavow their religion.

These issues were considered at length at the Australian GLBTIQ Multicultural Council AGM forum “Is my religion more important than my sexuality”, the findings of which will be reported by Maria Pallotta-Chiarolli at a Multicultural LGBTIQ Health Forum as part of the Diversity in Health 2010 conference in Melbourne.

what don't we know?

refugees and same sex attraction

Mark Camilleri, the psychologist at Family Planning Victoria's Youth Action Centre has noted an increase in referrals of clients reporting same sex attraction as part of their application for refugee status or asylum.

Red Cross has been referring lots of young people to me, who've told their Red Cross worker they are same sex attracted, and that's what they want to get refugee status on. They're applying for visas, (and) they'll say 'I can't go back to my own country because if I come out, they'll kill me', so therefore apply to become permanent residents. And then (Red Cross are) sending them to me for further counselling and support. So this is one place where maybe we could be working with these agencies that support that particular type of community – with newly arrived/refugee status.

Mark pointed out some refugee MSM are being diagnosed with blood-borne viruses without being provided with the pre- and post-test counselling, required by Victorian law, that would enable them to seek appropriate services and to protect their sexual partners from onward transmission.

When they're doing STI testing (for the immigration health requirement), I've found they're just giving them the results, with no pre- and post-test counselling! They just tell them “Your test came back positive...” and (the clients) turn to me and go “They told me I was positive and what does this mean?” That's one place where they could get knowledge about support services.

Mark also mentioned the difficulty of evidencing claims for asylum based on same sex attraction.

But then they're asking me to write – how to prove this person is gay, and I can't do that! How do you do that? — Interjection: It's the creases, down the front of the pants... — All I can say is, well, they came to the same sex attracted young person's group and they interact with the other young people without showing any homophobia. What (else) can you write in a letter to support their application? But (DIAC are) worried that people have been tricking them to get into the country.

This is an important gap in our knowledge, and it overlaps with the gap in our knowledge about the needs and experiences of African MSM in Australia. Lemoh (2010) reports on a case series of African Australians living with HIV, which included four who became infected through male-to-male sexual encounters. This will be an important area of research for MHSS and the Multicultural BBV/STI Working Group to monitor.

consequences of family rejection

Most participants at the forum did not undertake case management with CALD MSM and therefore saw only particular aspects of their needs and experiences when things go wrong. At an in-depth interview held after the forum, Mark Camilleri described the severity of the consequences of family rejection for same sex attracted young people from CALD backgrounds. They include loss of financial support, sudden homelessness, interruption of study, and serious emotional and identity crises.

The more chaotic their experience of “coming out”, the more chaotic same sex attracted young people are in using drugs and having sex. Achieving stability depends on how quickly they can access emergency accommodation. The more chaotic their initial presentation, we've found, the less they test (for STI) and the more STI they encounter, the lower the priority they place on health and the more “tricky situations” they get themselves into. (Interview notes)

huy's story

The following narrative was developed following an interview conducted with a 21yo Vietnamese Australian gay/bisexual man, Huy (a pseudonym). The interview gives a clearer sense of how it feels to negotiate disclosure of same sex attraction in the context of an ethnic family and community.

telling mum

Yeah, (Mum has) kind of just gone with it, she likes the fact that everyone else is really accepting as well – the fact that my brothers and sisters are really accepting.

Has that made it easier for her?

Yeah, easier. Lately she's been starting to tease me about it, which is a sign of acceptance, you know. She'll say things like, when I'll go to hug her and I haven't seen her for days, like, "Go away, you're like a stranger to me! You're gay, mate!" (laughs) And then she'll just start laughing. She'll say like "You're my daughter!"

It's kind of mean, but the fact that she's joking about it, and where she's come from... she hasn't even accepted that her brother is gay, so the fact that her son is gay and she can joke about it is... good.

How was she when you first came out?

When I first came out she was shocked and immediately started to question me and ask me if I was sure, and no, I'm going through a phase, and she insisted that I was going through a phase, because she had gone through a phase when she was younger... and she kept trying to convince me that it was wrong...

Like what was she saying?

Um, well she was bringing religion into it. Uh, from religious teachings of Buddhism and stuff like that... but I don't think she properly read up on it; she did mention to me that it was wrong, in the religion, but um... the fact is she was just kind of straightaway against it, said "no, you can't be, no, it's not right."

But I did push on to the fact that... okay, she was making the point that it was 'not normal' – so I averted her attention towards the fact that okay, it's not normal, but it's *natural*.

The conversation went on for around two hours and... she wanted to know, because she never really knew about homosexuality, and why people are homosexual, so she started asking me questions: is there a scientific explanation?

I gave her one theory – like the gene theory – and after that, she was still adamant that she was right and that I was wrong... but she said "Okay, you will have to give me some time." Because she accepted that all this philosophy was indented in her brain, so she acknowledged that she needed to change.

choosing the timing

How did you choose the right time?

(long silence) Um... my sister... kept pushing me to tell her... um... and I thought about it... and... I thought that there would never really be a right time. So... there wasn't... a right time because, either way, I knew that it was going to be hard for her. So I was... I was sitting there in front of the TV with her one day, in the lounge, and that's where the conversation took place... I was sweating, it was 'now or never, I have to tell her', and that's when I kinda pushed my mouth to say the words, so that it was over, finally.

Why was your sister pushing you to tell Mum?

Because... because she thought that it would be good for me, that I should, you know, be open with myself. And that my Mum would be – either way, the fact that I was coming out, my sister saw that as a sign that I wanted to be open in the end – very open – so for that to take place I needed to tell my Mum, and she wanted me to be myself sooner than later. And that's how I felt as well.

brothers and friends

Probably the most important person to tell was my older brother. In the sense that... it would really change the way I socialise... well, me and my brother and even my younger brother, we're all pretty, our social circles are really closely related. So for me to tell my brother about being gay, it could impact on them.

But my brothers are really strong characters, in their social circles, and so am I... they've always kind of set the standards for their friends as well? My brother is someone that a lot of people look up to, he takes care of his friends like family, and his values are just to treat everyone like a brother. His only concern for me was that I would stay closeted just because of what other people might think.

He specifically told me when I came out to him that "I don't want you to live a lie just because you know you're around all these gangsters... you should be yourself, and you know that all of us – the way we were raised is that, just to be yourself and be proud."

arjun's story (1)

At the forum, Arjun, an up-and-coming young Indian writer, gave the following speech about his experiences as a gay man from India living, studying and looking for work in Australia.

About twelve years ago, my aunt, who had recently immigrated to Australia, sent me a card. The card had a stamp with a strange-looking animal holding a mirror and saying, 'Who am I?' When Daniel told me all I had to do today is to say who I am, I was reminded of the strange-looking creature on the stamp. About 12 years later, here I am, trying to answer the same question that animal in the stamp was asking itself.

So: who am I? I am gay. I am Indian. I am also many other things, but I won't talk about them now. So, I will talk for a few minutes about my life as a gay Indian international student in Melbourne.

Before I go into that, I guess I should give you a bit of a background. I came to Melbourne two years ago. I did a course in Communications and Media Studies and then a short course in Creative Writing. I have been living with my uncle and his family ever since I came here. I haven't come out to my uncle and aunt, but they would really have to be blind and deaf not to know I am gay, I guess. Maybe as a token of acknowledgement, they give me birthday cards with pink butterflies dusted with glitter (pink is my least favourite colour) and t-shirts that are extra-tight (and which I don't end up wearing because I look like a skeleton in them). I came out to my cousins a few months after I came to Melbourne. One of them – the girl – is very supportive and her boyfriend is, too. The other one – the boy – is very homophobic and makes comments like 'Gay people are disgusting. They need to be killed' etc every time something about gay people is shown on TV. I used to find this behaviour frustrating in the beginning, but now I don't bother to listen.

I think one of the reasons I came to study in a foreign country is because India is not exactly the most gay-friendly nation on earth. Before I go further, I should point out that I am still not out to my parents. I think there are two main reasons for this. One of them is that I am not financially independent at the moment, and I want to make sure I can support myself if they are not okay with the fact that I am gay. The second reason is that I haven't had a long time relationship so far. I don't want my parents to think I'd end up lonely and bitter when I come out. Having a job and a partner when I come out, I hope, won't make them feel I am a total loser.

Back to my life in Melbourne. I have met numerous guys in bars and on the net, and I had something similar to a relationship with one guy. That didn't really work out. The question people, white people who do research especially, ask me is: Do you experience sexual racism? The answer is I am not sure. I do see people saying things like 'Not in to

Asians, Indians or fatties' on online dating sites. A guy who contacted me on a dating site chatted with me and said 'I didn't realise you are Indian, I can't chat with you' once. I told him he was being racist and he said he was so not a racist. If that's not racism, then I am sure there is no sexual racism in this city.

Another question people ask me is: Why did you choose Australia? To be honest, I wanted to go to England. My parents weren't very keen on the idea, though. They didn't want me to leave India at all. They kept saying I'd have to be a second-class citizen if I live in a foreign country. I wanted to leave India mainly because of my sexuality. Finally, they said I could come here instead. Because my mum's brother lives in Melbourne, my mum felt he and my aunt could keep an eye on me. My parents still want me to go back to India. And it is quite possible I will have to go to India soon. I am applying for my residency and seeing how things go. If it doesn't work out, I will have to go back to India.

If I go back to India, I will miss Melbourne for sure. It has been a good experience for me so far. There have been ups and downs of course, and I am terrified of being the victim of a racial attack, but it's been a good experience overall. Although I have had relationships back in India, I started coming out to friends and family after I came here. I first came out to my friends at uni here, then to my cousins, to the people I worked with and friends back home in India. Some people, like the cousin I was talking about earlier, have not received it positively, but by and large people were very supportive. At both my universities – Monash and La Trobe – I was the only openly gay person in class, but people were very cool about it. Some of my straight male friends even exploit it. They make me a sample audience to test their level of attractiveness and ask me to help them with shopping. There are exceptions, of course, but the homophobic ones were never really vocal about their disgust or whatever it is that homophobes feel.

I saw from the handout that one of the topics this forum covers is 'obstacles to health and barriers to service access'. I go to the Melbourne Sexual Health Centre to get myself tested, and they have been very friendly and helpful so far. No judgements, or for that matter, discrimination. I see a lot of Indians, Asians and Germans there (those were the only non-Australians I could recognise), and I guess a lot of immigrants use the service. That's just an observation, and like everything I said today, I have nothing to back it up. I hope this presentation was helpful, and I wish you all a good morning.

arjun's story (2)

Five months later, Arjun wrote the following post on his blog (reproduced with permission). It gives a really clear example of the intensity of despair and anomie that CALD MSM can sometimes experience. In giving his permission to reprint this post, Arjun asked us to note it reflects his feelings and outlook at a particular moment in time, rather than representing his entire life: "I'm not depressed all the time!"

The Nameless Post, Thurs 25 February 2010

I'm trying to find the right words to express myself, but I'm finding it very difficult to do that. I want to express how hopeless my life feels at this particular moment, how boring and vacuous, but I can't seem to find the right words. I wake up every morning at six dreading to have to go to work. It's not that I don't like to work; it's just that I don't like what I'm doing. I don't drive a car, have never been interested in them, and here I am working for a car company and answering car-related queries over the phone. I don't like talking on the phone. I always avoid calling people. I prefer texts. But now I spend my days calling people and talking about cars. Come back to India, my parents tell me. I respond with vague answers. They get angry. They say I'm wasting my life, that I'm only growing older, that I need to find a 'proper' job. They call my uncle and ask him to convince me to go back to India. I don't know India would be the right place for me, though. Considering I'm gay. But then I wonder if I'm having a gay time living in a gay-friendly country. I am still single. I don't have any gay friends I can count on. The people I feel attracted to are always moving on, finding men who are more desirable, easier to love. Like Patrick. We have been chatting for weeks. But it doesn't seem like he wants to meet me. He talks to me about other people he meets, other people he chats with. And no, not over the phone. We chat on MSN. And we text, occasionally.

conclusion

Sexual prejudice in ethnic communities can present a major challenge to CALD MSM trying to integrate their same sex attraction into their family and community life, but there are signs that change is possible and already taking place in some communities' attitudes towards same sex attraction. As always, however, there is an enormous diversity among the different CALD communities and individuals, with some families responding with tolerance and understanding and others, not so much. Research has repeatedly found that strength of connection to family and community is a protective factor against HIV acquisition and mental health problems for CALD MSM. Work is needed to support CALD MSM in negotiating that integration of identities and social relationships, and to tackle upstream factors making this difficult.

recommendations

- Coordinated campaigns to (a) reduce sexual prejudice (homophobia) in ethnic communities and (b) reduce ethnic prejudice (sexual racism) in the gay community. (Chapter One)
- A plain language resource should be produced for CALD MSM community members responding to the particular health and social support needs identified in this chapter and elsewhere.
- Research is needed into the experience and health needs for CALD MSM from non-South East Asian backgrounds, particularly African, Middle Eastern, and South Asian cultures, and refugees.
- Groups like Gay Asian Proud which provide social connectedness and culturally responsive peer-based health education should be further resourced and strengthened.

4 navigating the health system

Are there obstacles to health and barriers to service access for CALD MSM?

overview

Upfront cost, system complexity, and reliance upon ‘word of mouth’ for advertising services present significant barriers to vulnerable CALD MSM with unmet health needs. At the consultation the Melbourne Sexual Health Centre was acknowledged by participants as providing a world-class sexual health service, which is available on a walk-in basis without a Medicare card and provides service to large numbers of CALD MSM. A strong theme in this report has been the vulnerability that can arise from lack of social connectedness and corresponding missed opportunities for social learning and support, and this affects whether a person has ‘bridges into’ sexual and other health services.

findings

what do we know?

Navigating the health system in Australia is difficult, especially understanding the configuration of primary, secondary and tertiary health services. Friends are an important source of support, in the form of practical know-how about navigating the health system and accessing health services. As it does with sexual risk, vulnerability in terms of barriers to health and service access comes from a temporary or ongoing lack of social connectedness.

The health system is very complex in Australia, dealing with Medicare issues and overseas student insurance; I’ve been using it for three years and I’m pretty much unsure about if I need services, how do I access (them) – going to the GP, getting the appointment; I reasonably speak well but I’m a bit concerned about (those) who can’t speak well. I can read and I have that access and I can ask friends for support, but for a new young boy it’s pretty hard. The health system in Australia, with due respect, it’s fantastic, but navigating it is not easy. (Social researcher)

For migrants without Medicare access and international students with Overseas Student Health Cover (OSHC), upfront cost presents a major barrier to sexual health service access. A participant who works in sexual health with general practice estimated the upfront cost of a sexual health screen at \$250, and another participant noted that’s about half the average yearly income in his country (Bangladesh).

Sexual health services are available free of charge at Melbourne Sexual Health Centre if CALD MSM are aware of the service, which is not promoted in mainstream, student or ethnic media outlets. This intensifies the importance of social connectedness for support and information.

Main problem is they don’t know about testing facilities. Even with the Australian kids. Particularly in rural areas, sexual health services are mainly focused on preventing unwanted pregnancies. (Social researcher)

Melbourne Sexual Health Centre was recognised as a provider of world-class sexual health and HIV services, located in proximity to a

large population of international students.

Melbourne Sexual Health (Centre) is the ideal service, because I've been working with sexual health services for the last 12 years and this is the ideal centre that I've come across. (Social researcher)

At MSHC and the HIV service of course, you see people from everywhere... If you don't have Medicare then I would always suggest to somebody to go to MSHC. (Clinical worker)

Confidentiality is an ongoing process of reassuring service users and discouraging onward disclosure by third parties such as interpreters. There is real diversity among CALD MSM in how much confidence they feel about disclosing personal information:

So (with) that whole issue of confidentiality, you might get one person happy about it and feels confident about it and you get the next person who arrives from overseas and they don't feel comfortable about it or you might have somebody who's been in the country for a long time and still not feel comfort about the confidentiality thing. I guess it's up to us health professionals to keep reiterating how confidentiality is very important in Australia and there's rules around it and (how) the interpreters are to be confidential in their work – but then you might get someone who's not going to be... (Clinical worker)

what are we assuming?

evidence of access to services

Participants assumed that the particular CALD MSM in greatest need of sexual health care can access services because they witness CALD MSM in general accessing their services.

The volume of people coming through our service is an indication they can find it. And obviously word of mouth as well... There is an indication that CALD MSM are accessing our service because ours has gone up 7% in one year! (Clinical worker)

However, the largest service barely advertises, and reports that most users heard about it through 'word of mouth'. This is unlikely to reach vulnerable individuals, who are vulnerable because of their lack of social connectedness – so they lack bridges into service access.

sexual health education before Australia

It was assumed that recent arrivals (both humanitarian entrants and international students) have zero exposure to sexual health education before their arrival in Australia. In fact, CALD MSM from refugee backgrounds in Africa

and international students from some South-East Asian countries may have encountered HIV education, albeit focused exclusively on heterosexual transmission or 'social evils' (as risk factors are characterised in Viet Nam).

adaptability

One participant noted the danger in assuming that people from CALD backgrounds lack skills and capacities to solve health problems themselves. Best practice in health promotion involves taking an 'asset based' approach, seeking to build on the strengths and resources that exist in individuals and their local cultures. By comparison, a 'deficit' approach focuses first on problems then looks for ways to fix them.

(There is an assumption) that people from different cultural groups and international students whose first language isn't English are somehow not that competent or a bit helpless, which I don't think is true. We frame – there's this 'othering' of people from other language groups. We know that people, no matter what language you speak, are as intelligent as anyone else, and there may be some challenges but that ingenuity is still there. (Forum participant)

coming out

As in other groups, participants assumed a Western 'coming out' model of gay identification in their discussion of obstacles to health and barriers to service access for CALD MSM. Reluctance to access services was often explained as a practical concern about family members finding out – a problem of information control.

One of the main (issues) is the cultural identity and the silence about sexual practice with men and how that can't be discussed within the family environment as a rule. From the point of view of (service users), they have had conversations with me about their fear of going to services, in case a family member finds out. Often they're staying with aunts and uncles... (Community worker)

However, the experience of shame about same sex attraction may be a more direct and primal explanation for this concern: it is a reluctance to take any action that might externalise and make that attraction socially real and publically visible.

Although 'coming out' and gay/bisexual identification might never occur, social connections with other CALD MSM can enable social learning around the life integration of same sex attraction, so the fact a person does not 'come out' may not indicate a barrier to their health and happiness.

what don't we know?

African and Middle Eastern MSM

Matching the lack of research, there is minimal working knowledge (experience/anecdote) about CALD MSM from cultural backgrounds outside South East Asia.

In primary health care, we see, I see, Asian guys primarily. (Among CALD MSM) I don't think I've ever seen anybody outside of that cultural group in primary care. (Clinical worker)

Likewise, there is a gap in research and working knowledge around the experience of CALD MSM living with HIV, especially those living in the Western suburbs.

sexual assault

We know very little about the experience of sexual assault among CALD MSM. This includes the sufficiency and cultural responsiveness of services for survivors. In Chapter Two, a

community worker who sees international students described a case of sexual assault which had arisen in a beat environment due to a misunderstanding of expectations and lack of competency in sexual negotiation.

over-testing

There was no discussion of over-testing among CALD MSM. In an in-depth interview conducted after the consultation forum, Mark Camilleri from Family Planning Victoria's Youth Action Centre described a pattern of CALD MSM from South-East Asian backgrounds seeking STI testing after every single sexual encounter – some going to the extent of seeing different doctors to avoid detection and frustration of this behaviour.

healthcare for non-refugee migrants

Among participants, there was a lot of uncertainty about OSHC for international students and immigration procedures (especially when a prospective migrant is HIV-positive).

conclusion

In Victoria the obstacles to health and barriers to service access faced by CALD MSM are addressed through a strategic mix of specialist multicultural health services like MHSS and the Alfred CALD HIV Service and through culturally-responsive service provision by mainstream agencies like MSHC and VAC/GMHC. Now that new National HIV and Sexual Health Strategies have been released by the Commonwealth, there is an opportunity to revisit that mix and see where relationships can be created or strengthened.

recommendations

- Clinical and community workers should take time during service orientation and intake interviews to build their CALD MSM clients' awareness of and trust in privacy and confidentiality.
- Clinical and community services should be advertised more widely, including outside the gay press and through online channels used by CALD MSM, in order to bridge the gaps in social networks across which 'word of mouth' cannot reach.
- Both service providers and community members should be made aware of free and low-cost opportunities to access sexual health care, including clinics that will bulk bill Medicare or overseas student health cover (OSHC) insurers.

5 discussion

Taking a population approach to understanding CALD MSM health needs

overview

In order to keep this report readable and accessible for as wide an audience as possible, we have chosen to contain the critical discussion of our findings to this chapter. It builds on the case study developed in chapter two considering South-East Asian (SEA) MSM. Assuming it remains current – and we have recommended further research to ascertain if this is actually the case – that research poses something of a paradox: how could a population with substantially lower overall risk produce higher HIV infection outcomes? This chapter uses the vulnerable populations approach (Frohlich & Potvin, 2008) and scales of adaptation to identity crisis such as the Minority Identity Development Model (Sue & Sue, 1990) to resolve the paradox, and suggests how these may be used to identify individuals in need of support and contexts such as primary relationships where risk taking may occur (Mao, Van de Ven & McCormick, 2004).

the paradox of low risk and higher HIV infections

Chapter Two presents a case study of MSM from South-East Asia – the best-researched group of CALD MSM in Australia – and notes that men in this group report substantially lower risk practices than gay/bisexual men from Anglo-Australian backgrounds.

The difference first became apparent in the Asian Gay Community Periodic Surveys (1998; 2002) but since these recruited only Asian MSM, it was possible the difference could be explained by differences in recruitment from the Sydney Gay Community Periodic Survey. A follow-up study by Mao et al (2004) recruited both Asian and White men and found the same difference – lower risk practices on average among Asian MSM compared to White MSM.

The titles of two articles about this research, in a 2004 edition of the journal *AIDS Education & Prevention*, really tell the story:

- Gay Asian Men in Sydney *resist* international trend: no change in rates of unprotected anal intercourse, 1999-2002 (Van de Ven, Mao & Prestage, 2004, italics added);

- Gay Asian Men in San Francisco *follow* international trend: increases in rates of unprotected anal intercourse and sexually transmitted diseases, 1999-2002 (McFarland, et al, 2004; italics added).

As the San Francisco authors wrote, “Studies of MSM usually include too few [Asians] to measure HIV prevalence or incidence with precision or to track temporal trends in sexual behaviour”, and note that the Sydney studies were exceptional in that they “*were able* to recruit a sufficient sample of MSM of [Asian] ethnic background in Sydney at two points of time” (my emphasis).

Their wording suggests that recruiting Asian MSM is particularly difficult – a version of the “hard to reach” stereotype.

In fact, this reflects a failure in study design to oversample in minority groups in order to enable valid statistical comparisons with majority populations, or alternatively to fund and conduct special purpose studies like the ethnospecific AGCPS or Mao’s cross-culturally comparative follow-up study. As Hurley (2008) notes, the

“hard to reach” stereotype projects blame onto the group for being “difficult” rather than taking responsibility for including the group at the level of study design and implementation.

Epidemiological and behavioural surveillance in Australia and overseas has typically focused on two things: whether risk behaviours are increasing, and whether new HIV infections are increasing. In the case of Asian MSM in Australia, risk practices on average have been lower than among White men, and at least from 1999-2002, they have been stable. (This may have changed since then.) Until quite recently, new HIV infections among Asian MSM have also remained stable, although since 2006 they have increased significantly among SEA-born MSM in Victoria.

The increases are cause for concern, but there is another issue that deserves attention: SEA-born men represent about 10% of new HIV infections among MSM despite making up only 3% of the Victorian population. This is an important and unrecognised health disparity. It translates into a small numbers of people infected every year – but the vulnerability that produces this disparate end result is likely to affect Asian Australians as a whole population, whether or not they end up becoming HIV-positive. The difference between vulnerability and risk helps explain the paradox that a population reporting lower risk practices on average also seems to produce a disproportionate number of HIV infections.

The public health researchers Frohlich and Potvin (2008) offer a useful explanation of the difference between ‘risk’ and ‘vulnerability’ – the latter, they say, can be understood as ‘risk of risks’. Vulnerability will not show up in a behavioural survey focused on current/past risk-taking, as it concerns the likelihood of risk-taking in future. As they point out, vulnerability is not distributed equally across a population: it is typically concentrated in some small fraction of the population, although all members of a vulnerable population share an increased likelihood of moving along the spectrum into that zone or fraction where vulnerability does translate into actual risk. Since this process happens over time, it again disappears from view when we use cross-sectional or ‘snapshot’ surveys to measure risk.

In the case of CALD MSM, this chapter attempts to sketch out a hypothesis (a ‘best guess’ explanation) about what factors or aspects of life experience lead to someone spending time in that zone of risk. I say ‘spending time’, rather than ‘ending up’, because I believe it is likely to be a temporary thing – because people are resilient and adaptive. (Research hasn’t shown any stable

and permanent sub-population of risk-taking Asian MSM – but, due to the gaps in the research identified above, it cannot be said that means one doesn’t exist.) If we understand those factors, we can ask about them in our friends and clients, to get a better sense of when someone might need a hand.

epidemiology & surveillance

Because of those gaps in the research, it is also difficult to say whether that disparity in HIV infection rates between Asian and White populations reflects vulnerability or differences in their age structure. When comparing incidence rates per 100,000 between populations, especially for sexual risk behaviours (or their outcomes), a population which skews younger or older might have different proportions of people in the age brackets where the risk behaviour is more commonly practiced. These could produce different outcomes without reflecting a real difference in risk-taking levels. It is plausible to suggest that age differences might explain the higher HIV incidence among South-East Asian MSM. The number of international students in Victoria has doubled since 2001, and the question about visa status/residency of newly-infected patients is ambiguous, to say the least:

3. Does the patient plan to **reside permanently in Victoria for at least 12 months?**

- Yes
 No
 Unknown

Source: **Victorian HIV Notification Form**
http://www.health.vic.gov.au/__data/assets/pdf_file/0005/367241/notification_hiv_form_aug09_.pdf

A student diagnosed with HIV part-way through a 3-5 year course, who may hope to obtain permanent residence at the end of it, could answer Yes or Unknown on this question.

Best practice in this situation calls for the calculation of an age-standardised rate per 100,000. This is a simple calculation which takes HIV infection rates by age bracket and ethnicity and compares them with the percentages of each population in those age brackets. There are Census data available to show the percentages of the Australian and South-East Asian-born general populations; however, the Burnet Institute has advised that it cannot calculate these rates without data on the age structure of the Asian-born homosexual population.

Based on the Australian Study of Health in Relationships (“ASHR”), it is possible to estimate that 3% of the Australian population are same-sex

attracted, and in their analysis this rate did not vary significantly with age. However, it is not safe to make the same assumption for Asian MSM who have migrated to Australia; among CALD male migrants to Australia there may be more than 3% MSM due to the ‘pull factor’ of Australia’s perceived liberality – or just its geographical removal from the oversight of family. Indeed, a study of students at universities in Brisbane found 22% of respondents from ‘East Asia’ reported same sex partnerships (Gu et al, 2008).

the vulnerability principle

Writing about another haemophilic families living with or affected by HIV/AIDS, the social researcher Angela Kelly (2002) describes what could be called the ‘vulnerability principle’ –

[I]t is important to note that ‘AIDS is not an ‘equal opportunities’ disease, affecting everyone and all communities equally’; rather, AIDS reinforces ‘existing social inequalities—of gender, of social status, of race, and of sexuality’ (Aggleton 1994: vi). AIDS also reinforces inequalities of health, biology and access to health care, and has exposed the ‘hidden vulnerabilities in the human condition that are biological and social’ (Fineberg 1988: 106).

Both quotes cited by Kelly pre-date the explosion of research and prevention work that occurred in the late Nineties, when UNAIDS finally got its act together to advocate for global aid funding priority (Pisani, 2008). The vulnerability principle was a “rule of thumb” to guide prevention work at a time and in settings where research had not yet been undertaken.

As funding became available, the vulnerability principle still remained in use, causing frustration to some researchers who were doing work to identify which *particular* social groups most needed prevention work. For instance, the epidemiologist and commentator Elizabeth Pisani has been very critical of vulnerability claims for groups at very low risk of HIV infection, especially

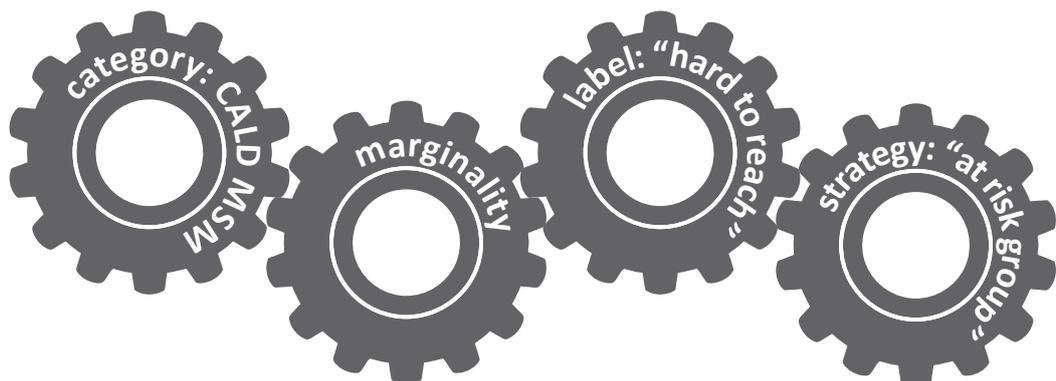
We would like to suggest a change to the notification form to ask a question explicitly about visa status, and that research be conducted to establish a reliable estimate of the proportion of male migrants to Australia who report same sex partnerships and/or identity. The Department of Health has funded MHSS to undertake a community-based research project exploring the sexual health needs of international students, both same-sex attracted and heterosexual, in Victoria.

when those groups are more appealing to politicians than MSM, IDU and sex workers. (This is a complicated argument, since it both critiques and invokes vulnerability and marginality.)

In this respect, vulnerability claims involve representational politics not unlike claims to marginality (Hurley, 2008; Gunew, 1994). They can be useful as a way of getting the ball rolling, but as Hurley points out, not without risks:

In social research into health, ‘marginality’ is often configured ‘naturally’ as an unproblematic given, with a mostly unspoken link to what are configured as pre-existing social categories: ‘women’, ‘black women’, ‘Third world women’, ‘intravenous drug users’, ‘sex workers’, ‘people with disabilities’ and ‘gays and lesbians’. The social, political and theoretical constitution of these categories inside and outside of the research disappears in the process of making them operational. Indeed what sometimes emerges is a conceptual slide between ‘marginal groups’ and ‘hard to reach populations’. They often become synonyms. This slide then ‘reappears’ on the field of service delivery. ‘Hard to reach’ populations are often intrinsically linked to notions of risk practices and collapsed into ‘at risk groups’. (2008:175)

The ‘conceptual slide’ Hurley describes starts out slippery, but another metaphor might treat it as a ‘drive train’ that becomes rusted into gear. (See figure below.)



The word ‘articulation’ is most commonly used to mean ‘expression’, but it has an important secondary meaning, referring to ‘jointedness’ and interconnection.

The articulation of these concepts means that each one turns automatically as a consequence of the others, without invoking any question about whether that’s empirically justified or useful to practitioners – the same objection Pisani raises against vulnerability claims about heterosexual women and children in countries with concentrated (ie, non-general) epidemics among MSM, IDU and sex workers. As a solution, attention must be paid to the specific details of how those processes interact to increase the risk or vulnerability of a particular social group.

Equally important are broader questions about how the social science language of marginality interlocks with the public health language of risk

groups to transmit momentum into particular kinds of action and intervention. When disciplines or concepts are too tightly interlocked, there is little flexibility to consider alternative explanations and responses.

The next part of this chapter looks at the consultation findings, published and ‘grey’ literature, and working knowledge, to sketch a hypothesis about the specific mechanisms through which CALD MSM are vulnerable to HIV/STI infection.

At the same time, care is taken to keep flexibility in the analysis, recognising that something that is true at the population level may be totally wrong for a particular individual, and the reverse – that individual level concepts may do a lousy job of explaining what happens at the level of group, community and culture.

specific mechanisms of vulnerability

This chapter looks at four specific mechanisms of vulnerability for CALD MSM, focusing again on Asian MSM as a case study. The following four mechanisms are considered:

- (a) Identity conflict
- (b) Experiences of discrimination
- (c) Adaptation styles and stages
- (d) Social and situational factors

Again, these are components of the hypothesis this chapter seeks to sketch, and what follows is a critical evaluation of the extent to which they help understand the issue.

a) identity conflict

Identity conflict is a prominent and popular explanation for the vulnerability of CALD MSM to HIV infection and poor sexual and mental health outcomes. The hypothesis here is that identity conflict lowers self-esteem and that this in turn reduces the capacity to negotiate safer sex practices. It assumes that gay and ethnic identities conflict.

Mao, for example, in an article titled “Gay Asian men dealing with the divide”, says “a lot of internal as well as external pressures were the consequences of their conflicting status as members of a minority ethnic group within a minority sexual orientation group” (p425).

Other Australian research in social psychology, quoted in Pallotta-Chiarolli et al (1999:5), describes interactions between cultural and sexual identity and practice, conceived in separation from each other:

‘It is possible that one could strongly identify with one group and not the other, have relatively strong levels of identification with both groups, or have low levels of identification with both groups’ ([Boldero, Sanitioso & Brain], 1993:3). Several Australian studies have demonstrated that the strength of identification with the gay community is important in the promotion of safe sex practices (Gold, 1993; Kippax & Crawford, 1993). Boldero et al found that ‘a stronger identification with the Asian community was related to weaker attitudes to safe sex behavior’. Participants believed that the more positive were their friends and other Asians to homosexuality, the stronger the participants’ identification with the gay community and the more informed they were in ‘safe sex effectiveness skills’.

However, Chong-Suk Han (2008) criticises the view that gay and Asian identities conflict in some kind of ‘zero sum’ fashion, along with the resulting implication that what’s needed is to engineer the closer assimilation of Asian MSM into gay identity and community.

A common view assumes that minority status is a health risk, therefore ethnicity and homosexuality are health risks, therefore being

an ethnic homosexual must be even more of a health risk, with debate ensuing about whether these risks are additive or multiplicative – the “double trouble” of the forum title. Writing about lessons learned from her studies of stress and resilience in Black lesbian women, Lisa Bowleg (2008) makes a crucial point: “ask an additive question, get an additive answer”.

Our forum title “double trouble” invited participants to question the assumption that being ethnic and gay is a “double disadvantage”. The notion that ethnic men have lower self-esteem is, like the vulnerability principle, an oversimplification. It masks the considerable diversity that exists among CALD MSM and the resilience and resourcefulness of individual members of that group.

From my experience working in a sauna, plenty of international students do come through, so they know how to find them and use them. I’ve seen no obstacle for them to find sex. They know where the beats are, exactly the same as locals. Their ability to navigate the scene using the net is the same as anyone in Melbourne. (clinical worker)

However, this observation should not be allowed in turn to mask the fact that living in a minority social group, dealing with discrimination and overcoming marginalisation are major life challenges for CALD MSM, and each individual will deal with them differently.

Research in counselling and social psychology has described a “stagewise” process of adaptation to these challenges (Sue & Sue, 1990; Roccas & Brewer; Operario, Han & Choi, 2008). In all of these studies, some respondents reported extremely high levels of distress, and depression was more common among Asian MSM than in the mainstream population. These are important health and social support needs that deserve to be met in their own right – not just when they might lead to HIV infection. A quote from Tony Ayres’ (1999) article illustrates the slow process of becoming aware of self-doubt induced by racism and sexual rejection:

I think, “Maybe it’s just me, maybe I’m being paranoid.” After all, everyone has to deal with rejection. What makes mine worse than anyone else’s? Maybe I have to face up to the fact that I am not the most attractive man in the world. For years, I have wrestled with doubts. Do other people have the same problems? It has only been recently, when I have met other gay Asian men who suffer from a similar lack of self-esteem, that I have realized that there is something more to it than my own foibles and vulnerabilities.

Just as Bowleg pointed out about questions in a research context – ask an additive question, get an additive answer – Operario, Han & Choi (2008) make the important point that “identity conflict” is not due to inherent differences between gay and ethnic identities but most often arises in response to external social situations. “Participants stated that the conflict and discomfort around dual identities was a consequence of situational pressures, usually reflecting others’ discomfort around sexuality or others’ racial prejudice, rather than reflecting internalised states” (p454). There was:

a tendency for participants to compartmentalize their identities when the situation warranted compartmentalization. The dominant pattern was for men to conceal being gay from family and other members of the Asian Pacific Islander community, a behaviour motivated by cultural norms and familial obligations around gender roles, the importance of perpetuating the family name and taboos against open discussions of sexuality, rather than reflecting internalized conflict about being gay. (p455)

Importantly, this research suggests ways forward to reduce the experience of identity conflict:

Rather than compartmentalizing their identities, men who had merged their racial and sexual identity appeared to do so by creating an accepting and supportive community that accommodated their complex social identities. Having a social environment and support system where participants’ race and sexuality were mutually affirmed appeared vital to a feeling of security and integration. (p456)

This report recommends the initiation of a collaborative partnership to pursue funding for a ‘twin’ campaign to promote acceptance of same sex relationships in CALD communities and tackle racial prejudice and discrimination in the gay communities.

Having established that sexual and cultural diversity do not in themselves produce “identity conflict”, and that different men go through different approaches and stages in adapting to the social pressures placed upon them by sexual and racial prejudice and discrimination, the next parts of this chapter look at how these differences may predict and contribute to vulnerability to HIV acquisition and poor sexual and mental health.

b) experiences of discrimination

Díaz and Ayala (2001) produced a report which has been widely cited in support of the idea that experiences of discrimination are associated

with unsafe sex and HIV infection in Latino MSM. The report was written for a community organisation and subsequently published in book form, but it was not possible to locate a peer reviewed, published article about the work, and other authors tend to cite but not quote from the report. It is a classic example of “fugitive” literature. Other examples are monographs published in Australia before 2000 which are now difficult to source, including important works on CALD sexual health published by Maria Pallotta-Chiarolli and colleagues (1998; 1999) at the National Centre for HIV Social Research before it moved from Macquarie University. Follow-up research found that internalised homonegativity predicted risky sex with partners of negative/unknown status among HIV-positive Latino MSM, but failed to replicate the initial finding that ethnicity and poor self-esteem predicted risky sex among HIV-negative Latino MSM.

Wilson & Yoshikawa (2004) completed in-depth interviews with 23 Asian & Pacific Islander men, eliciting 166 narrative episodes of discrimination as well as data on HIV risk-taking. Their analytic method combined qualitative data analysis using open and axial coding following Strauss & Corbin (1998) with statistical analysis using crosstabs to quantify the strength of association between dichotomous (yes/no) measures of HIV risk-taking and different kinds of response to discrimination (confrontation, self-attribution, external attribution, avoidance, and social network-based). Self-attribution responses were significantly associated with HIV risk-taking, while confrontational, social network-based and avoidance responses were associated with no/lower HIV risk-taking (p77).

By “self-attribution”, the authors mean that respondents had internalized and essentially agreed with the stereotype or prejudice others applied to them, such as: “You should exercise and so on. Otherwise, you cannot get somebody you want. White men like well-built and muscular bodies. For that reason, White men don’t like Asians very much” (p76). Or, more alarmingly, stereotypes of sexual availability, passivity and submission: “Well, the whole stereotype... gay Asians kind of have a similar reputation as Asian women, that we’re passive and gentle and we’re the bottom. ... I had people just assume that I’m a passive whore.”

Other small qualitative studies have expressed the concern that these two stereotypes may either make it difficult for Asian MSM to negotiate safer sex (Han, 2008) or even, as “low sexual status” men, encourage them to “trade off”

protected sex to attain partnerships with “higher sexual status” men (Green, 2008). What’s nice about the Wilson & Yoshikawa (2004) paper is that it also shows the capacity of individuals to respond adaptively to these pressures, and with its companion paper Yoshikawa & Wilson (2004, p93, p97) conceptualises the critical importance of social support from friends and family as a protective factor against risk-taking.

In Australia, Ridge, Hee & Minichiello (1999) have written about the experience of young gay Asian men on the gay scene in Melbourne, expanding on sociological PhD research by the first author. Under the rubric of “assimilation”, they describe the interaction of individual adaptation and social/cultural processes in the experience of a respondent, Denis, “an overseas student from a wealthy family in Southeast Asia”. Initially, “he experienced a kind of unremitting discrimination on the scene”, in the push-and-shove of a nightclub where he felt both stared-at and ignored (p53). “However, Denis did go back to this popular gay nightclub and eventually managed to fit in and assimilate to the scene culture. ... Since these changes, Denis has reported far fewer instances of discrimination. ... At a subsequent meeting, Denis seemed less interested in, and could barely recall, the discrimination he first reported and had been perturbed by.”

At this point, what matters is the progression in Denis’ accounts of experiencing racism and hostility on the scene. The question is not here whether Denis’ initially negative experiences “were really racism”. Reading Tony Ayres’ quote above, it is clear that one of the most insidious effects of modern racism is the way it leaves its victim to constantly doubt themselves and interrogate their experiences with exactly that question. As both Elisabeth Young-Bruehl (1996:102) and Sue et al (2007) have documented, “modern racism” has evolved into forms intended to fly below the radar.

The “old fashioned” type where racial hatred was overt, direct, and often intentional, has increasingly morphed into a contemporary form that is subtle, indirect, and often disguised. Studies on the existence of implicit stereotyping suggest that the new form of racism is most likely to be evident in well-intentioned White Americans who are unaware they hold beliefs and attitudes that are detrimental to people of color. (Sue et al 2007, citations omitted).

Sue et al (p72) use the concept of “racial microaggressions” to describe the mechanism of modern racism. These are “brief and commonplace daily verbal, behavioral and

environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group.” The physical disrespect (jostling, shoving, stares) and the sexual rejections described by Denis and Ayres in their quotes above clearly fall within the scope of this concept.

Sue et al (2007) found three major consequences of racial microaggressions:

First, they remarked that it was often difficult to determine whether a microaggression occurred. Were they being oversensitive or misreading the remarks or questions? They described spending considerable psychic energy trying to discern the motives of the person and/or dealing with inner turmoil and agitation caused by the event. A few stated that it was often easier to deal with a clearly overt act of bias than microaggressions that often created a “guessing game.”

Second, most of the racial microaggressions that occurred came from peers, neighbors, friends or authority figures. It disturbed them that personal or respected acquaintances could make such insensitive or hurtful remarks. What bothered them most, however, was their occasional tendency to “make excuses” for friends by rationalizing away their biases and by denying their own racial reality. Although we did not specifically explore the differential impact of microaggressions from acquaintances versus strangers, it appears that some of the participants felt that microaggressive behaviors were easier to handle and less problematic when they came from strangers.

Third, many expressed severe conflict about whether to respond to microaggressions given that most were unintentional and outside the level of awareness of the perpetrator. Pointing out a microaggression to a friend, for example, generally resulted in denial, defensiveness, and a negative outcome for the relationship. A few shared that they simply were at a loss of how to respond, or that the incident occurred so quickly a chance for some sort of intervention had long passed. They described being angered and upset without any recourse other than to “stew on it.” ... We can only conclude that the emotional turmoil could be long lasting and take a psychological toll on the recipient. (Sue et al, p78).

This accords with the case studies of Asian MSM experiencing intense distress, presented at the consultation by Asvin Phorunggam, and the intense “guessing game” and self-doubt described by Ayres in the quote above.

In recordings of the breakout groups and consultation forum, it was striking how often CALD MSM community members and workers were interrupted sceptically by Anglo-Australian workers when they were describing personal episodes they had experienced as racially prejudiced. This would, in itself, fall under the “denial of racial reality” type of microaggression. It points to the incredible poverty of the popular Australian political discussion of race and ethnicity, where the concern to avoid blame constantly impedes the ability to listen and to acknowledge the experiences of others. It is for this reason that “sexual racism” has been conceptualised – because it is qualitatively different from the racism of apartheid, slavery and the Stolen Generation; it is subtler and easier to doubt and deny, and that precisely is what makes it so intensely difficult to deal with.

Quoted in Catherine Kohler Riessman’s seminal *Narrative Methods for the Human Sciences* (2008:86), Dennie Wolf describes the “teller’s problem” – a challenge faced by anyone who would tell a story:

The problem is, at least in one sense, to convince a listener who wasn’t there that these were seriously troubled times and that the speaker hasn’t just cooked up this account in order to entertain, lie, or get attention. It, like many other kinds of therapeutic discourse, faces a speaker with justifying her/himself as the main character—both in the sense that s/he was a central agent (not just furniture) and was deeply affected (not indifferent). A speaker also has to prove that the times really did have the qualities s/he says they did. To do this often means finding some way to provoke a similar state in the listener, at least enough so as to argue, “*This is veridical. It did happen. I am justified in having felt as I did.*” (italics added)

As Riessman says, the “teller’s problem” is to overcome a potential “so what” response. An objection that is constantly raised against tellers of stories like Denis and Tony Ayres is that White men also face difficulties in learning and adopting the social and identity rituals of the gay scene:

Their ability to navigate the scene using the net is the same as anyone in Melbourne. Can they navigate the scene and/or healthcare afterwards? I would say Caucasians here.. or Melbournites would have the same problems. So I would have to say I don’t see a huge difference between someone who wasn’t born in Melbourne from someone who was, at a sauna. The issues they’re dealing with about shame—guilt—nervousness—anxiety—lack of comfort, it’s the same for white fellers, black fellers, whatever. (Clinical worker)

	STAGE 1 Conformity	STAGE 2 Dissonance	STAGE 3 Resistance & Immersion	STAGE 4 Introspection	STAGE 5 Integrative Awareness
<i>Attitude toward self</i>	Self-depreciating	Conflict between self-depreciating and appreciating	Self-appreciating	Concern with basis of self-appreciation	Self-appreciating
<i>Attitude towards others of same minority</i>	Group-depreciating	Conflict between group-depreciating and appreciating	Group-appreciating	Concern with nature of unequivocal appreciation	Group-appreciating
<i>Attitude towards others of different minority</i>	Discriminatory	Conflict between dominant-held views of minority hierarchy and feelings of shared experience	Conflict between feelings of empathy for other minority experiences and feelings of culture-centrism	Concern with ethnocentric basis for judging others	Group-appreciating
<i>Attitude towards dominant group</i>	Group-appreciating	Conflict between group-appreciating and depreciating	Group-depreciating	Concern with the basis of group-depreciation	Selective appreciation

Adapted from Sue DW & Sue D, *Counselling the Culturally Different (1990:97)*.

What this overlooks is that White men don't have to deal with racial difference as well. It's a "so what" response that suggests the storyteller has failed to achieve even the minimum threshold for concern. However, there is another way of understanding it. Racism is an incredibly hot topic of discussion in Australia. Neal Norrick, in an article titled "The Dark Side of Tellability", points out that some stories are too salient for some audiences and thus produce discomfort. In *The Anatomy of Prejudices*, Elisabeth Young-Bruehl (1996) calls attention to the plurality and differences between various kinds of prejudice, and takes a psychoanalytic approach that asks what emotional purposes the different kinds of prejudice serve for their practitioners. Many gay men put a lot of psychic energy into forgetting how helpless and undesirable they felt upon first entering the gay scene, and this blocks off the emotional basis of an empathetic response.

Absent that imaginative capacity, the result is an insistence upon formal equality – providing the same services regardless of difference – rather than a substantive response that takes cultural differences into account. The next two parts of this analysis describe the adaptation styles and stages used by CALD MSM to negotiate their engagement with gay identity, community, sexual encounters and relationships, as well as the social and situational factors that confer protection or contribute to HIV risk-taking. The objective is to enlarge our imagination of the needs and experiences of CALD MSM, so that as a sector we may better identify how and when we can helpfully respond to them.

c) adaptation: styles and stages

In 1990, Derald Wing Sue and David Sue wrote a second edition of their classic text on cross-cultural counselling psychology, *Counselling the Culturally Different*. In a chapter on racial/cultural identity development, they note the danger of applying group-level knowledge about differences between cultures in a stereotypic manner – failing to recognise within-group differences and individual variability (p93). Recognising that the adoption of a minority cultural identity involves a slow process of adaptation over time, adapting both to differences from the majority culture and the lived experience of prejudice and discrimination as a minority within it, they propose a five-stage model of Racial/Cultural Identity Development (R/CID) (table, above).

Their model shares many stages and features in common with other similar models discussed in Operario, Han and Choi (2008). It should not be applied too rigidly – in reality the stages shade into each other, and as Parham (1989) points out, "the process of racial identity development continues throughout the lifespan" – a process he describes as "cycling". One of the key features of stagewise models is that they depend upon encounters producing crisis to engage the critical and reflective processes that result in forward movement. Crises are normal, usually temporary, and personally productive (unless the individual gets stuck) and involve changing attitudes/relations toward the individual's ethnic group and majority culture.

The R/CID model ties all the threads of this chapter together. It helps resolve the paradox that in a population with lower risk-taking there are disproportionately higher outcomes of HIV infection. It shows how and why a member of the population may move into periods of what we have chosen to call ‘time in crisis’, when vulnerability may translate into risk-taking. ‘Time in crisis’ calls attention to the temporality of the concept – for many, it will be relatively brief, while for others it may be prolonged – as well as the intensity of the experience. Although Stage 1 “Conformity” seems inherently to involve the self-attribution of risk that Wilson & Yoshikawa (2004) identify as a predictor of risk-taking, it is worth noting that every stage transition will involve some aspects of crisis. The model draws together aspects of vulnerability, risk and protective factors:

1) For CALD MSM, if time in crisis is particularly intense or prolonged (“getting stuck”), risk-taking may result.

The more chaotic their experience of ‘coming out’, the more chaotic same sex-attracted young people are in using drugs and having sex. Achieving stability depends on how quickly they can access emergency accommodation. One client grabbed onto a series of different subcultures – raver, greenie, beatboxer – with initial optimism followed soon after by disillusionment and rejection. “He’s grabbing at straws, trying to work out who he is.” (Notes of interview with Mark Camilleri, psychologist at Family Planning Victoria Youth Action Centre).

2) CALD MSM may go through the process in relation to their ethnic identity, sexual identity, and possibly an intersectional form of identity (“gay Asian male”) as well. These might occur in sequence – Australian-born CALD MSM interviewed for this project reported dealing with ethnic minority first, followed some years later by sexuality. Alternatively they might occur simultaneously, such as when an international student arrives in Australia, never having experienced being considered an ethnic minority, and begins to engage with gay life as well. These could result in quite different experiences, support needs, and intensities of crisis.

3) The changing attitudes (relations) toward self and group conceptualised in the R/CID model present the major contextual factors associated with HIV risk-taking —

- (a) self-attribution of stereotype/prejudice and an avoidant coping style
- (b) loss/lack of social support (either through self-isolation or being ostracised by groups)

4) It also offers strong support to an empowerment model of service delivery using a mix of peer education, social events, campaigns targeting racism and homophobia, and appropriate and timely referral to counselling or peer support for CALD MSM experiencing time in crisis.

At the moment, this is just a hypothesis that might be used to guide service planning and delivery, so long as that provides for a substantial component of formative research intended to evaluate whether it is useful and accurate. However, support for this approach may be found in Rosenthal, Russell & Thompson’s (2006; 2007; 2008) study of international student health and wellbeing at the University of Melbourne – a population which has some important similarities with CALD MSM, not just their cultural and linguistic diversity but also their engagement with a social setting (the university) which presents a steep learning curve (just as gay life does). Based on analysis of student responses (n=979) across the different wellbeing domains the study investigated, the authors found the population distributed into three main groups based on coping style, social support, and risk-taking:

The majority of students, 59 per cent, exhibit a positive, connected style of adaptation; these students have a sound sense of well-being. A substantial minority of students, 34 per cent, are unconnected and stressed in their approach, while a very small group, 7 per cent, have a distressed and risk-taking mode of adaptation. The latter two groups of students are the ones whose well-being is in need of strengthening. With appropriate support, these students could have much more satisfying and productive experiences as university students in Australia. (Rosenthal, Russell & Thomson 2006:7)

d) social and situational factors

This is the ‘last word’ in this discussion, but there was a relevant quote that first unlocked my understanding of the issue – an insight producing the ‘click’ that led to deep understanding:

I feel like I’ve thrown away my whole future, my study plans, my job plans, my part in the family to be part of the gay community which so far I’ve found is unable to even begin to replace what I’ve lost. (Pallotta-Chiarolli, 1998:8)

This requires a different way of understanding the vulnerability of CALD MSM. It’s not due to their risk practices, necessarily – although primary relationships are an important context for unprotected sex, and we probably shouldn’t assume they practice negotiated safety. Rather, it’s about disconnection from social support,

which is an important protective factor for this group, and the sense of crisis, as much about the future as it is about identity, this can engender.

Mao, Van de Ven & McCormick (2004) use the concept of Western individualism versus Asian collectivism to conceptualise differences in cultural orientation. We would suggest another framework might help complete the picture: Simon and Gagnon's (1999:30) idea of paradigmatic and post-paradigmatic societies. They write about the 'scripts' or narratives that guide people through the negotiation of sexual and other kinds of social encounters, and obviously the value a culture places on shared meanings affects the influence of these scripts.

In traditional societies, cultural scenarios and a limited repertoire of what appear to be 'ritualized improvisations' may be all that is required for understanding by either participants or observers. Such societies might be termed paradigmatic societies. They are paradigmatic in a double sense: in the sense of a high degree of shared meanings and in the sense of specific or concrete meanings being perceived as consistently derived from a small number of high integrated master meanings. Specific shared meanings are experienced substantially as being consistent both within and across distinct spheres of life.

Postparadigmatic societies are those in which there are substantially fewer shared meanings and, possibly of greater significance, potentially profound disjunctures of meaning between distinct spheres of life. As a result, the enactment of the same role within different spheres of life or different roles within the same sphere routinely requires different appearances, if not different organisations, of the self.

The cultural scenario that loses its coercive powers also loses its predictability and frequently becomes merely a legitimating reference or explanation. The failure of the coercive powers of cultural scenarios occasions anomie, personal alienation and uncertainty. Much of the passionate intensity associated with anomic behaviour might best be interpreted as restorative efforts, often desperate efforts at effecting a restoration of a more cohesive self, reinforced by effective social ties. Anomie feeds on the ultimate dependence upon collective life that describes all human experience. The integration of personal metaphors and social meanings that make social conduct possible is complex. Scripting becomes a useful metaphor for understanding this process.

Within this framework, CALD MSM may have arrived in Australia from paradigmatic societies organised primarily around gender and marriage, and face a steep learning curve to adapt to the

postparadigmatic spheres of (a) ethnic community in an ostensibly multicultural but predominantly Anglo-cultural society and (b) performing different selves 'in the closet' and among other MSM. Arguably the gay community has undergone just such a transformation itself since the end of the HIV/AIDS crisis and the dissolution of unitary, crisis-oriented ways of doing community. Anomie is not a bad description for the personal crisis occasioned by loss of social connection and support among CALD MSM as a result of the mechanisms of vulnerability described in this chapter (see Arjun's story (2) on p28).

The search for a relationship partner is, for many Asian MSM, the 'master meaning' organising their gay sociality, and in negotiating cross-cultural encounters this comes under considerable pressure:

When I talk to people on the phone ... Australian [guys], they'll say, "Do you want to go further than that?" "Further than that" means having a relationship. But ... in Asian culture, when you say "Do you want to go further than that?" we mean, having sex after the relationship [has been established]. So, of all the times I meet Caucasians, we end up having sex first. (Denis, Asian MSM respondent, quoted in Ridge, Hee & Minichiello 1999:55).

mao's research into cultural differences and risk-taking behaviour

In Mao, Van de Ven and McCormick (2004), Asian MSM reported much lower risktaking than Caucasian MSM, just as the comparison of the Asian and Sydney GPCS suggested. The follow-up study compared Asian and Caucasian men's responses to the same survey. The factors which predicted variations in individual levels of risk-taking were different between the groups. For example, in Caucasian men in Sydney, being younger was associated with more risk-taking, whereas it was not for Asian men. In both groups, having more gay friends was associated with more risk-taking. Among Asian respondents (but not Caucasians), the factor most strongly predicting risk-taking was "low self-efficacy in the practical use of condoms with casual partners".

"Self-efficacy" is a central concept in Bandura's (1997) Social Cognitive Theory, a psychological model of health behaviour that has found extensive use in HIV prevention research and program development. In a person, "self-efficacy" is a personal attribute which basically combines both confidence and know-how, often held in relation to some particular skill. Mao's follow-up study measured participants' self-efficacy towards practical use of condoms with casual partners.

“Practical use of condoms” was measured through questions about using condoms without fumbling or slippage and enjoying the experience. Although these look like personal or individual attributes and physical skills, the crucial point is made by Kippax and Race that “‘practices’ unlike ‘behaviours’ are socially produced between people, intersubjectively, and are subjectively meaningful” (2003:3). The same ability could be called “practiced” and related to the care of the self and ways of being gay (Hurley, 2003).

An equally strong predictor of variations in risk-taking among the Asian men surveyed was “self-efficacy in risk avoidance with casual partners” (Mao, Van de Ven & McCormick, 2004:63). Together with the other finding about practical

use of condoms, this lends strong support to our own findings and recommendations about the need to build skills among CALD MSM in sexual negotiation and avoiding unwanted sex.

Further, the study shows that psychologically based health promotion theories like Bandura’s (1997) Social Cognitive Theory are well able to accommodate the more social, cultural and contextual factors that account for risk-taking among CALD MSM. Kippax & Race (2003) call for a “social public health” informed by sociology, anthropology and cultural studies; the Social Cognitive Theory approach may help make their outputs intelligible for public health practitioners who are trained in the more quantitative and psychological traditions of health sciences.

conclusion

the need for change

After the forum, participant and PhD candidate Budi Sudarto asked “We talk about these things all the time – why does nothing ever change?” It is our challenge now to build momentum for change.

It may help to understand what has produced inertia in the past:

- Findings have been written up in academic language, rather than the language of funders, clinical service providers, and organisational change
- Findings have been inaccessible – in reports only available offline or in paid-access journals
- Forums are attended by individual workers who lack power to initiate organisational change
- Forums are held too far apart to generate momentum for change
- Defensiveness from Anglo-Australian workers about the reality of racial difference and discrimination
- Assumptions (no-fault stories) held over from previous eras of multicultural policy

However, there are also reasons for hope. For one thing, the richness of detail and complexity of themes considered in this report show much effort workers in the BBV/STI sector are already putting into working out how they can best respond to the needs and experiences of CALD MSM. The effectiveness of the CALD MSM consultation forum working group shows the energy and commitment that exists for change. In her report on the same topic, Maria Pallotta-Chiarolli concluded by calling for solutions “beyond ‘problematizing cultures’ and ‘culturalising problems’” (1998:22). In this report we have tried to meet her challenge by identifying a set of specific and practical recommendations to guide further action in the sexual health and HIV community sectors to meet the needs and respond to the diversity and lived experience of culturally diverse men who have sex with men.

recommendations

- Innovative public health frameworks such as the vulnerable populations approach and social cognitive theory should be combined with “social public health” methods of enquiry to better understand the needs and lived experience of culturally diverse men who have sex with men.
- Peer education and empowerment models of education are the most appropriate methods for addressing the social and situational factors that lead to risk-taking among CALD MSM.
- It is essential to ask direct questions about visa status in epidemiological survey instruments.

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