Casual Sex?

In July, the Australian Federation of AIDS Organisations (AFAO), the peak body representing the non-government and non-medical sector, formally proposed shifting resources in AIDS education to aim primarily at reinforcing behaviour changes in the frontline communities.

On the face of it, gay activists and AIDS workers have come to the same conclusion as the most conservative sectors of the medical elite: AIDS education should focus on sex between men.

However, this apparent unanimity disguises quite counterposed strategies. In the ‘traditional public health’ corner lurks a preference for a quarantine of AIDS-affected people—a preference based on generic distrust of patients. Following this approach, gay venues would be closed, the Sydney Gay Mardi Gras banned, sex workers rehabilitated, and drug addicts dosed with methadone daily. Conservative doctors, such as AMA head Bruce Shepherd, want to reassert medical control over AIDS prevention.

New HIV infections peaked in Australia in 1983-84, and are now estimated at 300-600 per year. Now, as then, the overwhelming majority of infections are made possible by unprotected anal sex between men. Of course, this is not to say that there are no infections outside that population—around 700 women are reported to be HIV positive—but rather that the pattern of infection in this country has remained much more localised than in comparable countries. However, while the general population in Australia has a high level of awareness of HIV transmission, there has been very little behaviour change by people outside communities specifically targeted for AIDS education.

Australia’s relative success in lowering rates of new infections has been due to a number of factors: prevention efforts by the gay communities in the mid 1980s, the organisation of sex workers to insist on an industry standard of condom use, and the early introduction of needle and syringe exchange programs.

The co-operative and planned approach sponsored by Neal Blewett as federal health minister stands in stark contrast to the approach of many European and North American countries.

However, the new apparent consensus between doctors’ groups and AIDS organisations is not the result of complacency. With almost 17,000 people notified as testing positive for HIV nationally, even if no new infections occur, the burden of illness, death and grieving will become more intense as asymptomatic infections ‘mature’.

While the cost and urgency of treatment and care increases, so too does the difficulty in sustaining behaviour changes in the frontline communities.

Ten years into the epidemic, gay men in Sydney may be finding it hard to remember always to use condoms and stay sober, to keep giving money and time to AIDS groups, and to keep up volunteer care programs when many or all of their friends have died. Young men coming onto the gay scene may feel that AIDS is old news and affects only the older, leather-clad set. Some Asian migrants, who make up perhaps 10% of the gay community in Sydney, may feel that, just as they are marginalised by racism, so too is AIDS a distant concern.

In an extremely youth-oriented culture, older gay men may feel that they cannot afford to say no to unsafe sexual opportunities. And the 10-13% of gay men who have used ‘speed’, cocaine, heroin or ecstasy in the last 12 months may shun unprotected sex but still share infected needles because they are ‘not really junkies’.

And, of course, men involved and identifying with the gay community make up only a minority of men who have sex with men. Although paid or volunteer outreach educators work in most Australian cities, only a small percentage of the men who have anonymous sex in car parks or on beaches and parks have ever spoken to one.

Allocations to AIDS education and social research have very often been directed to people only marginally affected by the epidemic. If, as seems likely, AIDS money is to be devoted increasingly towards the international pharmaceutical companies for antiviral and preventive therapies, different community sector groups may compete for dwindling education resources. In this scenario, HIV positive people, gay men, ethnic and Aboriginal communities, drug injectors, sex workers, and women would increasingly stake their claims against each other, and against mainstream programs.

Within the Australian National Council on AIDS, as well as within AFAO, there have been strong arguments for a shift of research and education emphasis towards the communities where the major burden of infection has occurred and continues to occur. The national strategy proposal launched by AFAO in July also seeks faster action on the availability of treatment and on legislative changes to eliminate barriers to HIV health promotion programs: stronger anti-discrimination laws, tighter confidentiality laws, and the repeal of anti-homosexual laws, Summary Offences laws and laws penalising drug users and sex workers.

The national strategy developed under Neal Blewett in 1989 ends in mid-1993. The stakes are high in the debate on the shape of the strategy that will take Australia through the next five years—years when the burden of illness will be greatest, and when Australia’s progress to date will be put to the test.

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