The impact of migration on the sexual health of migrant men who have sex with men (MSM) in Dublin, Ireland

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This dissertation is submitted to the University of Dublin for the fulfilment of the requirements for the award of MSc Global Health degree

2006–2007

DECLARATION

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ABSTRACT

The impact of migration on the sexual health of migrant men who have sex with men (MSM) in Dublin, Ireland – Daniel J McCartney *(Word count: 14,148)*

Keywords:
HIV, sexual health, MSM, migration, qualitative

Background:
With a long history of emigration, Ireland has recently experienced an unprecedented growth of immigration due to rapid economic growth and recent European Union (EU) enlargement. Migrant men who have sex with men (MSM) are particularly vulnerable to HIV infection and other sexually transmitted infections (STIs) due to limited availability and accessibility of services, social barriers such as stigma and marginalisation, and increased likelihood of engaging in high-risk sexual behaviours. This study examined the views and experiences of migrant MSM in Ireland to identify the factors influencing their vulnerability to HIV and other STIs.

Methods:
Qualitative, semi-structured interviews were conducted to explore the views and experiences of migrant MSM. Purposive sampling methods were used to recruit a sample of MSM from HIV prevention and support services. The study sample included men who were born outside of Ireland and migrated to Ireland aged 16 or above. The interview transcripts were subjected to thematic analysis.

Results:
This study involved fourteen (14) men from a wide range of countries, whose primary purpose of migrating to Ireland was for work or education. Findings indicated a number of behavioural, social, and structural factors that influence the vulnerability and increase the sexual health risk of migrant MSM. These factors are affected by the dynamic migration process, which is further complicated by the role of sexuality.

Conclusions:
With the increased vulnerability of migrant MSM, a number of interventions are required to address their unique needs beyond conventional programmes for gay, bisexual men and other MSM. With similar patterns of migration in other European countries, the issue of HIV and migration will require a cooperative effort of individual countries and multilateral agencies.

ACKNOWLEDGEMENTS

I wish to acknowledge all participants who generously volunteered their time for this study. I would like to thank Mick Quinlan, Ronan Watters, Gerry Kennedy, and James O'Connor for kindly assisting with participant recruitment, and Dr. Adebola Adedimeji for his support as research supervisor.

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1. INTRODUCTION

Globalisation is having an unprecedented impact on human health, influenced by the rising level of migration and population mobility. With historical connections between migration and the spread of communicable disease, increased attention is being given to the impact of migration on the spread of HIV (MacPherson et al., 2007). One country that has recently experienced a significant change in migration trends is the Republic of Ireland.

Due to rapid economic growth and recent European Union (EU) enlargement, Ireland has recently experienced an extraordinary growth of immigration. Increasingly, population mobility and migration are influencing the HIV prevalence in Ireland and many other countries in Europe (EuroHIV, 2006). Studies have shown the linkages between migration and the spread of HIV, indicating that the migration process increases vulnerability to HIV infection (IOM, 2005; UNAIDS, 2001). Some migrant groups have been identified as more vulnerable than others, including refugees, those without legal status, and women (UNAIDS, 2001).

However, an important vulnerable group has received insufficient attention in the response to HIV, migrant men who have sex with men (MSM). In the context of the concentrated HIV epidemic among MSM in Europe, migrant MSM are particularly vulnerable to HIV and other sexually transmitted infections (STIs) due to limited availability and accessibility of services, social barriers such as stigma and marginalisation, and increased likelihood of engaging in high-risk sexual behaviours. This study aims to conduct a qualitative investigation to explore the views and experiences of migrant MSM in Ireland to identify the factors influencing their vulnerability to HIV and other STIs.

2. LITERATURE REVIEW

HIV remains an important public health issue in Europe, with an estimated 740,000 people living with HIV in Western and Central Europe in 2006 (UNAIDS, 2006b). Increasingly, HIV prevalence is being influenced by migration, with many newly diagnosed HIV infections being reported among individuals originating from countries with generalised HIV epidemics (EuroHIV, 2006). Many countries are also reporting a resurgence of high-risk sexual behaviour between MSM leading to rising incidence within this population group (EuroHIV, 2006; Hamers et al., 2006). However, appropriate responses are not addressing these shifts in the epidemic and require urgent strategies to improve HIV interventions among these population groups (EuroHIV, 2006; UNAIDS, 2006a).

HIV in Ireland

In 2006, the total number of newly diagnosed HIV infections in the Republic of Ireland was 337 (Health Protection Surveillance Centre/HPSC, 2007). Of these newly diagnosed cases, 50.1% were acquired through heterosexual contact, 24.6% were among men who have sex with men (MSM), and 16.9% were among injecting drug users (IDUs). Although not a notifiable disease in the Republic of Ireland, information on newly diagnosed HIV infections is collected by the Health Protection Surveillance Centre (HPSC) (Devine et al., 2006; HPSC, 2007). Since 2002, annual

reports of HIV diagnoses have included country of birth, however this information has not been consistently recorded. Between 2002 and 2006, country of birth was reported for 1470 (92%) of newly diagnosed HIV infections, illustrated in Figure 2.1. Of these, over half (59%) were among those born abroad, indicating the influence migration has had on HIV prevalence in Ireland.

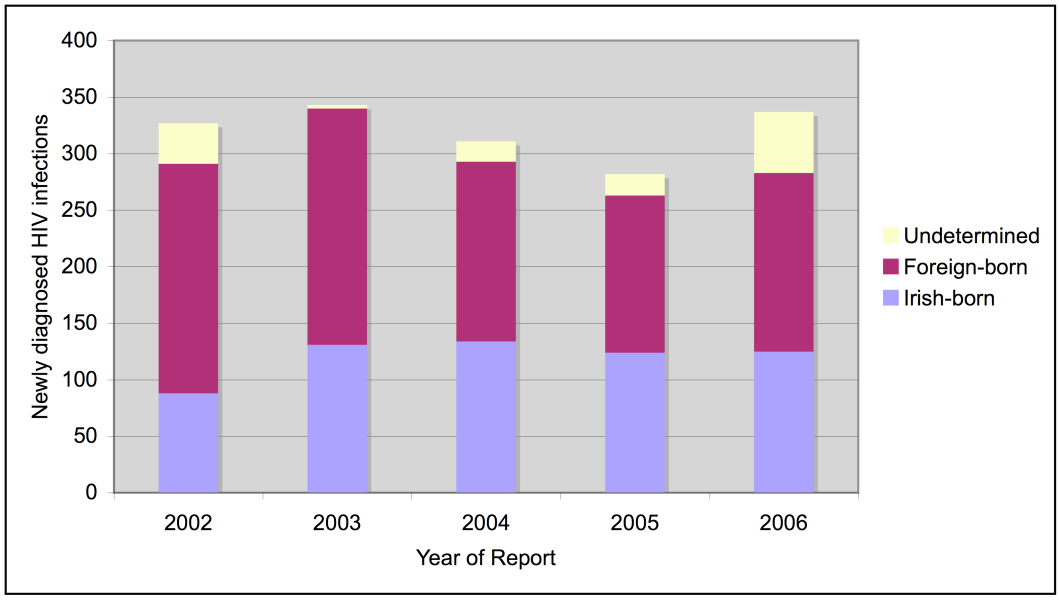

Fig 2.1: Total number of newly diagnosed HIV infections by geographic origin between 2002 and 2006 (Health Protection Surveillance Centre, 2003-2007)

Recent trends of migration in Ireland

Ireland has a long history of significant emigration, with many Irish citizens moving to the United States, Canada, Australia, and the United Kingdom, primarily due to low economic development in the country (Ruhs, 2004). As rapid economic growth created an unprecedented demand for labour, Ireland began to observe an upward trend in net immigration in 1996 (Ruhs, 2004; Immigrant Council of Ireland, 2005). Ireland is facing another period of dramatic change ever since EU enlargement on May 1, 2004. Following the enlargement of the EU, Ireland granted workers from the 10 EU accession countries[1] unrestricted access to Ireland for employment and other purposes such as study (Immigrant Council of Ireland, 2005; National Economic and Social Council, 2006). Along with the United Kingdom and Sweden, the opening of labour markets to these new member states drastically increased population mobility and migration between these EU countries.

The latest national census data in 2006 reflects this shift in Irish demography, with an increased proportion of the population born outside of Ireland. Residents born outside of Ireland accounted for 14.7% of the total population, with the highest proportion found in Dublin, the capital city (Central Statistics Office/CSO, 2007). The most significant change is the high proportion of immigrants from the 10 new EU accession states. Persons born in Poland are now the second largest group of foreign-born individuals in Ireland after Great Britain (England, Scotland, and Wales), as illustrated in Figure 2.2.

[1] 10 EU accession countries: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, and Slovenia.

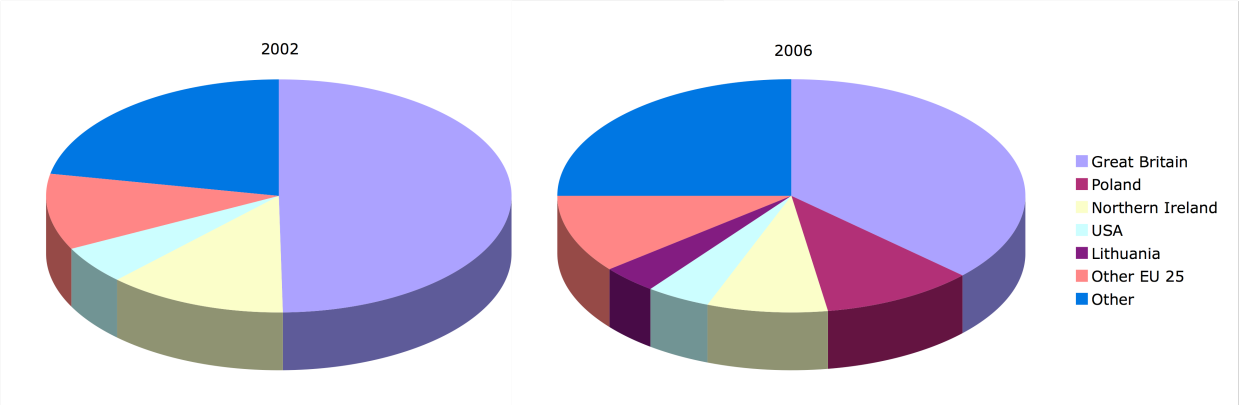

Fig 2.2: Proportion of foreign-born residents in Ireland by place of birth in 2002 and 2006 (Central Statistics Office, 2007)

This increase in immigration is also affecting the age structure of the population, with large proportions of young individuals migrating to Ireland. According to census data, over half (51%) of all immigrants were aged 20-29, and a majority (58%) of immigrants aged 25-44 were males, illustrated in Figure 2.3 (CSO, 2007). This signals an increasing trend of migration among young, unaccompanied men to Ireland.

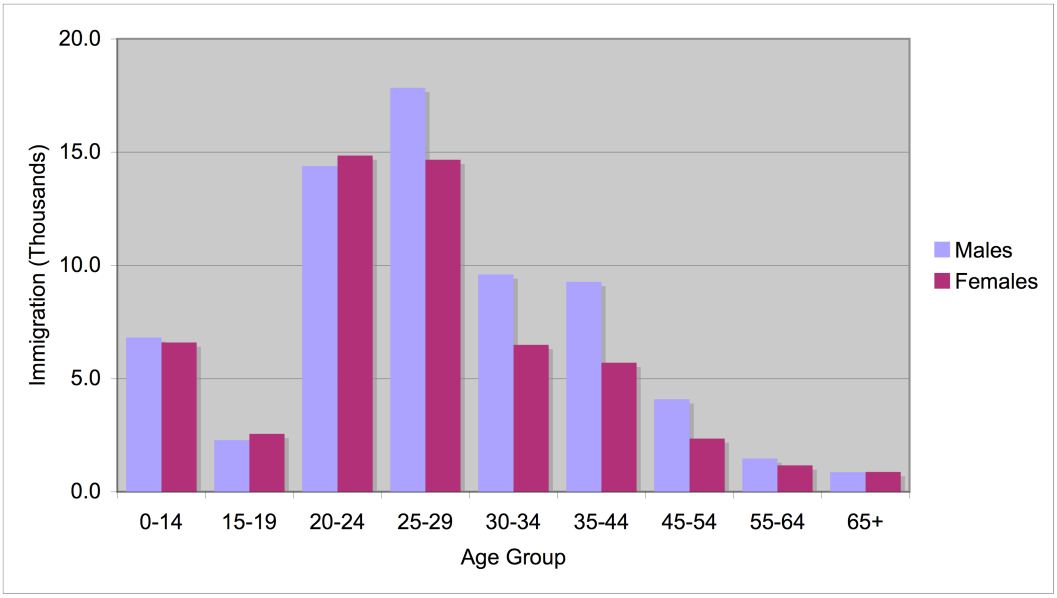

Fig 2.3: Immigration in Ireland between 2005 and 2006 classified by sex and age group (Central Statistics Office, 2007)

Relationship between migration and HIV

Migrants are broadly described as mobile people who move from one place to another, for a number of reasons, with the intention to stay in the host country permanently or for an extended period of time (International Organization of Migration/IOM, 2006; UNAIDS, 2001). The push and pull factors influencing migration can be voluntary or involuntary, including professional or economic opportunities, educational improvement, family reunification, warfare, poverty, and human rights abuses (IOM, 2006). The relationship between migration and HIV infection was

identified in early epidemiological studies, where an increased HIV prevalence was observed among certain highly mobile groups (IOM, 2006; UNAIDS, 2001).

The effects of migration on HIV prevalence is only receiving recent attention in Western Europe, as high proportions of newly diagnosed HIV infections are being reported among individuals originating from countries with generalised HIV epidemics (EuroHIV, 2006). For many migrants, these infections are acquired elsewhere and are only realised once they arrive in their destination country (Hamers and Downs, 2004; Hamers et al., 2006). In Ireland, almost one-third (109 of 337 cases; 32.3%) of new HIV diagnoses in 2006 were among individuals from sub-Saharan Africa (HPSC, 2007).

These figures can lead to the perception that migrants are spreading HIV in the host country, but evidence supports the contrary. The conditions and structures during the migration process often create an environment where migrants themselves are more vulnerable to HIV infection (IOM, 2006). Increased vulnerability is influenced by cultural and linguistic barriers, stigma and discrimination, separation from regular sexual partners, risk-taking due to sense of anonymity, and lack of access to health and social services (IOM, 2006; UNAIDS, 2001).

HIV and sex between men

High-risk sexual behaviour between men remains an important factor for the transmission of HIV and other STIs. Men who have sex with men (MSM) are at an increased risk of infection as a result of both specific sexual practices, including receptive anal intercourse, and high rates of partner change (Johnson et al., 2005; UNAIDS, 2006d). The term MSM includes not only self-identified gay or homosexual men, but also includes men who identify as bisexual, transgender, or heterosexual men who may at times have sex with other men (UNAIDS, 2006d). In many countries MSM have been a part of the HIV response since the 1980s. However, a number of studies have reported a recent resurgence in high-risk sexual behaviour among MSM. This increase may be the result of a perception that HIV infection is less severe due to the effectiveness of antiretroviral therapy, and accompanied with high levels of drug use and fatigue of 'safer sex' messages within this population (Hamers et al., 2004; The Lancet, 2007; UNAIDS, 2006c). In 2000, a syphilis outbreak was identified in Dublin, Ireland where 92% of infectious syphilis cases were identified among MSM in an eighteen (18) month period (Hopkins et al., 2001). Infected MSM reported high-risk sexual behaviours including high numbers of sexual partners, penetrative sex without condoms, and increased likelihood of drug use in connection with sexual activities (Hopkins et al., 2001). Syphilis and other STIs are known to increase the transmission rates of HIV.

In Ireland, the number of MSM newly diagnosed with HIV in 2006 increased by 45.6% compared to 2005 (HPSC, 2007). MSM remain a key population at higher risk in Ireland, contributing a significant share of HIV incidence among all men infected through sexual intercourse. An analysis of HIV surveillance data released by the Health Protection Surveillance Centre (HPSC) between 2002 and 2006 determined that men born abroad represent a significant proportion of HIV diagnoses among MSM in Ireland, with 28% born abroad and mostly from other countries within Europe. This proportion has remained relatively constant over this period, illustrated in Figure 2.4.

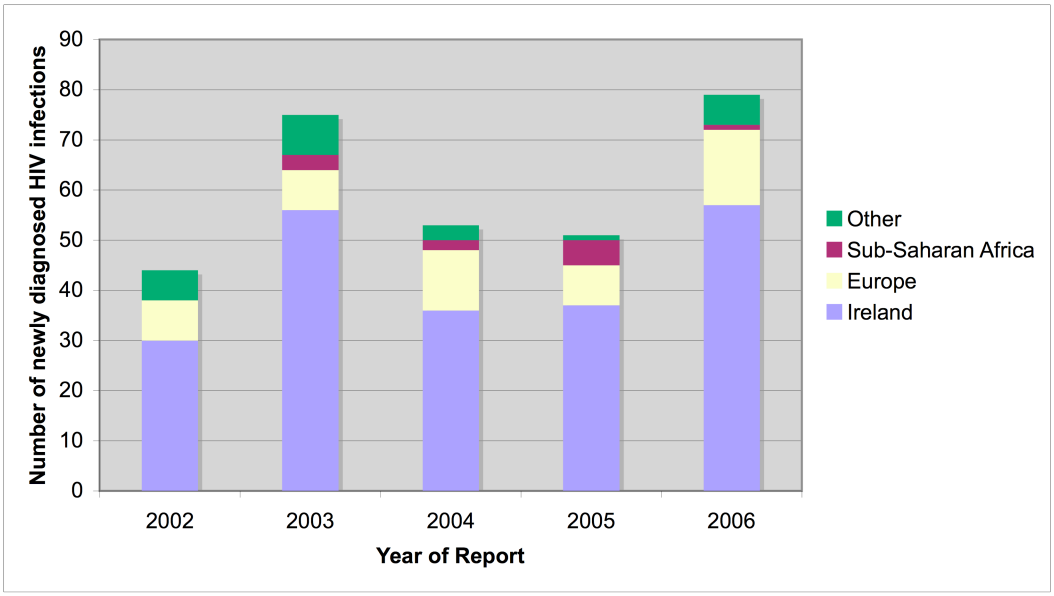

Fig 2.4: Number of newly diagnosed HIV cases among MSM between 2002 and 2006 by country/region of birth (Health Protection Surveillance Centre, 2003-2007)

Probable country of infection is not recorded in Ireland, therefore it is not possible to determine where HIV infection was acquired. However, a similar analysis of surveillance data was conducted in England and Wales. Between 2000 and 2003, 27% of MSM diagnosed with HIV were born abroad and more than half (52%) probably acquired their HIV infection in the UK (Dougan et al., 2005b). Considering similar patterns of HIV prevalence between Ireland and the UK, it is likely that a majority of MSM born abroad probably acquired their HIV infection within Ireland.

There is a lack of information to accurately determine the population size of migrant MSM in Ireland. In 2003 and 2004, two 'All-Ireland Gay Men's Sex Surveys' were conducted to identify the sexual health and HIV prevention needs of gay and bisexual men (Devine et al., 2006). The combined survey sample of respondents within the Republic of Ireland (n=1278) indicated that 8.1% (n=104) were born outside of Ireland and the United Kingdom (Devine et al., 2006). Recent data from the Gay Men's Health Project (GMHP) clinic, a community-based sexual health clinic for MSM, suggests a much larger migrant MSM population in Ireland. The country of birth data from all new attendees (n=1153) registered at the GMHP clinic in 2004 and 2005 indicated that 25% (n=288) were born outside of the Republic of Ireland and Northern Ireland (Quinlan, 2007). This diverse sample is illustrated in Figure 2.5.

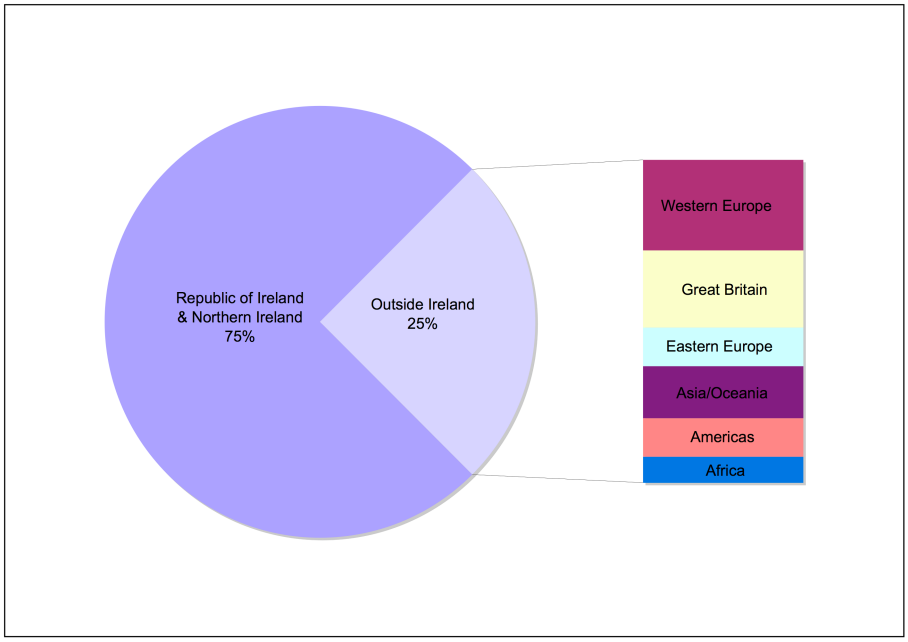

Fig 2.5: Data from the Gay Men's Health Project (GMHP) of new attendees registered at the GMHP clinic in 2004 and 2005 (Quinlan, 2007)

Vulnerability of Migrant MSM

The factors influencing MSM to migrate are often the same as described for other migrants, but for migrant MSM this may also include the perception of greater openness to sexual diversity in the host country (Padilla et al., 2007). Migration that is motivated, either fully or partially, by the sexuality of those who migrate has been termed 'sexual migration' (Carrillo, 2004). For many migrant MSM, the experience of international migration is a continuum linking their experiences migrating from rural communities or small cities to larger, more urban centres in their country of origin in the search of this openness (Padilla et al., 2007). This component of sexuality adds to the dynamism of the migration process, and few studies have addressed the particular issues faced by this migrant population.

Existing research on migrant MSM is limited, with most available research predominately focussing on MSM from different ethnic minority groups. Research in the United States tends to focus on Hispanic MSM groups, while research in the United Kingdom focuses on black MSM populations (Diaz et al., 2001; Dougan et al., 2005a; Hickson et al., 2004). Although this research is necessary to characterise how ethnicity influences vulnerability of MSM, there is a need for research specifically on migrant MSM. This is highlighted in a recent Canadian study that unexpectedly found that white foreign-born MSM exhibited higher sexual risk-taking behaviour compared to other foreign-born or Canadian-born MSM (George et al., 2007). The authors described this as surprising as it is often assumed that white foreign-born MSM have similar risk profiles to North American white MSM since it is perceived that there are less barriers preventing acculturation to North American gay culture (George et al., 2007). Further research needs to address this misconception and focus on how the migration process influences the vulnerability of all migrant MSM.

With little information known about migrant MSM, there is also a need for qualitative research to identify factors that influence sexual health outcomes. A qualitative study in the United Kingdom

conducted by Keogh et al. (2004) focussed on the experiences of eighteen (18) migrant MSM in London, many of whom migrated in search of economic opportunities and an openly gay lifestyle. The majority of participants were legal migrants from Southern Europe, South America and the Caribbean, as well as illegal migrants and asylum seekers. One limitation of the study was due to the research design, generating a sample that overwhelmingly consisted of migrants with low educational qualifications. The report illustrated a link between social exclusion and HIV infection, as these migrant men found little support within the gay or expatriate communities. Better access to social support and other services was only gained once many of these migrant men were diagnosed with HIV, concluding that these migrants should have been targeted with such support services upon arrival in the country.

The findings of this study in London motivated the need to undertake a similar qualitative study in Dublin. Although similar cultural backgrounds exist between Ireland and the United Kingdom, Ireland has only recently experienced increased immigration. In addition, London is a well-established global 'gay city', attracting numerous lesbian, gay, bisexual and transgender (LGBT) individuals (Keogh et al., 2004). As sex between men was only decriminalised in 1993, it may take a considerable amount of time for Dublin to acquire this global status (Devine et al., 2006).

3. RESEARCH OBJECTIVES

As HIV prevalence in Ireland is increasingly influenced by migration, there is an urgent need to better define most-at-risk migrant populations. With minimal information about the sexual health of migrant MSM, as illustrated by the literature review, this study aimed to further characterise and identify the factors that increase their vulnerability to HIV and other STIs. Using qualitative methods, the views and experiences of migrant MSM relating to the migration process, sexual behaviour, and use of sexual health services in Ireland were analysed. This information was used to generate concepts that may be generalizable to other migrant MSM and help inform health agencies in order to strategically respond to the unique needs of this migrant population.

4. METHODOLOGY

Fourteen (14) in-depth interviews were conducted with individuals over a one-month period in 2007. Participants were recruited at two (2) recruitment sites in Dublin: a community-based support centre for people living with HIV, and the Gay Men's Health Project (GMHP) clinic, a sexual health clinic for gay, bisexual men and other men who have sex with men. Thirteen (13) of the interview participants were recruited at the GMHP clinic. With operating hours two (2) evenings per week, participant recruitment at the GMHP clinic required six (6) recruitment visits over a four (4) week period. The response rate of this volunteer sample was very high and no incentives were given to study participants. During the interviews, participants freely discussed their views and personal experiences surrounding sensitive issues such as sexual behaviour and sexual health. A level of saturation was achieved with the realisation of repetitiveness and a small amount of new

information coming out of the interviews. This study was undertaken with the ethical approval of the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin (see Appendix 1).

Recruitment

Due to the small population size and sensitivity surrounding the issues of sexual health and sexual identity, purposive sampling was employed. As random sampling would not be an efficient method to collect data, this non-probability sampling method involved the deliberate choice of respondents and settings to reflect the specific interest of the study (Browne, 2005). Participants were selected with the following four (4) inclusion criteria:

1- born outside of Ireland and the United Kingdom;

2- migrated to Ireland aged 16 or above;

3- reported having at least one male sexual partner in last year; and

4- possessed good English language skills.

The decision to choose participants also born outside the United Kingdom was due to the similar cultural backgrounds and disproportionate representation in the sample population. Age of migration over 16 was chosen to increase likelihood of an autonomous decision to migrate to Ireland.

At both recruitment locations, access was negotiated through service management who made initial contact with potential participants fitting the inclusion criteria. Interested participants were introduced to the lead investigator who provided additional verbal and written information (see Appendix 2) about the study in a private setting. Interviews with interested participants were scheduled at least seven (7) days after the initial meeting to allow time for further reflection. At the scheduled interview time, participants read and signed a consent form (see Appendix 3) indicating that they agreed to participate.

Data collection

One-on-one, in-depth interviews were conducted by the lead investigator in a private setting chosen by participants, either at Trinity College or at the location of recruitment. The interviews lasted between sixty (60) and ninety (90) minutes and were guided by a semi-structured interview guide (see Appendix 4). Formulated based on the literature review, the interview guide covered topics including basic demographics, sexuality, migration, social networks, perceptions of sexual health risk, and experiences with various health services. With the consent of respondents, all interviews were digitally recorded and transcribed verbatim by the lead investigator for further qualitative analysis. At the conclusion of the interview, participants received an information sheet (see Appendix 5) listing various counselling, clinical and support services available in Ireland.

Data analysis

A five-stage framework approach was used to guide a thorough qualitative analysis of the data. This approach, developed by the UK National Centre for Social Research, was used because it is particularly useful for studies oriented towards policy outcomes (Green, 2005; Green and Thorogood, 2004). The five-stages include *familiarization*, *thematic analysis*, *indexing*, *charting*,

and *mapping and interpretation* with a focus on maintaining the integrity of the individual accounts of participants (Green, 2005; Green and Thorogood, 2004). The transcripts were transcribed and read several times by the lead investigator to allow for familiarization. The transcripts were then subjected to a thematic analysis to identify the key themes that emerged from the data, forming the basis of the preliminary coding scheme. Resulting codes were then applied to the whole data set using the *QSR NVivo 7* software package. This qualitative data management software assisted with organising all coded data according to themes and maintaining reference to the original source. The resulting outputs were used to interpret the findings by exploring patterns and relationships between the data. This analysis relies on the analyst's familiarity of the issues and ability to determine the meaning of the connections.

Strengths and Limitations

Reflexivity is an important concept in qualitative research that describes the active participation of the researcher in the research process (Dowsett, 2007). As the lead investigator of this study meets the inclusion criteria for the study, the researcher's familiarity and understanding of participants' accounts plays a central role not just in the analysis but also during the entire research process. Being 'an insider' has a number of strengths and weaknesses, including objectivity of the researcher and level of disclosure by respondents. In this sample, a high level of rapport was built with the participants resulting in very candid responses relating to a number of sensitive issues. This indicates a level of trust with the investigator and impression that the investigator could relate to their experiences. However, difficulties were experienced surrounding the boundaries between researcher and research participant, with some participants seeking relationships outside of the research study.

As a non-probability sample, a limitation of this study is the difficulty in determining how representative the sample is of the population (Browne, 2005). The sample consists solely of migrant MSM that access sexual health services and who are open about their sexuality by identifying as gay or bisexual men. Recognising the sensitive nature of this topic, an effort was made for further recruitment by utilising referrals from participants, or 'snowball sampling', as well as utilising contacts at other LGBT community organisations. However, these attempts were unsuccessful. Reaching men who do not identify as gay or bisexual men but have sexual relations with other men is a population group that is very difficult to reach.

5. RESULTS

In-depth interviews were conducted with fourteen (14) individuals between the ages of 22 and 40 years. The findings are organised by the four (4) major themes that emerged from the interviews: *adapting to a new environment*; *sexual networking*; *awareness of sexual health*; and *accessibility of sexual health services*. Table 5.1 lists the characteristics of the fourteen (14) study participants and Table 5.2 outlines the demographic information of the sample. The sample includes individuals born in ten (10) countries from five (5) regions[2] of the world: Eastern Europe (Czech Republic, Lithuania, and Poland), Latin America (Brazil), Oceania (Australia), Western Europe (Germany, Italy, and Spain), and South-East Asia (Malaysia and Singapore). The majority have been living in Ireland for at least two (2) years, and migrated directly from their respective country of origin. All were legal migrants in Ireland, twelve (12) possessed EU citizenship by birth or by ancestry, and two (2) held student visas. Thirteen (13) participants identified themselves as 'gay', and one (1) identified as 'bisexual'. All participants had visited a sexual health clinic in the last year and received a sexual health screening. Six (6) participants had been diagnosed with an STI while in Ireland, including one (1) individual who also tested positive for HIV.

Table 5.1: Characteristics of the fourteen study participants

Participant	*Age range*	*Region of birth*	*Length of time in Ireland*
1	21-25	Eastern Europe	<1 year
2	21-25	Eastern Europe	1-3 years
3	21-25	Eastern Europe	1-3 years
4	26-30	Eastern Europe	>5 years
5	36-40	Eastern Europe	3-5 years
6	31-35	Latin America	3-5 years
7	36-40	Oceania	<1 year
8	21-25	South-East Asia	3-5 years
9	21-25	South-East Asia	3-5 years
10	21-25	Western Europe	1-3 year
11	26-30	Western Europe	<1 year
12	26-30	Western Europe	1-3 years
13	26-30	Western Europe	3-5 years
14	31-35	Western Europe	1-3 years

[2] According to UNAIDS regional classifications (UNAIDS, 2006)

Table 5.2: Demographics of the fourteen study participants

Age	21-25	6
Range: 22-40	26-30	4
Mean: 29	31-35	2
Median: 28	36-40	2
Region of birth	Eastern Europe	5
	Latin America	1
	Oceania	1
	South-East Asia	2
	Western Europe	5
Length of time in Ireland	Less than 1 year	3
	1-3 years	5
Range: <1-7 years	3-5 years	5
	More than 5 years	1
Migrant type	Legal (EU citizen)	12
	Legal (Student visa)	2
Education level	Secondary level	4
	Third level or higher	10
Employment status	Employed	11
	Employed student	2
	Unemployed student	1
HIV status	Tested negative	13
within last year	Tested positive	1

1. Adapting to a new environment

Participants expressed various reasons for migrating to Ireland including job opportunities, higher education, improving English language, or following a partner. The decision to migrate to Ireland was influenced by Ireland being an English-speaking country within the European Union, with a close proximity to the rest of Europe for the purposes of travel or being close to home countries. For many, the ability to live in an open society was an important factor for migrating. The interview allowed participants to recall their initial experiences of migrating to Ireland and describe how they adapted to living in their new environment.

Experiences with adaptation in Ireland

The initial difficulties of adapting to life in Ireland varied widely depending on the background and previous experiences of the participants. Dublin is a small European capital city with a population slightly over one (1) million people (CSO, 2007). Many of the participants expressed being from a similar sized city and described moving to Dublin as 'easier' because they found similarities between Dublin and their native city.

> *Dublin is the same size as [city name]. It looks a little bigger when you are here, maybe because it is the capital. But [city name] is almost the same size, I didn't felt like this is a huge change for me.* (Participant no. 2 from Eastern Europe)

Some participants described adapting to life in Ireland relatively easy because of their ability to blend in or assimilate within Irish society.

> *In general, I can tell you, it's not really a problem, as far as being prejudiced and discrimination is concerned because the [home] community, um, we are white, as you are, um, we are catholic, as you are, and we can speak English when we come here […] the fact that we are the same kind of, the same, um, the same skin colour and the same religion, that helps a lot.* (Participant no. 1 from Eastern Europe)

Participants expressed a number of difficulties including problems with language and limited social networks. The following participant described initial difficulties that included finding employment and accommodation.

> *After a few months I was trying to settle in and those few months were kind of rushed, harsh because I had to find job, I had to find a perfect place to live in, that's not so easy in Ireland. After awhile I just start missing your friends, cause you discover that the relationship you have with people that you have met in here aren't that strong. After some time it changed, now I can say that I have some friends in here, but the first few months were like there's no one to talk with, to be honest.* (Participant no. 2 from Eastern Europe)

For those with a lower level of English capabilities, language is seen as a major barrier as it makes meeting people difficult.

> *…it takes awhile to meet new people, new friends, everything that one time you have, everything then you are like, kind of home, you know. (I: How long do you think that took?) A few months, [once] I start to speak and understand everything, then life, that's when you feel adapted to the place, because you can communicate with people.* (Participant no. 14 from Western Europe)

The following excerpt from a participant who migrated from South-East Asia described how he had difficulties holding onto his religious practices in Ireland, and decided assimilation was the best strategy to cope with the situation.

> *I'm thinking if you go to, like everywhere in the world, you have to adapt yourself, you don't look back, you don't have to bring your culture here, that's what I'm thinking, I think I have to adapt and try to [adapt] myself in this new culture, environment. And I stopped doing that, I stopped buying meat, Halal meat, I just buy any meat, like I go to Dunnes or Spar, anywhere, so I'm getting used to, it's good now, I enjoy myself.* (Participant no. 9 from South-East Asia)

Experiences with sexuality

All participants discussed their ability to be open about their sexual identity in Ireland. For many, sexuality was a major motivation factor for leaving home, in search of an environment to live openly with their sexual identities. Before moving to Ireland, many had previously moved away from their families to larger cities within their home country seeking this freedom. Freedom was a common theme. Many participants described their ability to express themselves freely here in Ireland due to freedom from family as well as freedom from homophobic society.

> *…in my hometown, of course, I have to behave, I mean, here in Dublin I don't care, sometimes I walk on the street with my boyfriend hand to the hand, I couldn't imagine to do the same in my hometown, no way.* (Participant no. 12 from Western Europe)

In their home countries, many felt that they could not be open about their sexual identity because of perceived or experienced disapproval from parents and other family members, which could have a negative impact on relationships.

> *At home in [country name] I would be selectively open, because I come from a very strict, um, Muslim family, I was brought up to be a very, you know, very Muslim kind of way. And there, so ya, there's only one member of my immediate family that I'm open to is my mom. I don't think I'm confident or ready to come out to um, my dad or my siblings, and my other relatives yet. So I am open in Ireland. I walk down the street holding hands with my boyfriend, and I don't mind that at all.* (Participant no. 8 from South-East Asia)

Living in Ireland allows some of these men the ability to live openly and to maintain their relationships with family at home.

> *I have a great relationship at the moment with my parents and I don't want to destroy my moment. […] I'm happy like that, so I don't feel the need now to tell anything. And here I'm totally free anyway to be whatever.* (Participant no. 12 from Western Europe)

This freedom is greatly influenced by the ability to remain anonymous in a different environment, allowing them to live openly and feel safe.

> *[In Ireland] you can do anything that you want, without any supervision, without people telling you that's wrong, you can do whatever you want*. […] *In [home country], I'll never be, never be. I couldn't live openly at all because it's really hard as a gay even to live, for example, if you do have a gay relationship in [country name], you live with someone, people will keep asking you who's that. You don't want to live in sort of like uncomfortable like, you know, that's why I never ever tried to be open about gay in [country name].* (Participant no. 9 from South-East Asia)

Not all participants had the same perception of society in Ireland.

> *…in a public place it's very hard, because the Irish are more conservative and they don't like it, so it's, um, sometimes, I don't want to say to be careful, but sometimes you have to be.* (Participant no. 13 from Western Europe)

The wider views of Irish society tend to differ depending on the society the men are coming from. Men who described coming from more homophobic societies than Ireland tend to view Dublin as more open, less conservative and less homophobic, whereas men who described coming from less homophobic societies expressed the opposite. Table 5.3 provides a comparison of these views from participants.

Table 5.3: A comparison of the perceived societal attitudes towards the gay community in Dublin separated by participants' descriptions of level of homophobia in home societies compared to Ireland

Men from more homophobic societies compared to Ireland described Dublin as:	**Men from less homophobic societies compared to Ireland described Dublin as:**
Less homophobic	More homophobic
Less closeted	More closeted
Less conservative	More conservative / not as progressive
Ability to express self freely	More religious / very Catholic
Less fear of insult or attack	Less comfortable expressing self

Limited interactions with expatriate communities

When migrants move to a new country, many find comfort knowing communities of people from their country of origin exist in their new environment. However, as many participants in the study already felt alienated by society at home, they perceived these communities as being homophobic. Some described not wanting to feel like at home, where they were unable to live openly or anonymously. Others describe avoidance for the purposes of learning English or the desire to assimilate into Irish society.

> *It's different because you're gay. Um, I said before, like they don't like gay people, [people from home country] don't like gay people. So that's why I probably don't want to, you know, join the community or I don't want to, you know, have too many friends from that country. They don't like it, so… What's the point to try, like you know what I mean, I have enough friends and they're all gay…* (Participant no. 4 from Eastern Europe)

Some participants describe limited interactions with expatriate communities for the purposes of support during their initial period in Ireland. This assistance included finding the necessary information for finding accommodation, obtaining employment, and registering with the government. Some participants found this information on foreign-language websites, in community magazines and by visiting their respective embassies. One participant who arrived in Ireland with a

low level of English-speaking ability described a situation where he was interacting with others from his home country until his language ability was strong enough to form social networks elsewhere.

> *I suppose it's very easy, because if you have to speak in English it's pretty difficult to express yourself or in another language that is not your mother language. So if you want to make friends, it's much easier to do it in your own language, you can express yourself*. (Participant no. 10 from Western Europe)

Without close ties to their respective home communities, many participants expressed feeling closer to the gay community as it helped them to adapt to society here by fostering relationships, meeting friends and sexual partners.

Closer connections with the gay community

Participants described the gay community as the social venues to interact with other members of the lesbian, gay, bisexual and transgender (LGBT) community, mainly the bars and clubs. This is commonly referred to as the 'commercial gay scene'. Participants frequently portray the commercial gay scene in Dublin as smaller than expected, consisting of only three (3) permanent venues. Again, the views of the gay community in Dublin differed depending on the society the men came from, with men from more homophobic societies describing the gay community as more open, less hidden, whereas men from less homophobic societies express it as being more closeted with little variety.

However, many described Dublin's commercial gay scene as friendlier and more relaxed than other gay communities they have experienced. A number of participants considered Dublin as an alternate to London, England. London's gay community was described as more exciting with a great deal more activity.

> *[If] someone was looking for gay life I would strongly recommend going to London, because its not that exciting in here. Someone looking for a really, really exciting gay life, London is a good destination. Dublin is smaller and is more quiet.* (Participant no. 2 from Eastern Europe)

However, many held negative views towards London in regards to its larger size and ironically towards its large commercial gay scene. Some felt that living in a thriving gay community would have negative consequences, describing London as 'risky' and 'dangerous'.

> *I decided against London because I thought the city would swallow me whole, […] I didn't think I would be able to cope. Dublin is like a little London.* (Participant no. 8 from South-East Asia)

Many feel it is necessary to meet other men like themselves, either for friendships or sexual relationships, but many find it more difficult than expected. For these men, interacting in the gay community is the main method of creating social networks. For some, this is not the ideal situation, however, they expressed the feeling of no other choice for meeting other men like themselves. Meeting other men is often expressed as the most difficult aspect of adapting and integrating into

society in Ireland. Many men expressed loneliness, as they felt their friendships were not as strong as their friendships they left behind.

> *I will be two years, but still I feel so alone, you know, there's not my friends, I don't know these people, everything (inaudible), yeah, these people that I know now it's not friends, this is only people that go with me to work, or people who go with me out, this is not really friends.* (Participant no. 3 from Eastern Europe)

Many strive for meeting someone for partnership, as this is seen to greatly facilitate adaptation and formation of social networks. The majority of men interviewed expressed meeting a partner in Ireland. Seven (7) individuals met an Irish partner and one (1) met a partner from another country. Four (4) of the men interviewed moved to Ireland with a partner from their previous country of residence, two (2) of which were Irish. Having a partner has greatly facilitated the development of their social networks and feeling of integration into society.

> *I decided, you know, I'm going to settle in here now, and it would be really nice to be with someone, especially that it's not my country, and maybe I would feel more comfortable, and so on.* (Participant no. 1 from Eastern Europe)

2. Sexual networking

The process of 'sexual networking' refers to the creation of social networks that are influenced by the sexuality of the individuals. Developing social networks is a part of adaptation, and these participants expressed the need to meet other men like themselves. However, participants expressed a number of difficulties in meeting other men as outlined in Table 5.4.

Table 5.4: Difficulties experienced by participants in meeting other men

- Language
- Seen as novelty by others
- Work and time constraints
- Others only looking for casual sex
- Not knowing venues to meet people
- Going to venues alone
- Influence of alcohol

In the interviews, participants were asked where they meet other men like themselves, either for friendship, partnerships or casual sex. The main venues these men identified for meeting other men were through internet dating sites, bars and clubs (commercial gay scene), and social groups. Some men also expressed visiting saunas and certain public places for negotiating casual sex. The venues identified for sexual networking are further discussed below.

Meeting men through the internet

Using the internet to meet people is expressed as one of the easiest methods of meeting new people, especially during their initial period in Ireland. The most often cited dating websites for meeting men in Ireland was Gaydar (www.gaydar.co.uk), as well as GayRomeo to a lesser extent (www.gayromeo.com). Some also mentioned the use of internet sites based in their respective home countries (ie. www.gaydar.pl) that enabled them to chat with men from their home country in Ireland. A number of men interviewed expressed that this was the method through which they met their current partners. The internet provides a level of anonymity and safety when compared to methods of meeting other men in person.

> *I think its just a way of getting in touch with people, and you're not really obliged to do anything, you can just have a chat with someone and finish it after five minutes or you can spend two hours, talking with someone and finally deciding that he's nice guy and it's good to go out and have a pint or something and see what will happen. […] Until you meet someone you're still in that virtual world and you can be whatever, whoever he wants also, and you can be more honest about yourself at the same time. You don't see the person, so you can't be intimidated by the person as well.* (Participant no. 2 from Eastern Europe)

These internet sites allow men to send messages to those they are interested in, with the potential to arrange a meeting in person. This is an ideal method for those who do not feel comfortable going to meet men in bars and clubs, as well as the possibility of meeting others who also do not go out 'on the scene'. It also allows a 'pre-selection' as each user has the ability to create a user profile with a picture.

> *When you go to a club there is no such a thing as a pre-selection, it's only judging by appearance, you know. And when you go to profile, you can read that person's description, what they write about themselves, what they like, and so on.* (Participant no. 1 from Eastern Europe)

Other men expressed that using the internet is the easiest method to arrange for casual sex. The negative aspects to using the internet include the fact that internet profiles are not necessarily true, they are unsure if they are open about their sexuality, and often have different agendas (ie. only looking for casual sex). This also creates a potentially unsafe environment depending on the location agreed to meet (ie. private residence).

Bars and clubs / Commercial gay scene

The commercial gay scene refers to the establishments such as bars and clubs for the gay community. All participants expressed visiting gay bars and clubs in Dublin, with various levels of interest. For many, going out in the 'scene' is not ideal, however, they have a feeling of no other choice if wanting to meet other men. In Dublin, three (3) bars or clubs are commonly referred to as the main venues for socialising with other gay men, but not necessarily for meeting others, as they prefer to go for entertainment with friends. As these bars and clubs are considered part of the gay

community or scene, only men who are comfortable with their sexuality will be visiting these venues. Expressed benefits of meeting men in these venues are that they are meeting in person and are able to assume they are open and confident about their sexuality if comfortable to be in the venue.

> *I would prefer bars and clubs because you would meet them in person, and um, you know what their like when they are drunk and the fact that they are at a bar or a club and a gay one at that makes it uh easy for me to assume that they are open about sexuality and that confidence is hard to come at times and the fact that they have it is great.* (Participant no. 8 from South-East Asia)

However, many are not comfortable to go to these venues alone, and would prefer to go with others. Some barriers identified with meeting men at bars and clubs include the influence of alcohol, preference not to meet others that are intoxicated, choices solely on appearance, lack of anonymity, and fear of rejection.

> *Meeting new people at bars, most of the time they would be severely intoxicated, and you know, they're just not the best people to interact with* (Participant no. 8 from South-East Asia)

> *If you're going out trying to hook up with someone, you can end up having great time or spend a few hours in [names of clubs] and not being approached by anyone and getting really, really upset.* (Participant no. 2 from Eastern Europe)

During the initial phase of living in Dublin, many participants expressed meeting as many people as possible, going to bars and clubs more frequently, in the search of gay friends and sexual relationships.

> *I think at the beginning I used to go more frequently than now. I don't feel such a need now. But, um… but when I came here at the beginning, I tried to meet as many people as, not as many people as possible, but at least a few people so that I, I could, you know, have some friends here to talk to. And I met a few nice people, and I still have contact with them, so that's good.* (Participant no. 1 from Eastern Europe)

Participating in social groups

The use of other social groups or venues for the LGBT community was rarely expressed as many were not familiar with any such groups or organisations. Although expressed as an ideal method to foster friendships within the gay community, only a few participants acknowledged the existence of other venues or activities outside of the commercial gay scene. Only one (1) participant described being briefly involved with a group for LGBT youth, but expressed that it did not meet his expectations for meeting other men with similar interests. Others expressed hearing about other social groups such as sports and leisure groups, but none have participated. Reasons for not participating included time constraints, waiting until 'settled', laziness, not enough information, and just not interested.

> *I can foresee with so few bars, like the same thing all the time, that, you know, once this honeymoon period, this initial holiday is over, we might think it might get quite boring, and you might start meeting other people, so maybe if there was any sort of sports organisation, you know, football or like squash or something, um, you know, it would be about just to meet people.* (Participant no. 7 from Oceania)

For those interested in joining, they cite language as a potential barrier as well as not feeling confident going alone.

> *I would like to go, but I'm not sure, I'm a little bit afraid about… because sometimes of the language problem, so I'm not the person who's always talking, so like it's, I don't know, if someone is taking, escorting with me, so then I would go […] I don't want to go by myself. For me, um, the first, the first contact, it's um, for me it's hard, so I have to go with someone else.* (Participant no. 13 from Western Europe)

Some described how social groups would offer the potential to better facilitate the meeting of other men with similar interests and without the pressure or expectations of casual sex. One participant describes how the Outhouse, a LGBT community organisation located in Dublin, may have been useful during his initial period in Dublin.

> *I think the Outhouse, like have activities for gay men and everything, so maybe it could be [useful] to join the, I mean to use the Outhouse at the very beginning, but it was something that I didn't think about.* (Participant no. 10 from Western Europe)

Venues for seeking casual sex

Participants openly discussed their experiences of seeking casual sex while in Ireland. Besides using the internet or the commercial gay scene, participants described other venues MSM visit predominately for casual sex. This includes saunas and outdoor venues such as public parks, commonly referred to as 'cruising' areas.

> *I know there's a sauna which I went twice when I first arrived here and when I was single I went twice. I didn't like it, and then I never went back there, and if I'm looking for sex, casual sex, I wouldn't go to the sauna, I wouldn't go to the bars, it would probably be the internet or cycling in the park or by the sea.* (Participant no. 6 from Latin America)

Eight (8) of the participants expressed visiting a sauna in Dublin, while four (4) others described experiences in other cities outside of Ireland. In Dublin, it is cited that there are two (2) saunas, with one being far more popular. Three (3) participants described experiences of meeting men at outdoor venues. Two (2) main areas are described by participants, both in park settings around the city, often located by word of mouth or online (www.squirt.org). They perceive that many people who visit these venues are not open about their sexuality, such as married men, who visit for the level of anonymity these venues afford.

> *…they just want to have privacy, without having any difficulties, like being specified as openly gay, and they want to hide. If they want sex, they just go there. For those people, that I think they want privacy, and people don't know that they are gay, that's what I think. And one more thing I think that if they do go there, they can't find anyone on the internet, they just go there for casual sex.* (Participant no. 9 from South-East Asia)

One participant describes being seen as a prostitute while seeking casual sex in one of the described public places.

> *…they look at me like I'm a prostitute, a couple of times they offer me money, no sorry, I won't do that for money. And some of them are very persistent, so it can be frustrating as well.* (Participant no. 6 from Latin America)

All of the respondents being comfortable with their sexuality expressed using these venues for entertainment purposes and for casual sex. Some described visiting outdoor venues for the excitement of 'cruising' and the prospect of being caught. Some participants discussed visiting these venues regularly, while others visited only once for the experience.

> *It was a long time ago, but it was the time like I wanted to experience everything. So somebody was speaking about the sauna and I went there.* (Participant no. 14 from Western Europe)

> *Yeah, just to see what it's like, check it out, when in Dublin do as Dubliners do it, […] it wasn't that I was desperate for sex, I better go to the [name of sauna], I'm going to go check this out see what it's like, it's like checking out a new restaurant more than anything else.* (Participant no. 7 from Oceania)

Although many described these venues as exciting, some also described a level of discomfort of visiting these venues as they feel they are putting themselves at risk due to the level of promiscuity and high-risk sexual behaviour.

> *Because some people, if you go to the [name of sauna], want to have fun without condoms…* (Participant no. 13 from Western Europe)

Influence of drug and alcohol use

The influence of drug and alcohol use towards sexual networking was a common theme. Many described a high level of drug and alcohol use in the commercial gay scene. Alcohol is heavily used in these venues.

> *I think I'm drinking more than I would in [city name]. […] You feel like you have to drink to keep up with what other people are doing here, and buying rounds, people, you know, you don't just buy a drink for yourself, everyone buys drinks for each other, so you go, and you already are drinking more.* (Participant no. 7 from Oceania)

Some describe the use of drugs and alcohol as a factor that facilitates meeting other men by making them feel more confident.

> *I'm shy, well, without a drink. And it's like, difficult to, it's just like, I'm too shy, that's all.* (Participant no. 4 from Eastern Europe)

> *Drugs make you feel more confident, so, it's always when you feel confident that you want to meet people. I always say after two pints your English is perfect, you are completely fluent, after two pints, maybe not after four, but after two pints it's like, okay, I want to talk, I'm going to talk.* (Participant no. 10 from Western Europe)

One participant described how alcohol influenced his visit to a venue for casual sex.

> *Yeah, the reason was that I drank too much, it was the reason, because then, you know, it's coming to me always after the alcohol, so, something to, you know, not stay in the home, just go somewhere and find somebody* (Participant no. 5 from Eastern Europe)

Three (3) participants described regular or occasional drug use in Ireland. All three were between the ages of 21 and 25. For these three (3) participants, their drug use either started or has increased since living in Ireland.

> *I used to use poppers and um… god… pills as well, MDMA, and cocaine, in powder form, but those are the ones I've used before and currently, oh cannabis as well, and currently I've stopped all but alcohol and um, MDMA and poppers… occasionally cocaine, those sort of four that I use from time to time.* (Participant no. 8 from South-East Asia)

The availability of drugs such as ecstasy, cocaine, and poppers (amyl nitrate) in the commercial gay scene is described as particularly high.

> *I was kind of surprised by the amount of guys that I met in Ireland for the last 2 years… taking drugs, taking even stronger drugs then ecstasy, and offering it to anyone who would like to share their experience. So I think that loads of guys take, gay guys in Ireland takes drugs, and we talk about cocaine pretty often.* (Participant no. 2 from Eastern Europe)

3. Awareness of sexual health

The issue of sexual health was discussed with participants during the interviews to determine their understanding and perceived risk of infection from HIV and other STIs, as well as their sexual risk behaviour. All participants had visited a sexual health clinic in the past twelve (12) months for a sexual health screening. Six (6) participants expressed being diagnosed with an STI at a sexual

health clinic while in Ireland. Two (2) of the participants were diagnosed with syphilis, two (2) with gonorrhoea, one (1) with hepatitis, and one (1) had an unknown STI. One (1) individual who was diagnosed with an STI subsequently tested positive for HIV in Ireland.

Perception of risk

During the interview, participants were asked about their perceived risk of being infected with HIV or other STIs here in Ireland compared to their home country. The majority expressed that their level of concern was the same as it was at home. Two (2) participants from Eastern Europe perceived a higher risk here in Ireland due to the level of promiscuity of Irish men and lack of condom use.

> *People are really, really sexually active in here, guys are having loads of guys… so it might be more risky.* (Participant no. 2 from Eastern Europe)

One (1) participant expressed a lower concern due to a perceived lower number of people living with HIV in Ireland.

> *I use the same precautions so it doesn't really matter, but if something does happen, like a condom breaks, I'd probably feel safer here then if a condom broke when I was in [home country].* (Participant no. 7 from Oceania)

Many of those who have been treated for an STI in the past expressed a blasé or indifferent attitude towards the possibility of being infected with another STI knowing that these infections can be cured.

> *I mean I think gonorrhoea and Chlamydia are the most common. (I: And do you think they are very serious?) Ah, no they are not that serious, I mean you can take ah, they gave me like three pills and that was it. I mean, I don't want to have it again, of course, it's not deadly, it's not something that you can die from, I think.* (Participant no. 10 from Western Europe)

Knowledge of HIV and other STIs

All participants expressed having a good understanding of methods to prevent HIV transmission. Participants discussed an understanding that condom use during anal intercourse will prevent HIV transmission, but expressed being unsure or receiving mixed messages towards the risk during oral intercourse and through other bodily fluids.

> *Well, apparently, you can have the HIV virus in the saliva, or yes, you know, I have conflicting versions (Laughter) I don't really know.* (Participant no. 11 from Western Europe)

Participants were also uncertain of their risk or how other STIs are transmitted, and none of the participants expressed an awareness that STIs increased the risk of HIV transmission. Of the participants diagnosed with an STI, many expressed a level of shock and surprise with the

diagnosis. Not fully understanding their diagnosed infection, many had to seek information on their own, receiving limited information upon diagnosis. The internet proved to be the most common location to obtain knowledge, usually on a website in their native language.

> *They told me that it was gonorrhoea […] they told it to me like it something from the seventeenth century, it's like (Laughter). (I: You never heard about it before?) I've heard of it before, but it was like it was something very far away from me…* (Participant no. 10 from Western Europe)

With an understanding of preventing transmission of HIV, many had a limited understanding regarding HIV infection. Many held misconceptions and stigma regarding HIV infection. The participant diagnosed with HIV described a situation where he believed he had a general understanding of HIV transmission, but once diagnosed, he was unsure what to do. He explained that he had no prior knowledge about the ability to live with HIV, believing HIV infection inevitably leads to death. This limited information exacerbated his shock and stress upon diagnosis.

> *'Excuse me, what I have?' And she told me this, I cried… Because when I went to school, ah, I had information about someone catching HIV and later you have AIDS and everybody, everybody person who has this has died.* (Participant no. 3 from Eastern Europe)

Level of condom use and unprotected anal intercourse

Ten (10) participants expressed regularly performing unprotected anal intercourse (UAI) with their regular partners. The decision not to use condoms during anal intercourse was commonly negotiated after deciding with confidence that both partners were being monogamous. Some participants expressed this enabled them to have better sex with their partner and to be closer to their partner.

> *Yeah, we talked about it, because it was okay we're in a closed relationship, what's the point of using a condom if we know that both of us are [monogamous]. I suppose that if you're in a relationship using a condom it's like something that stops you from getting closer.* (Participant no. 10 from Western Europe)

However, some participants showed some uncertainty of their level of confidence in their partners or discussed situations that questioned the true monogamy of their partners.

> *After the first time, he had discharge and then… there's no big thing about it, and then we say, well we got a condom, we use a condom for six months, and then everything's okay, but then we don't use condom anymore.* (Participant no. 9 from South-East Asia)

Three (3) participants expressed having UAI with their regular partners but continue to have irregular partners or have negotiated an 'open' relationship. One participant expressed the reason he uses condoms with irregular partners is for the safety of his partner.

I love one person, and I want to, to spend long time with that person. I don't want, ah neither for me, it's for him, if I met someone outside of my relation now, and then, I would be protected not for me but for him. (Participant no. 6 from Latin America)

Three (3) participants also described situations where they mistakenly performed UAI during casual sex due to alcohol use, intensity of moment, or unavailability of condoms.

Yeah, because one day we, we've run out of condoms, and we said well we have been like six, seven months, so I don't think like anybody of us have anything, so we decided to do it. But it was a mistake anyways. (Participant no. 14 from Western Europe)

4. Accessibility of sexual health services

In this sample, participants reported visiting either of two different sexual health clinics in Dublin, the Gay Men's Health Project (GMHP) clinic or the Genital Urinary and Infectious Diseases (GUIDE) clinic at St. James's Hospital. Ten (10) reported visiting the GMHP, one (1) reported visiting the GUIDE clinic, and three (3) reported visiting both clinics. With the majority of participants recruited at the GMHP clinic, many of the participants' experiences focussed on this service. While participants visited the clinic for various reasons, many decided to visit only after a sexual risk incident, after becoming symptomatic or a sexual partner was diagnosed with an STI, encouraging their use of a sexual health clinic.

Factors facilitating accessibility

Without prior knowledge of sexual health services in Ireland, participants became knowledgeable of sexual health services through various means. Many participants located the GMHP clinic through advertisements in GCN, a monthly magazine for the LGBT community, or were referred by friends or partners. Participants visiting the GUIDE clinic reported locating the service either through their partners or after an initial visit to a general practitioner (GP) presenting with symptoms of an STI. A number of participants also reported visiting these clinics as part of a vaccine schedule for hepatitis A or B.

I went there for the first time just to have the HIV test, and I already knew that I could have a, a vaccine as well for free. (Participant no. 1 from Eastern Europe)

The main reason many participants decided to visit the GMHP clinic was that it provides services specifically for gay and bisexual men. This increased their comfort in visiting the service knowing they would not be questioned about their sexuality.

Normally, I mean, I feel comfortable being gay, but it's always easy to tell a doctor, you know, if he's gay, she's a lesbian or gay friendly. […] You can feel more comfortable if it's a gay clinic, so because sometimes if you go to the doctor you're

nervous that the doctor could be homophobic, and if you have to talk about having anal sex, if you're straight, normally you don't have anal sex… if you have to talk about that, you know that it's a gay place, a gay clinic, it makes much easier, I think. (Participant no. 10 from Western Europe)

I thought that was the best option that you have, and that you felt very comfortable in the place they know that you are gay and they expected you to be gay, and you don't have to really be bothered with the questions, 'Why would you like to get tested?' and 'Ah, are you gay?' So I choose that place to be more comfortable, I don't have anything to hide, but I wouldn't like to have chat with someone who would react like I'm not really happy with your sexuality, and I will make that test, and I'll let you do the test, but you're a bad person. (Participant no. 2 from Eastern Europe)

One participant who received a sexual health screening for the first time in Ireland describes why he never had a sexual health screening in his home country.

I never got tested before in [home country] because I don't know where should 'I' go. If you do that in [home country], of course the doctor will ask you why you want to get this blood test. […] If I do tell, I'm not willing to say that I'm gay, even though the doctor has to be open about it. Like, I'm thinking, I never ever say that I'm gay, that's why I never get the blood test done in [home country]. (Participant no. 9 from South-East Asia)

Also, as most other health services in Ireland bear a fee, the fact that these services are free facilitated their use. Other factors facilitating use include the location near city centre, opening hours in the evening, and the availability of free condoms and personal lubricant.

Barriers to accessibility

For a number of participants, a major barrier to accessing these services is a desire not to go alone, as many made their first visit either with their partner or a friend. They cited that they needed social support.

The reason I think, probably, I'm not brave enough, I think. Like if I do find something wrong with me, for example, I know I had unprotected sex the year before that, and if I do go there, I'm alone. Like I never get any relationship, I don't know who should I be depending to like, if I do find, for example, I'm HIV positive, so that's why I didn't have any [courage] to go there, like, so I can't deal with that I think, if I do know something wrong happened to me, that's why I prefer to go with someone I can depend on. (Participant no. 9 from South-East Asia)

In relation to the GMHP clinic, some participants expressed discomfort regarding issues of anonymity. By using this service, they expressed that other users of the clinic would identify them as 'gay' or perceived to have an STI. This in particular would be a major barrier for those who are not open about their sexuality, or do not want to be identified as 'gay'. Those who expressed

feeling discomfort using this service due to other clinic attendees were unaware of other services they could use that would be open to their sexuality.

> *I know some people who avail of the service find it a bit, I suppose, put off, for them to go, it would stop them from going because it's a small city and it's, it's a small community, even smaller community, and if you go to the clinic you see the same people you see on the scene.* (Participant no. 8 from South-East Asia)

For those whose first language was not English, language was discussed as a major barrier to accessing these services. Some expressed knowledge of the option of translation in another language or receiving information in another language.

> *It was difficult for me doing it in [home country]. So doing in Ireland is even more difficult because it's the same but in English. I mean, I can talk in English, I can understand English, so no problem but it's still more difficult.* (Participant no. 10 from Western Europe)

Time was identified as another barrier. This included the long waiting time in the clinic and the opening hours of the clinic. For some, time constraints due to work made the hours of the clinic unsuitable, as the GMHP clinic is only open two evenings per week.

Negative experiences of other health services

Due to the nature of the interview, participants often shared their experiences using other health services in Ireland, specifically public hospitals and GP clinics. Many described the health system in Ireland as generally poor compared to the systems in their respective countries.

> *I was saying this gay men's health service is very good, but for generally for health service, it's very bad, that's what I can say. And you know yourself, the health service is quite poor, I mean waiting time, and, but usually I just go to my own GP in [name of street], and it's quite expensive, like you have to pay fifty euro consultation, just two minute checking, and you got nothing.* (Participant no. 9 from South-East Asia)

The two main concerns were long waiting times and the prohibitive cost of using services. There was general uncertainty among participants to the level of health insurance coverage they receive in Ireland. Many from other EU countries discussed their uncertainty of entitlement to free health services by possessing the European Health Insurance Card (EHIC), with inconsistent charges depending on the services they were using. From outside of the EU, participants were also unsure if they were covered by reciprocal agreements with their country, or if health insurance was covered in their educational tuition fees. Those with private health insurance expressed a feeling of comfort with insurance, but were also uncertain to the level coverage they were entitled to if something would happen. One participant expressed using services in their home country because service is cheaper and faster.

> *When I'm sick in Ireland I'm not just going to pay all that money to be seen and get antibiotic, um, but I know that if I'd like to get some more tests in here, as blood test, ah, I don't know, x-rays… I will have to pay a ridiculous money for that and I think I can get that sorted out in [name of country], much faster and a lot cheaper.* (Participant no. 2 from Eastern Europe)

Many described first-hand negative experiences of using other health services, the majority stemming from public hospitals. These negative experiences resulted in low trust of the health services in Ireland. Two (2) participants discussed experiences where they received poor treatment due to not having identification on them.

> *I had an experience of going to a hospital, for example, and not being well treated in there. Um, so there's plenty to be done still, people sometimes look at me different, like the experience in the hospital, the lady didn't want to accept me because I didn't have my ID. And I then I told her I can tell you who am I, you don't need to have my ID to allow me to see a doctor…* (Participant no. 6 from Latin America)

For some participants, trust in the health system is so low that they expressed the use of services in other countries.

> *Last time I got sick I flew back to [name of country] and I saw a doctor in [name of country]. (I: Really?) Yeah, I don't feel comfortable to see a doctor here. Um, I actually I feel afraid of being in the wrong hands. […] I don't feel safe if I have to use this system here. […] I would avoid, if I had an accident for example, my wish is not being treated in Ireland, it's to be transferred to [name of country].* (Participant no. 6 from Latin America)

This high level of mistrust also carried over into the sexual health services for the following participant.

> *Last year [in home country], I had an HIV test because I don't trust them (Laughter), or I don't trust test, um, I went to [home country] and did a HIV test there as well.* (Participant no. 13 from Western Europe)

6. DISCUSSION

The findings of this study enabled further characterisation of this vulnerable group. Although Dublin is not seen as a global 'gay magnet' like London, the results of this study confirmed several findings of the in-depth study of migrant MSM in London by Keogh et al. (2004). In both studies men described their main motivation for leaving home was a desire to live an openly gay lifestyle. For many of these men the initial period was not of gay liberation, but a period faced by a number of difficulties, in particular the formation of meaningful social networks. Many men expressed a closer association with the gay community, as sexuality was often cited as a barrier to accessing

their respective expatriate communities. The gay community, however, did not always provide the support required to meet the unique needs of these men and were often unaware of social support services available to them.

Factors increasing vulnerability

A major aim of this study was to identify the factors that increase the vulnerability of migrant MSM to HIV infection and other STIs. The qualitative analysis of the in-depth interviews identified that vulnerability of migrant MSM is influenced by a dynamic interplay of behavioural, social and structural factors. A simple diagram of this interaction is illustrated in Figure 6.1. Increased risk is associated with each factor, but a combination of different factors will increase vulnerability to HIV and other STIs. All of these factors need to be targeted together to lessen the vulnerability of migrant MSM.

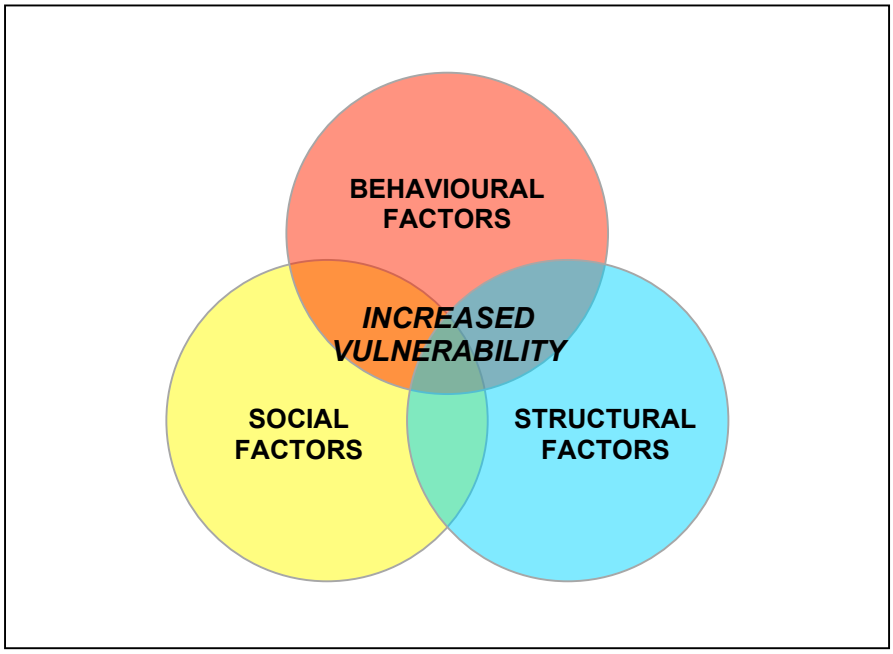

Fig 6.1: Diagram illustrating the interaction between behavioural, social, and structural factors increasing vulnerability to HIV and other STIs

Behavioural factors

High-risk sexual behaviour among MSM is the main characteristic putting this population at a higher risk of exposure to HIV and other STIs. However, it is important to determine the behaviours that lead to increased vulnerability among migrant MSM.

Behaviour is directly influenced by knowledge, attitudes and perceptions of risk. The migrants in the sample demonstrated a differential understanding of the modes of transmission of HIV and other STIs. Their understanding may be dependant on the level of knowledge received in their countries of origin in relation to the level of attention MSM receive in the national response to HIV. Many Eastern European countries, for example, are faced with increased prevalence among IDUs, therefore, fewer resources are directed towards MSM populations. Knowledge migrants attain in their countries of origin also affects the level of stigma surrounding HIV infection, increasing their vulnerability to adverse stress if infected with HIV.

Perception of risk to HIV and other STIs varied widely among participants in the sample. A perception of a lower sexual health risk in Dublin than in other cities with a larger gay community is of concern. For example, many men expressed a low concern over infection of other STIs, not realising that this increases risk of HIV transmission. The number of men in the sample that reported unprotected anal intercourse (UAI) was surprising. Although there is no risk of HIV infection with UAI among seroconcordant[3] partners, the uncertainty of monogamy of regular partner and low confidence of remaining monogamous themselves carries a high risk. In addition, lower-risk sexual behaviour with irregular partners still carries a high risk of being infected with other STIs.

For migrant populations, it has been suggested that the feeling of anonymity in a new social environment may increase the likelihood of engaging in high-risk sexual behaviour (UNAIDS, 2001). Anonymity may influence the number of sexual partners, casual sex, and drug use. In this sample, many described their initial period in Dublin as a time of experience, with a number of participants visiting venues for casual sex such as saunas.

Sexual risk-taking is closely linked to drug and alcohol use. Many men described increased alcohol consumption since migrating to Ireland, and some expressed high-risk behaviour while under the influence of alcohol. A number of men in the sample also described using drugs here in Ireland, and for some this was their first experience. Drugs such as ecstasy and cocaine are cited as being readily available in the commercial gay scene. A recent study in Ireland found the level of drug use amongst LGBT young people widespread and more prevalent than within the general youth population (Sarma, 2007). One finding of the study by Sarma (2007) was a high number of respondents reporting unprotected sex attributed directly to being under the influence of drugs. Interestingly, the participants who reported recreational use of drugs in this sample were aged 21 to 25. A low level of knowledge towards drug use may have wider implications on the health of these men, requiring the need of targeted harm reduction strategies.

Social factors

The formation of social networks is often the most challenging experience for migrants in a new environment, especially for migrants arriving unaccompanied. Many migrants find refuge within communities of people from their home country or region, however this is not the case for many migrant MSM who already feel alienated by society at home. For migrant MSM, the migration process is complicated by the extent sexuality plays in the decision to migrate. Many perceive the gay community will easily facilitate the formation of social networks. Disappointment is experienced when these expectations are not met, along with a number of other difficulties faced when adapting to their new environment. This is a situation a number of participants in the sample experienced, which can be described as part of the process of 'acculturation'.

Acculturation refers to the transition process that is brought about by meeting people from two different cultures (MacLachlan, 2006). An acculturation framework has been developed that is useful to help conceptualise the experiences of migrant MSM in adapting and forming social networks in their new environment. The framework outlines four (4) acculturative strategies: *integration*, *assimilation*, *separation*, and *marginalisation*; each characterising how a migrant

[3] Sexual partners with the same HIV status (both partners HIV positive or HIV negative)

changes their cultural identity when in a new environment (Berry, 1997 cited in MacLachlan, 2006). This concept can be applied to migrant MSM to describe their level of attachment to expatriate communities in relation to their attachment to their new social environment, illustrated in Figure 6.2.

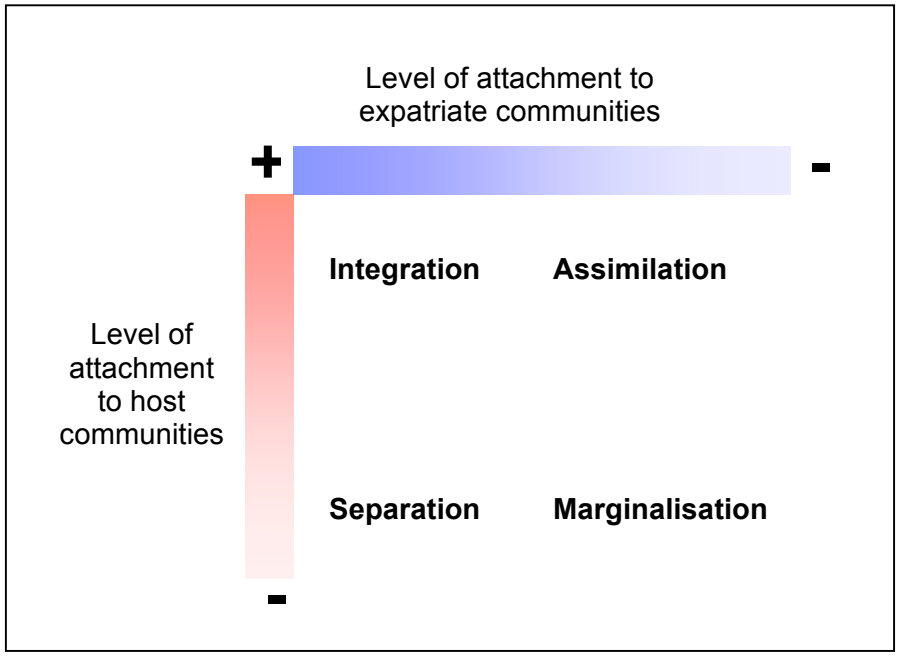

Fig 6.2: Acculturation strategies among migrant groups determined by level of attachment to expatriate and host communities; adapted from MacLachlan (2006)

From the results of this study, the assimilation strategy most closely relates to a majority of participants. Many described a low level of attachment to their respective expatriate communities and relied heavily on the gay community for the development of social networks. A number of participants expressed specifically seeking an Irish partner to ease with the adaptation process. This strategy creates an initial period of stress, as ease of developing social networks often relies on language, interpersonal skills, and relative similarity of cultural backgrounds. Additional difficulties are faced due to the avenues chosen to meet other men, which typically are highly sexualised and influenced by drug and alcohol use. The desire to be a part of a group also makes these men susceptible to peer pressure. All these factors affect the likelihood of engaging in high-risk sexual behaviour.

However, a major risk of assimilation is the vulnerability of marginalisation. If migrant MSM experience excessive difficulties developing social networks within the gay community, it may lead to the feeling of not identifying with any group. The stronger their rejection towards their expatriate communities, the more vulnerable they become. This results in higher levels of stress and may lead these men to undue risk by placing themselves in social situations outside their normal boundaries in an effort to find acceptance. Marginalisation further exacerbates their vulnerability to HIV and other STIs.

The importance of strong social networks is the level of social support they provide, which may enable individuals to cope more effectively with stressful situations (MacLachlan, 2006). This includes the required support for many to visit a sexual health clinic and seek necessary help to

deal with the resulting outcome, greatly decreasing their vulnerability to HIV and other STIs. Therefore, the best strategy for migrant MSM to form social networks would be through 'integration'. For this to happen, homophobia in expatriate communities needs to be addressed, as well as the availability of social networking opportunities for migrant MSM outside of the highly sexualised commercial gay scene. Such social strategies tend to overlook non-ethnic minority migrant MSM, as they are often seen to fit into conventional programmes for MSM.

Structural factors

Accessibility of sexual health services is a major factor influencing the vulnerability of migrant MSM. The findings of the study identified a number of barriers faced by migrant MSM in accessing sexual health services in Ireland, summarised in Table 6.1. Many of these barriers increase vulnerability to HIV and other STIs by limiting the health-seeking behaviour of migrant MSM.

Table 6.1: Barriers limiting accessibility of sexual health services for migrant MSM

- Limited social support
- Anonymity
- Language barriers
- Time constraints
- Perceived cost of services
- HIV stigma / fear of results
- Low trust in health service

An important factor limiting accessibility is unfamiliarity of the health system and a low awareness of available services. With no previous knowledge of the sexual health services available, many were only prompted to locate such services after a sexual risk incident or upon becoming symptomatic. Some participants have lived in Ireland for a number of years before availing of a sexual health screening for the first time. Health-seeking behaviour is also limited due to the cost of services. Without an understanding of which services bear a cost, many may hesitate to use health services unless affected by a serious health issue.

A number of behavioural and social factors also limit accessibility of sexual health services including fear of results due to HIV stigmatisation, language difficulties, and limited social support. A number of participants in the sample also expressed being unable to access services during operating hours.

All participants in the sample described the importance of visiting an LGBT-friendly doctor or clinic when dealing with issues of sexual health. Sexual health services specifically for MSM facilitated accessibility for many, but others expressed discomfort surrounding issues of anonymity. For men not wanting to be identified as gay, going to a clinic not specifically for the LGBT community would better facilitate access, however the visibility of such services being LGBT-friendly is low. Migrant MSM need to become more knowledgeable of the choice of services available to them, as many perceive the GMHP clinic as the only friendly and free option available.

With a general level of satisfaction with sexual health services, an unexpected outcome of this study was the number of negative experiences and high level of mistrust participants expressed towards the general health system in Ireland. This is worrisome if this low trust in the general health service limits accessibility of sexual health services due to negative perceptions held by migrant MSM.

Strategies to target vulnerability

A number of strategies are required to target the behavioural, social and structural factors that increase the vulnerability of migrant MSM to HIV and other STIs. These factors are intensified during the initial phase of the migration process, therefore it is necessary to reach this vulnerable group as soon as possible after arrival, or even before arrival. It is during this initial phase that migrant MSM are most vulnerable as they are unaware of services available to them, have minimal social support, and for some, experiencing an openly gay lifestyle for the first time. There is a need to move beyond translations of information materials and actively attempt to reach all migrant MSM. A number of recommendations are outlined below.

Reaching migrant MSM

- Utilise GCN to disseminate information to migrant MSM as many expressed reading this free monthly magazine for the LGBT community to gain information. The magazine is widely circulated around Ireland and is also available in a number of non-gay specific venues.
- Employ web-based advertising on popular dating sites (ie. www.gaydar.co.uk, www.gayromeo.com) to promote sexual health services for MSM. These websites are also used to meet other men before arriving in Ireland.
- Disseminate information in ESL (English as second language) schools, and target international students in colleges/universities.
- Take advantage of non-health services utilised by a high number of migrants. This includes Department of Social and Family Affairs offices where anyone seeking employment must apply for a Personal Public Service Number (PPS), and employment services such as FAS, the Government's Training and Employment Authority.
- Advertise services in expatriate community newspapers (ie. Gazeta Polska, a Polish newspaper published in Ireland; Metro Éireann, an Irish multicultural weekly newspaper).
- Develop a website for LGBT migrants as a comprehensive guide to living in Ireland, outlining services available for the LGBT community.

Addressing high-risk sexual behaviour

- Coordinate with national HIV programmes in other countries to provide approved web-links to foreign-language sexual health information for MSM.
- Address risk of unprotected anal intercourse with regular partners by raising caution and need for continued testing.

- Continue programming to increase understanding and risk of other STIs and reduce stigma surrounding HIV infection to address fear of testing.
- Communicate the increased risk of HIV infection when infected with an STI.
- Increase availability of free condoms, including increasing availability in social venues.

Supporting social networking

- Reduce reliance on commercial gay scene for social networking by increasing awareness of different social groups, including the Gay International Group (GIG) organised out of the OUThouse, a LGBT community centre.
- Encourage joining social groups by alleviating fear of going alone.
- Support the development of new social groups for LGBT migrant groups, such as the Pink Philippines Organisation, a Filipino gay support group in Ireland.
- Develop a Personal Development Course (six-week workshop run by GMHP) tailored for new migrant MSM in Ireland.

Encouraging health-seeking behaviour

- Increase visibility of sexual health clinics as LGBT-friendly centres.
- Emphasise no-cost service with free sexual health screenings for everyone.
- Target individuals hesitant to visit sexual health clinics for the first time or alone by providing support such as clinics specifically for first-time users.
- Promote availability of free hepatitis A and B vaccines, including the possible need for booster.

Future Research

With the exploratory nature of this study, a number of the findings merit further investigation, including the five (5) following suggestions:

1. Future surveys, such as the All-Ireland Gay Men's Sex Survey, must seek to gather information on migrant MSM to further characterise this group and provide estimates on the population size.
2. Further research is required to determine if certain high-risk sexual behaviour is more prevalent among migrant MSM, such as UAI, and investigate the possible explanations.
3. Studies must seek to include MSM who do not self-identify as gay or bisexual men.
4. Research is required on the acculturation strategies of the receiving society, specifically the views of migrants within the gay community.
5. The wider health needs of migrant MSM, beyond sexual health, require investigation.

7. CONCLUSION

The recent migration trend is playing an increasing role in HIV prevalence in Ireland. With concerns being raised around the effect migration has on the spread of communicable diseases such as HIV, focus has been diverted away from the most vulnerable population, the migrant groups themselves. This study considers migrant MSM as the most vulnerable among this population, as the migration process is further complicated by the role of sexuality. Along with migration, sexuality is an important determinant of health.

The exploratory nature of this study led to the identification of a number of collaborative factors that influence the vulnerability and increase the sexual health risk of migrant MSM. A number of strategies were recommended to simultaneously address these factors as their unique needs require efforts beyond conventional programmes for gay, bisexual men and other MSM.

This study also highlights the global health importance of sexual health outcomes that are influenced by experiences in other countries before the migration process. Therefore, the issue of HIV and migration not only requires greater attention within Ireland, but also requires a cooperative effort of individual countries and multilateral agencies such as the European Union.

8. REFERENCES

Berry, J. (1997). "Immigration, acculturation and, adaptation", *Applied Psychology: An International Review* (46) January, 5-34, cited in MacLachlan, M. (2006). *Culture and Health: A critical perspective towards global health, 2nd edition.* England, John Wiley & Sons Ltd.

Browne, J. (2005). "Survey design", in *Principles of Social Research,* eds. Green, J., Browne, J. United Kingdom, Open University Press.

Carrillo, H. (2004). "Sexual migration, cross-cultural sexual encounters, and sexual health", *Sexuality Research & Social Policy*, (1:3) September, 58-70.

Central Statistics Office, CSO (2007). *Census 2006: Principal demographic results.* Dublin, Government of Ireland.

Devine, P., Hickson, F., McNamee, H., Quinlan, M. (2006). *Real Lives: Findings from the All-Ireland Gay Men's Sex Surveys, 2003 and 2004*. Available from http://www.gayhealthnetwork.ie/pdf/Real Lives Report June 2006.pdf (6th November 2006).

Diaz, R., Ayala, G., Bein, E., Henne, J., Marin, B. (2001). "The impact of homphobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities". *American Journal of Public Health* (91:6) June, 927-932.

Dougan, S., Elford, J., Rice, B., Brown, A., Sinka, K, Evans, B., Gill, O., Fenton, K. (2005a). "Epidemiology of HIV among black and minority ethnic men who have sex with men in England and Wales". *Sexually Transmitted Infections*, (81) 345-350.

Dougan, S., Elford, J., Sinka, K., Fenton, K., Evans, B. (2005b). "Men who have sex with men who are born abroad and diagnosed with HIV in England and Wales: an epidemiological perspective". *International Journal of STD & AIDS.* (16:9) September, 618-621.

Dowsett, G. (2007). "Researching gay men's health: the promise of qualitative methodology", in *The Health of Sexual Minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations*, eds. Meyer, I., Northridge, M. New York, Springer.

European Centre for the Epidemiological Monitoring of HIV/AIDS, EuroHIV (2006). *HIV/AIDS Surveillance in Europe: End-year report 2005, No. 73.* Saint-Maurice, Institut de veille sanitaire.

George, C., Alary, M., Hogg, R., Otis, J., Remis, R., Masse, B., Turmel, B., Leclerc, R., Lavoie, R., Vincelette, J., Parent, R., Chan, K., Martindale, S., Miller, M., Craib, K., Schechter, M. (2007). "HIV and ethnicity in Canada: is the HIV risk-taking behaviour of young foreign-born MSM similar to Canadian born MSM?", *AIDS Care*, (19:1) January, 9-16.

Green, J. (2005). "Analysing qualitative data", in *Principles of Social Research,* eds. Green, J., Browne, J. United Kingdom, Open University Press.

Green, J., Thorogood, N. (2004). *Qualitative Methods for Health Research*. London, Sage Publications.

Hamers, F., Devaux, I., Alix, J., Nardone, A. (2006). "HIV/AIDS in Europe: trends and EU-wide priorities", *Eurosurveillance Weekly Release*, (11:11) 23 November. Available from http://www.eurosurveillance.org/ew/22006/061123.asp (17th May 2007).

Hamers, F., Downs, A. (2004) "The changing face of the HIV epidemic in western Europe: what are the implications for public health policies?", *The Lancet*, (364) 83-94..

Health Protection Surveillance Centre, HPSC (2003). *HIV and AIDS statistics in Ireland: Quarter 3&4 2002 & 2002 Annual Summary*. Available from http://www.ndsc.ie/hpsc/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/SurveillanceReports/ (9th February 2007).

Health Protection Surveillance Centre, HPSC (2004). *HIV and AIDS statistics in Ireland: Quarter 3&4 2003 & 2003 Annual Summary*. Available from http://www.ndsc.ie/hpsc/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/SurveillanceReports/ (9th February 2007).

Health Protection Surveillance Centre, HPSC (2005). *Newly diagnosed HIV infections in Ireland: Quarter 3&4 2004 & 2004 Annual Summary*. Available from http://www.ndsc.ie/hpsc/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/SurveillanceReports/ (9th February 2007).

Health Protection Surveillance Centre, HPSC (2006). *Newly diagnosed HIV infections in Ireland: Quarter 3&4 2005 & 2005 Annual Summary*. Available from http://www.ndsc.ie/hpsc/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/SurveillanceReports/ (9th February 2007).

Health Protection Surveillance Centre, HPSC (2007). *Newly diagnosed HIV infections in Ireland: Quarter 3&4 2006 & 2006 Annual Summary*. Available from http://www.ndsc.ie/hpsc/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/SurveillanceReports/ (15th June 2007).

Hickson, F., Reid, D., Weatherburn, P., Stephens, M., Nutland, W., Boakye, P. (2004). "HIV, sexual risk, and ethnicity among men in England who have sex with men", *Sexually Transmitted Infections* (80) 443-450.

Hopkins, S., Lyons, F., Mulcahy, F., Bergin, C. (2001). "The great pretender returns to Dublin, Ireland", *Sexually Transmitted Infections*, (77:5) October, 316-318.

Immigrant Council of Ireland (2005). *Background information and statistics on immigration to Ireland: June 2005*. Available from http://www.immigrantcouncil.ie (9th February 2007).

International Organiztion of Migration, IOM (2005). *HIV/AIDS and Population Mobility: Overview of the IOM Global HIV/AIDS Programme 2006.* Bangkok, IOM.

Johnson, A., Mercer, C., Cassell, J. (2005). "Social determinants, sexual behaviour, and sexual health", in *Social Determinants of Health, 2nd edition,* eds. Marmot, M., Wilkinson, R. Oxford, Oxford University Press.

Joint United Nations Programme on HIV/AIDS, UNAIDS (2001). *Migration and AIDS: UNAIDS technical update*. Geneva, UNAIDS.

Joint United Nations Programme on HIV/AIDS, UNAIDS (2006a). *2006 Report on the global AIDS epidemic*. Geneva, UNAIDS.

Joint United Nations Programme on HIV/AIDS, UNAIDS (2006b). *AIDS epidemic update: December 2006*. Geneva, UNAIDS.

Joint United Nations Programme on HIV/AIDS, UNAIDS (2006c). *HIV and men who have sex with men in Asia and the Pacific*. Geneva, UNAIDS.

Joint United Nations Programme on HIV/AIDS, UNAIDS (2006d). *UNAIDS policy brief: HIV and sex between men*. Geneva, UNAIDS.

Keogh, P., Dodds, C., Henderson, L. (2004). *Migrant gay men: redefining community, restoring identity*. London, Sigma Research.

MacLachlan, M. (2006). *Culture and Health: A critical perspective towards global health, 2nd edition.* England, John Wiley & Sons Ltd.

MacPherson, D., Gushulak, B., Macdonald, L. (2007). "Health and foreign policy: influences of migration and population mobility", *Bulletin of the World Health Organization*, (85:3) March, 200-206.

National Economic and Social Council, NESC (2006). *Migration policy, September 2006*. Dublin, NESC.

Padilla, M., Vasquez del Aguila, E., Parker, R. (2007). "Globalization, structural violence, and LGBT health: a cross-cultural perspective", in *The Health of Sexual Minorities: Public health*

perspectives on lesbian, gay, bisexual and transgender populations, eds. Meyer, I., Northridge, M. New York, Springer.

Quinlan, M. (2007). *Report on the profiles of new attendees at the GMHP clinic 2004 and 2005: unpublished data.* Dublin, Eastern Region Health Board Gay Men's Health Project.

Ruhs, M. (2004). *Ireland: A crash course in immigration policy.* Available from http://www.migrationinformation.org/Profiles/print.cfm?ID=260 (9th February 2007).

Sarma, K. (2007). *Drug use amongst lesbian, gay, bisexual and transgender young adults in Ireland.* Available from http://www.queerid.com/images/belongtodrugsreport.pdf (15th June 2007).

The Lancet (2007). "Protecting the health of men who have sex with men", *The Lancet*, (369) May, 1576.

APPENDIX 1 – Copy of ethical approval letter

THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

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Mr. Daniel McCartney
50.2.06 Pearse St.
Trinity College
Dublin 2

29 May 2007

Study: The impact of migration on HIV transmission among MMS in Ireland

Dear Mr. McCartney,

Further to a meeting of the Faculty of Health Sciences Research Ethics Committee 2006 - 2007, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Dr. Orla Sheils
Chairperson
Faculty of Health Sciences Research Ethics Committee

cc. Adebola Adedimeji – Academic Co-ordinator & Lecturer, Centre for Global Health, TCD

APPENDIX 2 – Participant information leaflet

Name of researcher: Daniel McCartney

Description of study: The aim of this study is to explore the views and experiences of migrant men who have sex with men in relation to sexual health and sexual health services in Ireland. It is hoped that this information will be used to help improve services for migrant men who have sex with men in Ireland.

Procedures: You have been asked to participate in this study because your personal views as someone born outside of Ireland are of great interest and will be valuable in answering the research questions. Your contribution would be to attend an interview to discuss your views and experiences. The discussion will last no longer than 2 hours and will take place somewhere private and convenient for you. The results of the study will be used for a Masters thesis in University of Dublin, Trinity College.

Benefits: The benefits from this study will be the opportunity to share your experiences and to be able to contribute to knowledge. This may have positive impacts on the services for migrant men who have sex with men in Ireland.

Risks: There are no risks involved in being part of this study.

Exclusion from participation: You cannot participate in this study if any of the following are true:

- You are under the age of 18
- You were born in Ireland
- You migrated to Ireland before the age of 16
- You do not have sexual relations with other men

Confidentiality: Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. Any information will be locked away and only the researcher and his supervisor will have access.

Compensation: This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary Participation: You have volunteered to participate in this study. You may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study.

Stopping the study: You understand that the investigators may withdraw your participation in the study at any time without your consent.

Permission: The study has Research Ethics Committee approval from the Faculty of Health Sciences Research Committee, University of Dublin, Trinity College, Dublin.

Consent: To take part in this study you must read and sign the consent form.

Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Daniel McCartney who can be e-mailed at mccartdj@tcd.ie. If the study team learns of important new information that might affect your desire to remain in the study, you will be informed at once.

APPENDIX 3 – Participant consent form

Project: The impact of migration on sexual health among men who have sex with men in Ireland

Principal Investigator: Daniel McCartney

Background: The aim of this study is to explore the views and experiences of migrant men who have sex with men in relation to sexual health and sexual health services in Ireland.

Procedures: You have been asked to participate because your personal views are of great interest and will be valuable in answering the research questions. Your contribution would be to attend an interview to discuss your views and experiences. The discussion will last no longer than 2 hours. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group. Any information will be locked away and only the researcher and his supervisor will have access. The results of the study will appear in a report submitted as part of the researchers Masters work in the University of Dublin, Trinity College.

DECLARATION:
I have read, or had read to me, this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I consent to possible publication of results or use of data in other future studies without the need for additional consent. I understand I may withdraw from the study at any time.

I have received a copy of this agreement.

PARTICIPANT'S NAME: ……..

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

DATE: ……

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE: ……..…… Date: ……..……

APPENDIX 4 – Semi-structured interview guide

Introduction

Read the following to participant:

I would like to thank you for agreeing to be interviewed as part of my research for my Masters degree at Trinity College Dublin.

The aim of the interview is to get your views in relation to sexual health and your experiences of sexual health service needs in Ireland. Don't be worried as there are no right or wrong answers. The interview will take approximately an hour and a half.

I want to reassure you that all the information you give me will be treated confidentially and that your name or any identifying information will not be used. I would like to record this interview to enable me to remember all the issues we talk about and for the purposes of transcription. I will be the only person who will hear the recording. Once the interview has been transcribed, the recording will be destroyed. Do I have your permission to record the interview?

The records of the interview will be stored securely and only those working on the project will have access to them. The results of this study will appear in a report submitted as part of my MSc work; however, neither your name nor any of your details will appear in it. If you are interested, I can give you a copy of the report when it is completed.

Your participation is entirely voluntary. If you want to stop at any stage just let me know, and if there are any questions you don't feel comfortable answering, just indicate and we can move on.

Do you have any questions before we begin? If you are happy to begin, we'll start with a few general questions about yourself.

General Questions / Adaptation to Ireland

Age:

Country of origin/birth:

Year moved to Ireland:

Ethnicity:

Education level achieved:

Type of migrant (legal / asylum / illegal):

Can you start by telling me a bit about why you are living in Ireland / moved to Ireland? Are there any reasons why you chose to come to Ireland and not elsewhere?

What were your initial experiences? Did you have any difficulties adapting? Did you notice any cultural differences?

How do you find life here in Ireland? Do you feel you have adapted to life in Ireland? Is there a *home country* community here in Dublin/Ireland?

Experiences in Ireland

Many men in Ireland who have sex with men identify themselves as 'gay' or 'bisexual', do you consider yourself 'gay' or 'bisexual'? Are you comfortable using this term?

Are you open to others about your sexuality / having relationships with other men? Are you openly gay or bisexual in Ireland? Why or why not? What would make it easier for you to be open about your sexuality?

Were you open about your sexuality in your country of origin? Why or why not? Describe the situation in your home country.

Do you know anyone with similar sexual preferences from your home country here in Ireland? Do you think that these other people from your country are open about their sexuality in Ireland? Why or why not?

Do you find that people treat you differently because of your sexuality or ethnic background? Why? Describe an incident/situation. If you are treated differently, would you say this is a result of your ethnic origin or sexual orientation? Why?

Social Network

Before coming to Ireland, did you have any expectations of the gay scene? Did it meet your expectations? How does this compare to *home country*?

How often do interact with other men from the 'gay community' in Dublin or elsewhere in Ireland? Have you met other people with similar sexual preferences as yours? What are your experiences with them?

Where do you meet men like yourself? Do you feel comfortable in these venues? Are you able to meet openly or is there some secrecy surrounding your meetings?

Please describe the context of your meetings? What factors facilitate or inhibit your meetings/interactions? Do you find it easy to meet other men like yourself?

Have you met others from *home country* in gay community? Do you think this is where other men from your country meet men like yourself? What would make it easier for them to meet other men?

HIV & Sexual Health

Have you ever had a sexual health screening in Ireland? How did you find out about this service? Why did you visit? Where did you get information about this service?

Are you currently in a sexual relationship? How do you protect yourself/others? Have you ever engaged in UAI?

Do you worry about STIs? Why or why not? Is this different from how you felt in your home country? Are there any STIs that you feel are particularly prevalent?

Have you ever been treated for any STIs? Where did you go for treatment?

In Ireland, have you noticed any safer sex campaigns / messages? If so, what were they about? Did you understand the messages? Do you think others from your home country would understand these messages?

If participant is HIV positive:

How did you learn about your HIV status? When did you learn about your HIV status? Where did you learn about your HIV status?

Are you open to others about your HIV status in Ireland? Why or why not? What would make it easier for you to be open about your HIV status?

Are you open about your HIV status in *home country*? Why or why not? Describe the situation in *home country*.

Do you find that people treat you differently because of your HIV status? Why? Describe an incident/situation.

Do you feel HIV stigma or discrimination exists here in Ireland? What do these terms mean to you? Does this apply to you? Do you ever feel discriminated against?

Accessibility of Health Services

Which health services do you use in Ireland? Where did you get information about these services? How did you find out about these services?

Describe your experiences using these services. Were you comfortable using these services? When using these services, did you feel like you were being treated differently because of your ethnic background / sexual orientation / HIV status?

Were these services easy to access? What factors facilitate or inhibit you from using these services? Did you have to pay for these services? What would make it easier for you to use these services?

Do you think others from your home country here in Ireland use these services? Why or why not? What facilitates or inhibits them from using this service? What would make it easier for them to use these services?

Can you discuss any other factors/barriers to utilising these services (ie. timing, costs, location)? Are there any laws/policies/regulations that you know of that encourage or constrain usage of services?

Conclusion

Do you have anything else you would like to add/share?

Do you have any further questions?

Give participant local services information sheet and explain.

Thank participant for participating in study.

APPENDIX 5 – Local services information sheet

Helplines

Drugs/HIV Helpline
1800 459 459 (Freephone)

Gay Switchboard Dublin (Helpline)
01 872 1055
www.gayswitchboard.ie
info@gayswitchboard.ie

Immigrant Council of Ireland (Drop-in & Phone-in Service)
2 St. Andrew St, Dublin 2
01 674 0200
www.immigrantcouncil.ie
info@immigrantcouncil.ie

Services

Dublin AIDS Alliance
53 Parnell Square West, Dublin 1
01 873 3799
www.dublinaidsalliance.ie
info@dublinaidsalliance.ie

Gay Men's Health Project Clinic Services (Drop-in Service)
19 Haddington Road, Dublin 4
01 660 2189
www.gaymenshealthproject.ie
gmhpclinic@eircom.net

Gay Men's Health Project Outreach and Counselling Services
Outhouse Community Centre, 105 Capel Street, Dublin 1
01 873 4952
www.gaymenshealthproject.ie
gmhpoutreach@eircom.net
gmhpcounsellor@eircom.net

Open Heart House
2 St. Mary's Place, Dublin 7
01 830 5000
www.openhearthouse.ie
info@openhearthouse.ie

Outhouse Community Centre
105 Capel Street, Dublin 1
01 873 4932
www.outhouse.ie
info@outhouse.ie

Transgender Equality Network Ireland
Outhouse Community Centre
105 Capel Street, Dublin 1
085 147 7166
www.teni.ie
info@teni.ie