

Asian Men Who have Sex with Men (MSM)'s perceptions of risk behavior
and attitudes towards HIV testing in New Zealand

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Abstract

This pilot study explores Asian Men Who have Sex with Men (MSM)'s perception of risk behavior and HIV testing in New Zealand using the Health Belief Model (HBM) framework. Though Asian MSM in this pilot report high recall of HIV prevention messages and high knowledge of HIV, their perception of HIV risk and what constitutes enough reason to test for HIV present as key barriers.

Participants did not perceive HIV testing as necessary for them as they mitigate HIV risk through modelling monogamous sexual relationships and avoiding condomless sex with multiple partners.

A perception that sexual partnering in the openly gay, non-Asian gay community as being more risky, a low involvement in openly gay community where targeted HIV testing is easily accessible, fear of stigma in the Asian community of homosexuality and HIV and limited desire to accessing primary health care (GPs) until the first episode of illness all present as barriers to HIV testing for Asian MSM. New HIV infections among Asian MSM are rising in New Zealand. Targeted outreach and further research are necessary if practitioners in HIV prevention seek to increase testing among Asian MSM in the country. As early HIV treatment is shown to reduce infectivity of people newly diagnosed with HIV, it is important for rates of testing to increase among this population group to fully realize the benefits of early detection, treatment and in preventing new infections.

A key outcome of this pilot study is a questionnaire for further research focusing on Asian MSM and their HIV testing behaviour.

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

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Chapter 1

Title

Asian Men Who have Sex with Men (MSM)'s Perception of Risk Behaviour and Attitudes towards HIV Testing in New Zealand

Introduction

Asian Men who have sex with men (MSM)'s perception of risk behaviour and HIV testing are at the center of this research. The focus is on the factors that underpin attitudes towards HIV testing behaviour among Asian MSM. The research proposes the Health Belief Model (HBM) as the framework for this research. It is used to organize data into themes emerging from interviews with Asian MSM and to investigate as well as to understand the experiences of Asian MSM and their access to HIV testing. Asian MSM seeking testing for HIV as well as their responses to health communication are understood as complex behaviour choices not solely conducted in a linear or simplistic fashion. Several factors such as perceptions of health, prior knowledge of health risks and health communication can influence health choices and health seeking behaviour. Health behaviour and choices are situated in the context of Asian MSM's beliefs about what constitutes good health, risk taking and sexual choices (Spector, 2004).

As the rates of testing amongst Asian MSM are seen to be low in New Zealand when compared to European MSM, the HBM as a theoretical framework is an appropriate fit for this pilot study in order to evolve an effective questionnaire for further research into this population group.

Research (Rosenstock, Strecher & Becker, 1996) has shown that the Health Belief Model is effective in predicting health seeking behaviour. However, it is pertinent to note some of the limitations of the HBM from the results of research on Taiwanese students in the United States by Lin, Simoni and Zemon (2005) which concluded that more culturally sensitive measures need to be developed and incorporated in the Health Belief model.

Background to the study: New Zealand's place in the global HIV epidemic

Internationally, the World Health Organization (WHO) stated that at the end of 2014 there were approximately 36.9 million people living with HIV. WHO estimates that nearly 2 million people become newly infected each year (WHO, n.d).

New Zealand (NZ) is considered to be a low prevalence country in the context of the global HIV epidemic. A high quality health care system (funded medicines and prevention outreach) and laws (homosexual law reform and human rights track record) aligned with HIV prevention efforts since the start of the epidemic in the 1980s have contributed to the low prevalence of HIV in the country. Over the years, consistent condom promotion has helped in keeping the HIV epidemic in the country at very low levels (NZAF, nd).

Since 2012, new HIV infections in New Zealand have been rising with 2016 being the highest they have ever been (NZAF, nd). In tandem, the country's response to the epidemic has been lagging due to an outdated policy and action which is not aligned to globally recommended best practice (NZAF, nd.). Researchers have asserted that adapting to a wider range of HIV prevention methods would go a long way to achieving even lower levels of transmission and new HIV infections (Saxton, Hughes, & Giola, 2015).

A combination of factors have an impact on and implications for the health of gay and bisexual men in New Zealand as they are the population group most at risk of HIV transmission. The health of this population group is not benefitted if HIV prevention methods in the country are not aligned to the global best practice or latest developments. For instance, until as recently as June 2017, New Zealand had a CD4 threshold, this meant that if a person is diagnosed with HIV they are not eligible for funded treatment unless their CD4 count dropped below 500. Though this may change in the near future, however, as of now, the CD4 threshold continues to be in place.

The CD4 count is an indicator of the condition of an individual's immune system and, typically, a person presenting late in infection would have a low level of CD4 count. In its recent guidelines, WHO has recommended that anyone affected with HIV should be put on antiretroviral treatment as soon after diagnosis as possible regardless of their CD4 count. Additionally, those that are at substantial risk should be put on preventative medicines such as Pre-exposure Prophylaxis (PrEP). PrEP is HIV medication given to those who are not living with HIV, but may be at risk from it, so that they benefit from the protective effects of the medicines. PrEP is currently unfunded. HIV testing is a key component of HIV prevention and has implications for diagnosing HIV infection early. This is because if HIV infection is diagnosed early and if those who are tested HIV positive are put on treatment to achieve undetectable viral load, their infectiousness is close to zero and thus it is highly unlikely that HIV is transmitted.

In New Zealand, currently there are 3,200 people estimated to be living with HIV. According to the latest results from Otago University's AIDS Epidemiology Group (AEG), men who have sex with men (MSM) continue to remain the population most at risk of HIV. In 2015, 224 people were diagnosed out of which 153 were MSM. Most MSM diagnosed with HIV were of European ethnicity. However, an increase in diagnoses of Asian MSM is reported (NZAF, n.d).

Since an increase in HIV diagnoses among Asian MSM is observed over time in New Zealand, this thesis identifies the perception of risk and attitudes towards HIV testing among Asian MSM. In a pilot study of Asian MSM living in New Zealand for less than 5 years, the influencing factors and their social location are taken into account; that is, Asian MSM's gender, race, social class, age, ability, religion, sexual orientation and geographic location, (People's Experience of Oppression, n.d). Emerging themes from data analysis and findings of this pilot research contribute to the creation of a questionnaire aimed at gaining a nuanced understanding of risk and HIV testing of this sub-population. Focusing on this sub-population is relevant and timely for a number of reasons as explained below.

According to data from the AIDS Epidemiology Group (AEG) at Otago University, the proportion of Asian MSM diagnosed with HIV increased from 10% to 15% since 2013 (NZAF, n.d.). AEG indicates that the HIV diagnoses reflect the overall makeup of New Zealand's Asian communities, with a significant number from Chinese, Indian, and Filipino communities.

Since 2005, the Asian population in New Zealand has reportedly doubled due to immigration and this is reflected in the epidemiological trend of increasing HIV diagnoses amongst Asian MSM (NZAF, n.d).

Table 1: Total number of Asian MSM diagnoses from AEG data indicating rising trend:

Years	Number of Asian MSM
2000-2004	20 Asian MSM
2005-2009	39 Asian MSM
2010-2014	84 Asian MSM

Globally, minority communities (migrants, MSM and women) are identified as the most at risk groups that face a range of social, economic, cultural and legal issues. In some cases, this includes a high HIV prevalence in their countries of origin according to the European Centre for Disease Prevention and Control. This increases their vulnerability to HIV in their country of destination (European Centre for Disease Prevention and

Control, 2011) due to several factors such as low access to health services, varying levels of knowledge of HIV transmission, cultural beliefs and racism.

As elsewhere, in New Zealand, Asian MSM belong to multiple minority groups at the same time and their experiences and perceptions of health may emerge from where the different minority groups intersect. That is to say, being of Asian ethnicity, they are already of a minority group, further to which they are MSM, which sets them apart within the minority population of Asians in New Zealand. Consistent with international findings in the context of ethnic and minorities accessing healthcare and HIV testing (Choi, Operario, Gregorich & Han, 2003), Asian MSM may experience disenfranchisement and barriers in a number of ways such as stigma related to HIV and homosexuality, taboos around sex and sexuality, racism and stigma in the healthcare system and the wider Asian community. Their experiences, perceptions and attitudes are thus likely to be unique and different from MSM of other ethnicities or races. A percentage of Asian MSM migrating to New Zealand are likely to be from countries that do not have a comparable human rights record like New Zealand and where homosexuality may still be a criminal offence (for example, India) (Prakash, 2016).

This would have an impact on their perception of risk taking and health seeking behaviour such as HIV testing (Asia New Zealand Foundation, n.d).

It is likely that Asian MSM (many may not be openly gay or may be selectively open about their homosexuality) are not as closely connected with other MSM community in New Zealand (who may be openly gay), and thus Asian MSM may not benefit from the support from or belonging to the openly gay community; or may not respond well to general social marketing campaigns (Wong, 2015) due to reasons like stigma, internalized homophobia, or the social cost of being excluded from the general Asian community (Silver, 2014).

Despite an increase in the diagnoses of HIV among Asian MSM, Asian MSM's health seeking behaviour such as HIV testing, sexual health checks, social ties, social location and their perception of or attitudes towards HIV testing are not sufficiently researched with gaps in the existing literature. Importantly, the reasons for their low levels of testing are not sufficiently understood. This is confirmed by researchers (Dickson, Ludlam, Saxton & Hughes, 2014) indicating that having sexual health check-ups was lower and less likely among Asian and Pacific MSM. The reasons for this are currently under-researched.

The current literature and findings on MSM in New Zealand are largely based on a sample size drawn from openly gay MSM where Asians are under-represented (Azariah

& Perkins, 2010). Another example of the under-representation of Asian MSM in current literature would be the Gay Auckland Periodic Sex Survey (GAPSS) and the internet based Gay Online Sex Survey (GOSS), the two largest surveys undertaken in New Zealand of gay and bisexual men. From the 3138 MSM who participated in GAPSS and GOSS in 2011, only 258 gay, bi or MSM reported to be of Asian ethnicity as compared to 2262 who reported to be New Zealand European. It should be noted that under-representation would reflect in any findings or conclusions that are subsequently drawn from the data GAPSS and GOSS relating to Asian MSM in existing literature.

There is no other means (or a list, like the census data which does not collect information on sexual orientation) which would give researchers an indication of the total number of Asian MSM living in New Zealand.

This thesis focuses on HIV testing and the perceptions and attitudes of Asian MSM to HIV testing. This is important and relevant because to be able to prevent HIV transmission in New Zealand, for those who may be at risk of HIV, the vital first step before starting treatment in the case of a positive diagnosis is testing for HIV. Similarly, accessing regular sexual health checks would contribute to the well-being of at-risk individuals.

Difference between HIV and AIDS

For the purpose of this pilot, it is relevant to understand the difference between HIV and AIDS.

HIV denotes Human Immunodeficiency Virus. HIV is transmitted from one person to another through blood and bodily fluids such as semen. It is primarily transmitted through unprotected sex, used needles and from mother to child. It's a virus that's passed from person to person through the blood stream. Once HIV is in a person's blood, it begins to attack a person's immune system and works to kill off healthy immune system cells.

AIDS denotes Acquired Immune Deficiency Syndrome and it is an advanced level HIV infection. Due to advances in science and medication today, not everyone that has HIV will develop AIDS. However, a person will develop AIDS if their immune system is damaged and weakened to a point that it is not able to protect the person from infections and diseases as it would otherwise do.

Social networks and Asian MSM's perception of community and its relevance to this pilot study

Social networks are relevant to this research as they offer a context to the experiences of Asian MSM. For the purpose of this pilot study, a social network is defined as more than just the sexual interactions between Asian MSM. Sexual partnering is a part of a social network, however, the holistic social connections and human interactions that exist between Asian MSM that go beyond sexual partnering constitute their social network (Yuri, 2015).

Tapping into the social network of Asian MSM in New Zealand has an important benefit as a vehicle and as a means for recruiting participants (Yuri, 2015) and this has been useful for conducting this pilot study. Additionally, it is also important and relevant to acknowledge a social network's importance to the health and well-being of Asian MSM and their health seeking behaviour. This is because the way in which HIV or STIs are transmitted in the community or the social network can be understood through the characteristics of the social network and the inter-personal influence the members of the social network or Asian MSM have on each other. Asian MSM are likely to share similar risk perceptions, experiences, share norms and values, share linkages with sexual partners (Yuri, 2015).

Social networks offer important support to MSM (Yuri, 2015). Research has shown other impacts of social networks on the life and living of those in the networks. For example, close relationships with others in a social network have been associated with reduced stress over identity, racism and homophobia (Wong, Schrager & Holloway, 2013).

A social network offers people who share similar norms, beliefs and attitudes, the opportunity to interact and share information. Members of the same social network will also share similar HIV risk behaviour levels and as these social networks are primary sources of social support for MSM, greater support predicts higher care uptake or in other words, greater likelihood of health seeking behaviour such as HIV testing (Yuri, 2015).

Consequently, a lack of social networks or the nature of social networks would be likely to have negative impacts on Asian MSM's health and well-being as well as their attitudes, perception of risks and health seeking behaviour like HIV testing. Research by Phillips, Birkett, Hammond, and Mustanski (2016) confirms that ethnic or racial minorities were at risk of social isolation due to ethnic or racial preferences in forming

partnership. Their research asserted that partnering preferences were also likely to affect the structure of their sexual networks among MSM.

Research conducted with Asian MSM in China found that the characteristics of a particular social network are associated with the experience of living with HIV, (Hao, Lau, Zhao, et al, 2013). Thus, characteristics and context of a particular network are seen to influence the behaviour of members of a particular social network.

Not all the effects of close knit communities have been identified by scholars as positive with potential risky behaviours such as unprotected sex along with lack of testing for HIV and health communication (Buttram & Kurtz, 2013). For instance, people with higher risk of HIV tend to belong to the same networks. The likelihood of risk is mediated or governed by venue and network type (Kelly, Easterbrook and Parsons, 2012), in other words, the physical spaces where Asian MSM socialize and who they socialize with. According to research, lack of support within networks for safer sex resulted in higher risky behaviours by members of the social network (Schneider, Cornwell & Ostrow, 2013). It is relevant for this study to note that interventions focused on social networks successfully and significantly reduce the levels of HIV risk behaviours (Kelly, Amirkhanian & Kabakchieva, 2006).

A fact-sheet from the University of California, San Francisco (2003) explains that the key concepts of sexual and social networks that contribute to a higher risk of HIV transmission include a number of partners and a large number of ties to others in a network which means multiple sexual contacts with high frequency as well as unprotected sex with a high number of partners. As per the fact-sheet, the wider the network of anonymous and random sexual partnering across age, ethnicity, class, religion or other categories, the quicker the spread of infection across all categories. When core members of a network are engaged in risky behaviours, it fuels sustained transmissions, and how central a person living with HIV is to the network, deeply influences and increases HIV transmission rates in a community (Choi, Operario, Gregorich and Han, 2003).

For city dwelling MSM, association with different groups, and mixed personal community is defined by sociability (Holt, 2011; Wilkinson et al., 2011). This is relevant as Auckland is the most populated city in New Zealand with a high number of Asian MSM likely to migrate to the city from overseas (as and in proportion to other migrants) However, physical spaces continue to act as places of safety (Weston, 1991), (Meyer et al, 2003), (McLaren et al, 2008), (Kertzner et al, 2009), Hammack & Cohler, 2011) and (Frost & Meyer, 2012).

Research has shown that Asian MSM are likely to have fewer connections with the openly gay community (Adams and Neville, 2014). While this may mean that Asian MSM, being at the periphery of the gay community and therefore the sexual network, consequently may not be at the risk of HIV in the same way as members who may be at the core, it still does not explain their low rates of HIV testing, nor does it shed any light on their sexual behaviour, perception of HIV risk or perception of community.

Therefore, it would be relevant for this research to gain an understanding of what community means to Asian MSM interviewed and to their lives in Auckland and New Zealand. Similar ethnic population groups of MSM have been studied elsewhere and would provide a helpful comparison to this study and to gain an understanding of what community means to ethnic sub-population groups of MSM. A study by Kraft, Beeker, Stokes and Peterson, (2000) found that when the researchers investigated perceptions of community among young African American MSM, many men reported feeling marginal to African, American and gay white communities. Lack of non-sexual interaction with other MSM, a lack of leadership to provide space for non-sexual interaction and negative attitudes towards homosexuality may make it difficult for MSM from minority communities to participate in activities aimed at altering community contexts that influence behaviour. Central to the issue in the research by Kraft, Beeker, Stokes and Peterson, (2000) are questions about the communities that the young men identify with and participate in and whether the community, rather than small groups or individuals, is the appropriate target of intervention.

In the sample studied in this research, Asian MSM migrants may already be experiencing a loss of community and social connections due to having immigrated to a new country. It would be important to bear in mind that most common places where openly gay MSM socialize are predominantly over-represented by white MSM in New Zealand. The lifestyles of openly gay men are perceived to be and are associated with risk and risky or irresponsible sexual behaviour by Asian MSM in this pilot research.

Their lifestyles may be avoided by Asian MSM for a myriad of reasons. They may find spaces where the MSM community meet non-inclusive and not meeting their need for non-sexual socializing. Other spaces for non-sexual socializing are predominantly white, and technology as a way of socializing through ways such as apps for hooking up do not offer many opportunities to simply socialize without the expectation of sexual encounters. This contributes to avoidance or risk-aversion and further self-imposed isolation, and thus an opportunity for HIV testing as an instrument for HIV awareness is lost and misses a key population of Asian MSM vulnerable to HIV.

Scholars Kelly, Carpiano, Easterbrook and Parsons (2012) point out the importance of networks and social relations on influencing health behaviour. Community may be experienced as interactions that go beyond the usually expected relationships. Friendships remain important for the social development of Asian MSM.

Social location and its relevance for this study

Social location of individuals offers insights into the context in which people place themselves. As such, defining social location and explaining the bearing social location will have on the way Asian MSM live is relevant to this research. The beliefs that Asian MSM hold will be a product of their social location.

Social location is defined as the groups people belong to because of their place or position in history and society. All people have a social location that is defined by their gender, race, social class, age, ability, religion, sexual orientation, and geographic location (Peoples Experiences of Oppression, n.d.).

People belong to different social groups and this is in part due to who they are in terms of their history and the society in which they belong aside from their gender, race, social class, age, ability, religion, sexual orientation, and geographic location. It is implicitly understood that their behaviour, perceptions and beliefs will be a product of and be influenced by the set of social norms, power relations, interpersonal dynamics and privilege (or lack thereof) conferred by the social groups to which they belong (Peoples Experiences of Oppression, n.d.). Their social location will determine how the individuals see or perceive their world and this is another reason, it is relevant to reflect on social location for this thesis.

Social location also has a bearing on people's life chances as it is what they are exposed to in their lived experience of belonging to different types of social groups and organisations as well as social location's simultaneous and interactive effects on individuals (Peoples Experiences of Oppression, n.d.). By extension, it will also impact and influence how well Asian MSM look after themselves and their health choices. In the case of MSM for this pilot research, social location will therefore have a bearing on Asian MSM's perception of risk and attitude to HIV testing and ultimately, whether or not they will seek HIV testing.

This research is focused on how community, perceptions and attitudes impact HIV testing of Asian gay, bi and MSM. For a sub-group amongst a sample that is vulnerable to HIV when compared to the heterosexual population, an understanding of articulation

of perceptions and attitudes would offer insights into removing barriers to HIV testing at the community level.

Cultural safety and its implications for Asian MSM's health seeking behaviour

In focusing on Asian MSM's access to health care in New Zealand, it is relevant to reflect on the role of cultural safety in health care. The concept of cultural safety asserts that each person is a bearer of culture and that we all need to be aware of and challenge unequal power relations at every level of our individual selves, family, community and society. The concept enables us to view hierarchies in our society and the position – social, economic and political – of particular groups within society. Researchers give the example of Maori people in New Zealand as well as the Aboriginal peoples in Canada (Ramsden, 1993).

A Maori nurse leader (Ramsden, 1993) developed the concept of cultural safety to focus on nursing education in order to draw attention to colonizing processes in New Zealand's health care. Ramsden's work focused not just on how the health of Maori was affected by years of colonisation, but also how in current times, neo-colonization perpetuated the same processes and same inequalities in the health system of today.

According to Ramsden (1993) and Papps (2005), the health and illness belief systems of Maori are often disregarded in the dominant health care culture in New Zealand. This has marginalized Maori and privileged the dominant Pākehā culture in health care.

Nowadays, nurses in New Zealand are required to meet standards of cultural safety along with clinical safety as cultural safety specifically enables those receiving the care to define what safe service means to them.

Researchers Ramsden (1993) and Papps (2005) provide an example of diet choices (when hospitals provide food of a particular dominant culture or population group) and how these would play out in clinical settings and in practice as well as policy from the perspective of cultural safety. Advocacy may result in alternative food choices, or discussion among clinical staff could involve critical reflection.

For this thesis, it is important to include cultural safety as a concept to contextualize the experiences of Asian MSM who are also a minority group in New Zealand and already vulnerable to HIV. Experiences of Asian MSM in the health care setting and any stigma within the health care system are relevant for this research as they could potentially pose a barrier to accessing health behaviour such as HIV testing. Other research by Mundt (2014) corroborates the finding that gay and bisexual men and people living with HIV report experiencing stigma in health care setting. This is a key barrier to them

seeking positive health behaviour, such as disclosing their HIV status, sexuality or accessing testing. Similar to the above study, African communities report to feeling HIV stigma (Henrickson, Dickson, Mhlanga & Ludlam, 2015), thus it is likely that Asian MSM, also a racial minority in New Zealand, might face similar barriers or have similar experiences. This is important as this research is placed in the context of experiences of Asian MSM.

Objectives and purpose of the study

The purpose and objective of this study is to develop a questionnaire that will provide deeper insights into Asian MSM's health behaviour and their attitudes and perceptions to HIV testing in New Zealand. Additionally, this research will potentially fill existing knowledge gaps in research and policy on the under-represented sample of Asian MSM in New Zealand. It specifically concerns itself with the question of the *perception of risk of HIV and its impact on HIV testing behaviour*. HIV testing behaviour may be impacted among the Asian MSM sub-population by the strength of Asian MSM's social connections with the overall gay community, preference of where tests are conducted (low preference for testing at GP practices), their perceptions of actual risk of HIV and attitude towards HIV testing. Additionally, what constitutes risky behaviours and thus warrants an HIV test falls under the gamut of perceptions of risk.

It is the aim of this research to inform policy and practice and to positively impact the experience of Asian MSM in their access to healthcare. This research will inform guidelines that seek to support socio-culturally relevant health promotion for Asian MSM.

An insight into the current policy on HIV prevention in New Zealand is relevant to this pilot study in order to give context to further research. Currently, New Zealand's national response to HIV is written under the policy structure of the HIV/AIDS Action Plan published by the Ministry of Health in 2003. The HIV/AIDS Action Plan (2003) lists the following objectives under which action points are based:

1. Societal attitudes, values and behaviour
2. Personal knowledge, skills and behaviour
3. Programmes and services
4. Information

This plan has not been updated since 2003. It currently has no information into Asian MSM, or the growing diversity of New Zealand's population and is unresponsive to a changing HIV prevention landscape. A responsive and up-to-date plan will be useful for

community workers or clinicians. There is no specific Sexual and Reproductive Health Strategy action plan either, which would address the public health benefits of health seeking behaviour or provide guidelines for clinicians and health workers.

A 2010 report written by Dr. David Miller, commissioned and published by the Ministry of Health titled 'Review of Services for People Living with HIV in New Zealand' (2010) confirmed that current services provided to people living with HIV (PLWHIV) in New Zealand were necessary, but not sufficient. The report stated that there is no coordinated or comprehensive research agenda linked to HIV or STIs and therefore there is a continual and pressing absence of data for policy and programme refinement' (Miller, 2010). The report highlights stigma as a public health issue of major concern among both African and Maori communities and a cause of sub optimal responses to prevention and support activities. There is very little mention of the Asian community in relation to HIV stigma but the report highlights stigma as an issue that creates obstacles for minority populations (such as Asian homosexuals).

Policy or guidelines informed by insights gleaned from research on Asian MSM's attitude and perception of HIV testing, the needs of Asian MSM in being served by health care professionals and how Asian MSM would like to be communicated to would have more likelihood of translating into positive health behaviour such as testing for HIV, and bring health benefits to Asian MSM. This pilot research will contribute (through a questionnaire used for future research) to gaining a better understanding of Asian MSM's attitudes and beliefs of HIV testing. This is relevant and fits into the larger context of HIV prevention in New Zealand.

It is useful to focus on Asian MSM as a separate group for this pilot research. Support and care mean different things to different people. Preferences and beliefs about health and wellbeing rest within the context of norms, world-views and beliefs, and cultural perceptions within diverse ethnic groups. Ideas of health-care and accessing services also vary according to different cultural worldviews. For example, what may be considered practical advice in one community may be considered impolite or inappropriate in another.

As elaborated before, HIV care delivery models currently have limited insights on specific needs and preferences of Asian MSM at individual or group levels. It would be important to acknowledge that recommendations need to come from the communities whom health care workers, NGOs or even the Ministry want to access or serve.

Research Question

What is the impact of communication within social groups and communities on attitudes and perception of HIV risk among Asian men who have sex with men?

Contribution of this research

This research attempts to identify the reasons behind the low levels of HIV testing among the Asian MSM sub-population in New Zealand. While previous research has looked into this from an epidemiological perspective through the AIDS Epidemiology Group at the University of Otago's counting of HIV diagnoses in New Zealand, this research looks at the question through the prism of cultural norms, perceptions of what constitutes risky behaviour and health beliefs. Through this work, access to health is not merely a question of Asian MSM taking an HIV test. It is associated with notions of necessity, sexual risk and a sense of responsibility.

The aim of this pilot study and its contribution is to develop a questionnaire that would shed more light on the reasons for Asian MSM's sexual risk taking and their low levels of HIV testing.

Summary

This thesis presents an understanding and relevance of HIV care and prevention to the lives of Asian MSM in New Zealand. The review of literature specifically presents the areas where more research is necessary on the health behaviours of Asian MSM as well as their under-representation in sampling for research that is conducted. Definitions and epidemiological trends provide a background and basis for this pilot research. The use of the Health Belief Model as a theoretical framework is explained and its limitations are examined for the purpose of answering the research question. The role of community, social connection, social position and communication of Asian MSM's HIV testing behaviour provides a context to this pilot research in this chapter.

The research strategy including methodology and method of data analysis is explained in detail in chapter 3. An understanding of the sample, the participants and the suitability of conducting a pilot is discussed, which provides the rationale behind the decisions taken while conducting interviews, data collection and analysis.

In chapter 4, the findings from the data analysis in answering the research question are discussed in detail. The following discussion chapter concludes the thesis with the outcomes that this pilot set out to achieve. A questionnaire for any future research is provided as well as the limitations and practical implications of this pilot research.

Chapter 2: Review of the Literature

HIV in New Zealand - Current literature that informs and contextualizes this research

The latest available epidemiological data show that there are currently approximately 3200 people living with HIV in the country. Men who have sex with men (MSM) are over- represented in the total number of people living with HIV. In New Zealand, as across the world, MSM are the most at risk group for HIV transmission. MSM account for only 2.5 per cent of New Zealand's total population, but are consistently over-represented in HIV diagnoses each year in New Zealand.

The global upward trends in new HIV infection in this population is reflected as an upward trend in New Zealand as well since the start of the HIV/AIDS epidemic 30 years ago. Still, when compared to other countries in the world, New Zealand is considered a low prevalence country (NZAF, n.d.). There has been an excellent track record in human rights legislation and homosexual law reform in this country that has contributed positively to ensuring successful HIV prevention programmes.

A condom culture has contributed to the low prevalence of HIV in New Zealand. In their paper 'Infrequent condom use with casual partners among New Zealand gay and bisexual men', the authors Peter, Dickson, Hughes and Ludlam (2015) analyzed data from the community based Gay Auckland Periodic Sex Survey (GAPSS) and Internet-based Gay Online Sex Survey (GOSS). Their findings suggested that attitudes to condom use and safe sex were strongly predictive of actual condom use. In their conclusions, the authors suggested that social marketing should target the modifiable predictors of condom use, such as attitudes to safe-sex. Interventions also need to engage successfully with MSM who are living with HIV (which is a non-modifiable trait).

Attitudes to safe sex and HIV testing are of relevance to the topic of this research as attitudes to sex and homosexuality are generally associated with guilt and shame as sex is considered taboo in many Asian cultures. Additionally, homosexuality is criminalized in many Asian countries such as India (Prakash, 2016). As the sample for this research is made up of Asian MSM who have immigrated to New Zealand and are new here (defined here as 0-5 years), this will have implications for their health seeking behaviour including condom use and HIV testing. Currently, very little is known about Asian MSM's knowledge of health access in New Zealand or their attitudes to HIV testing.

In their discussion, Saxton et al (2015) mention that gay men in New Zealand appear to report higher rates of casual partner condom use than gay and bisexual men (GBM) in Australia, the US and the UK, where similar surveys have been conducted. However differences in sampling, measurement and reporting likewise complicate comparisons. For researchers, this opens an additional line of enquiry: So far, condom promotion has been a preferred and successful method for preventing HIV among gay and bisexual men. Now, as a combination prevention method is being proposed involving testing, treatment and Pre exposure prophylaxis (PrEP), how would it impact the health choices of Asian MSM? The availability of additional methods of HIV prevention is bound to impact the gay community over-all and it is too early to know how. To begin with, any HIV prevention communication would become multi-faceted and more complex than a condom only message. Additionally, how the message would be received by a diverse MSM community in New Zealand or how it would impact their behaviour in real life settings or sexual partnering is yet to be fully understood.

At the same time, the number of new HIV infections in the country is rising. As per the epidemiological data reported by Otago University and published on the New Zealand AIDS Foundation's website (NZAF, 2014), in 2014, out of the 217 diagnoses, 136 were identified as gay, bi and other men who have sex with men. Out of the total number of gay, bi and other men who have sex with men diagnosed with HIV, 86 were infected in New Zealand.

From 2000-2005, there was a steep and rapid increase in the number of gay, bi and men who have sex with men infected with HIV in New Zealand. However, from 2005, the number of diagnoses has remained consistent. The stabilizing of the increase is considered to be encouraging since the more people there are living with HIV, the greater the risk of HIV spreading (NZAF, n.d). However, from 2014, this will be the fourth year in a row that the number of men who have sex with men diagnosed with HIV will be seen to be increasing.

Saxton, Hughes and Giola (2015) studied the coordinated action of the not-for-profit, primary prevention and New Zealand health care sector and its impact on HIV transmissions in New Zealand. The researchers attribute New Zealand's success in HIV prevention to several factors such as a culture of risk reduction through health seeking behaviour like condom use and HIV testing in most affected communities, and the laws and policies aligned to support prevention. However, the authors Saxton, Hughes and Giola (2015) point to the danger of complacency setting in especially as New Zealand

has recorded the highest ever number of new infections in 2015 among gay and bisexual men.

Infectious syphilis cases among MSM reported by sexual health clinics doubled in 2014 in some regions including Auckland, and the number of rectal gonorrhea cases reported in males rose from 31 in 2010 to 121 in 2014. Both are proxies or indications for changes in more frequent risky sexual behaviour (Saxton, Morgan & Ludlam, 2015).

An additional and inevitable result of the success in keeping HIV prevalence low in New Zealand is the sense of complacency among people generally as well as in the gay community. While at the start of the epidemic HIV was perceived as a death sentence, with advances in medicines today, it no longer the death sentence it once was. The availability of Pre-exposure Prophylaxis (PrEP), that is, HIV medication given to those not living with HIV as a means of HIV prevention, has seen condom use among MSM reducing globally. Global research points to a reducing perceived threat of AIDS and increasing sexual risks among MSM. Community beliefs of HIV risk have altered (with HIV no longer perceived as a serious health risk or an epidemic) over the years and are different now than what they were at the start of the epidemic (Kalichman, Price, Eaton & Burnha, 2015). Researchers point to several reasons such as HIV treatments undermining HIV prevention methods, issues of adherence to treatment and PrEP, as well as complacency. As medicine research has improved drugs over the years, HIV prevention has shifted and moved from condom first to treatment as prevention that is testing and treating early those people detected with HIV (Cohen et al. 2011).

The New Zealand AIDS Foundation (NZAF, n.d) advises caution with the use of PrEP as a tool for primary prevention. This is because of the potential of using PrEP leading to an increase the perception of safety amongst men who have sex with men. Therefore, the Foundation in its strategy lists PrEP as a primary prevention tool only for those MSM struggling with condom use. Their strategy also places equal importance on testing for HIV as integral in addition to the use of biomedical interventions to HIV prevention.

In New Zealand, MSM is the population group most impacted with HIV. Heterosexual infections are low when compared to the number of MSM diagnosed with the virus.

There are three main scientific reasons stated on the New Zealand AIDS Foundation's website as to why gay, bi and men who have sex with men are at a higher risk of getting HIV than the heterosexual population (NZAF, n.d). This also explains the risk within the MSM community of HIV transmission.

For this research focusing on HIV testing and Asian MSM, it is pertinent to briefly touch upon these scientific reasons.

MSM are most at risk when compared to the heterosexual population. Firstly, it is easier to get HIV from anal sex. Compared to unprotected vaginal sex, unprotected anal sex is 18 times riskier for HIV transmission. The biological environment in the human rectum, the rectal fluid, contains a high amount of the HIV virus and this in turn means a higher risk of HIV transmissions via unprotected anal sex (NZAF, n.d). Also, HIV transmission risk is further heightened if the rectum has wounds or its lining is damaged in some way and this can increase the risk of HIV transmission through blood-to-blood contact (Wilton, 2014).

Secondly, in New Zealand, there is a small percentage of men from the overall population who identify as MSM. Out of this small community, a high percentage is living with HIV. A proportion of these gay, bi or MSM may be living with HIV but do not know it. Therefore, this is a highly close-knit, closely connected community of men who are having sex with other men from a small pool of people from which to choose. The third reason is that when MSM are choosing their sexual partners from a smaller group of people that contains a high percentage of people living with HIV, and some who do not know they have it; the risk adds up. The chances of exposure to and spread of HIV is higher in this population group compared to the country's heterosexual population (NZAF, n.d).

Saxton et al (2015) place high importance on HIV testing as a key prevention tool. Their research states that HIV testing has to improve fully to realize the public health benefits of HIV treatment at the population level, as currently, neither Antiretroviral Treatment (ART) nor Pre Exposure Prophylaxis (medication given to people not living with HIV as a preventative in case of exposure to the virus) can be offered in the absence of confirmed HIV status.

Saxton et al (2015) currently estimate that 600 people living with HIV in New Zealand are undiagnosed, that is, they do not know that they are living with HIV. There is no data available on what proportion of the undiagnosed people living with HIV would be Asian gay, bi and MSM. This is particularly relevant to my research question as, from other research, it is known that Asian gay, bi and MSM are under-reported in data samples and are also less likely to access testing compared to those that report to be 'New Zealander'. Saxton et al (2015) note that testing access, testing uptake, testing frequency and exploration of new testing technology need to be key targets in the new HIV prevention area. My research is particularly relevant in the current scenario as it

potentially aims to shed light on the testing behaviours of a less understood sub-group of MSM in New Zealand.

A key point that Saxton et al (2015) make that is particularly relevant to my research is that a growing medicalization of HIV prevention, and clinic-based prevention models privatize HIV as opposed to it being an issue that impacts entire communities. This removes it as a subject of public discussion, debate and action with the latter being the foundation of early, effective community based HIV response. Thus, the more clinical or medicalized HIV becomes (as a condition that is easily treatable), the less likely is its social dimensions understood or discussed, and these are vital for primary prevention of the epidemic, including testing for HIV. This is particularly concerning as Asian MSM are acknowledged to be a vulnerable population. In a separate academic paper on views about HIV/STI and health promotion among gay and bisexual Chinese and South Asian men living in Auckland, New Zealand, authors Neville & Adams (2015) summarize and state in their findings that ethnic minority gay, bisexual and other MSM are considered to have a high risk of HIV infection. Their study attempts to understand and identify some of the ways in which Chinese and South Asian men talk about and understand issues related to HIV and STI health promotion as well as highlighting some of this group's health promotion behaviour. Neville and Adams (2015) in their qualitative study identify four themes: the importance of condoms; condom use; HIV/STI practices and HIV health promotion. The findings suggested that while the men had a good understanding of the benefits of using condoms for anal sex and a strong recall of local health promotion campaigns (Love Your Condom), they did not always report consistent condom use. This analysis is particularly relevant and complementary to this research as among the men who discussed testing practices, regular testing was much more likely to have occurred in men who have lived in New Zealand for more than 5 years.

For my research, inconsistent health seeking behaviour raises some important concerns. For example, the effect of inconsistent health behaviour on the sample of Asian MSM to be interviewed for this pilot and the ways in which Asian MSM adapt to life in New Zealand and in the openly gay communities here that makes them more likely to have regular testing.

Further research explains the role of 'community' on behaviour as defined by young African American MSM in US cities who form a part of two or more minority groups, being gay and being of ethnic minority identification on behaviour (Kraft, Beeker, Stokes & Peterson, 2000). In their conclusion, the researchers reported that young

African MSM defined 'community' as necessary places that offer a chance for conversation and community. The researchers noted that community development was necessary to foster meaningful participation of African American MSM that would in turn influence sexual behaviour and potentially reduce risk behaviour.

Although social connection within community is likely to influence HIV testing, HIV stigma as a key barrier has been discussed by those working in HIV prevention in New Zealand. MSM being most at risk of HIV are also the population group that bears the burden of HIV stigma and this is also a key barrier to people accessing HIV testing (Miller, 2010).

Researchers Henrickson and Fisher (2016) examined the qualitative results of two studies of African new settler communities in New Zealand. The research investigated the issues of stigma and micro aggressions and their effects on African communities. The findings of this study suggested that participants reported experiences of stigma and micro-aggressions based on their race, and a lack of knowledge about HIV among non-HIV specialist nurses and other health care workers. They also reported poor health care and education practices, professional prejudice against colleagues living with HIV and institutional challenges including failure to protect patient confidentiality.

These findings have implications for my research by drawing parallels to Asian MSM as stigma, racial prejudice and stereotyping that would impact the likelihood of Asian MSM testing for HIV and thus present a significant barrier for them to do so.

According to the Centre for Disease Control (2016), MSM are more likely to suffer negative mental and physical health outcomes due to stigma and discrimination fueled by homophobia and lack of awareness of HIV. In other settings as well, gay and bisexual minority youth are more likely to be rejected by their families thus resulting in homelessness. As per the Centres for Disease Control (2016) gay, bi and men who have sex with men are three times more likely to have risky sex. Additionally, they are eight times more likely to have tried to commit suicide, six times more likely to report high levels of depression and three times more likely to use illegal drugs.

Mundt (2014) notes that while much ground has been covered in HIV prevention, HIV stigma is still a significant issue and people living with HIV face stigma and discrimination within the health care sector as well as from wider New Zealand society. Mundt also found that patients raised issues in the healthcare setting such as: Being treated last, being refused treatment, breaches of confidentiality, and excessive infection control precautions faced by people living with HIV when accessing healthcare.

As well as the wider New Zealand society, a need for targeted and appropriate education for people from within the health care system is highlighted in a report by University of Auckland researchers (Ryan, Southwick, Teevale & Kenealy, 2011). The participants said that they experienced breaches of their privacy and confidentiality from healthcare professionals similar to Mundt's study. It was recommended in the report (Auckland University, 2011), that for health professionals to perform well in their roles while providing care to people living with or at risk of HIV, and at the same time ensure that their legal and human rights are protected, managers, nurses and health staff need appropriate HIV related education.

For the purpose of this research pilot, it would be relevant to consider that while Asian MSM may find New Zealand to be a more open society in accepting homosexuality, they are likely to have the same experiences related to HIV stigma and by extension, HIV testing as other MSM and Africans living in New Zealand. Mundt's findings showed that of the 213 participants who completed the survey, 47% had experienced HIV stigma and discrimination by health workers and providers and that many of these experiences had occurred within the last five years at the time of being interviewed.

Healthcare settings with the most complaints were GPs, dentists, non-infectious diseases hospital wards and non-infectious diseases outpatient clinics.

These findings reveal implications for HIV prevention in that people living with HIV would not find it easy to disclose their HIV diagnosis due to the fear of HIV stigma and consequently not access HIV testing. It will additionally have serious implications for Asian MSM in accessing testing as a first step to preventing HIV due to the many reasons stated above. Asian MSM interviewed for this study are migrants who have resided in New Zealand for under five years. Enrolment in Primary Health Care, that is GPs is shown to be low amongst migrants and Asians (Bennett, 2016). The likelihood of feeling stigmatized or facing HIV stigma in a GP setting where most HIV tests are likely to occur, is an additional burden or deterrent for Asian MSM to test for HIV.

In a research study commissioned by New Zealand AIDS Foundation and conducted by Colmar Brunton (2014) the findings revealed that reactions to HIV from mainstream New Zealanders are visceral and emotional in spite of high levels of knowledge and information on HIV and how it may spread.

Research shows the high impact of stigma and discrimination towards gay and bisexual men and New Zealand's changing demographic and cultural diversity in population adds another dimension of complexity for health care workers, practitioners and the Asian MSM communities themselves.

Epidemiological HIV trends and HIV testing in New Zealand amongst Asian MSM

Insights into epidemiological trends of the HIV epidemic in New Zealand are helpful to this research as it gives a clear understanding of the population groups that are most impacted by the epidemic. According to data from the AIDS Epidemiology Group (AEG) at Otago University, since 2013 (NZAF, n.d.) the proportion of Asian MSM who have been diagnosed with HIV increased from 10% to 15% with a significant number of those diagnosed from Chinese, Indian, and Filipino communities.

There are gaps in existing literature in New Zealand that directly concerns Asian men who have sex with men. The Gay Auckland Periodic Sex Survey (GAPSS) and the Internet based Gay Online Sex Survey (GOSS) are two largest surveys undertaken in New Zealand. From the 3138 MSM who participated in GAPSS and GOSS in 2011, only 258 gay, bi or MSM reported to be of Asian ethnicity as compared to 2262 who reported to be New Zealand European. This survey is the best indication of Asian MSM as there are no statistics or census data that records MSM or the number of Asian MSM residing in New Zealand. The surveys were being conducted in New Zealand's most populated city, the sample is large and sufficiently representative additionally considering that migrants are likely to prefer living in Auckland as their communities are in Auckland (New Zealand Herald, 2016). Thus, Asian gay, bi or other MSM are under-represented in New Zealand's largest survey of this population group. This would reflect in any findings or conclusions that are subsequently drawn from the data sets in relation to policy, health communication or health programmes aimed at promoting health-seeking behaviour from existing research. Additionally, sexual health check-ups was lower and less frequent amongst Pacific and Asian men, those identifying as bisexual and recruited online.

Due to a lesser likelihood of Asian gay, bi and MSM being openly gay due to fear of exclusion and associated stigma of homosexuality (New Zealand Herald, 2016), any health communication becomes problematic as it may carry the risk of being identified as gay in close-knit communities and would carry the cost of significant risk to their social and mental wellbeing. Thus there is a need for understanding testing behaviour through a different lens is necessary for the well-being of Asian gay, bi and men who have sex with men. Additionally, researchers Dickson, Ludlam, Saxton and Hughes (2014) point to the difficulty of making international comparisons as well as the limited research being conducted in community settings.

Dickson, Ludlam, Saxton and Hughes (2014) note in their finding that there needs to be access to sexual health checks and STI treatments for MSM in an environment in which they can safely discuss their sexuality and behaviour. The researchers also refer to a New Zealand 2008 qualitative study (Adams et al 2008) titled 'Doctoring New Zealand's Gay Men' which found that not all MSM (regardless of ethnicity) disclose their sexuality and/or sexual practices to their doctors.

Thus, the current literature on MSM in New Zealand has limited insights on Asian MSM and is largely based on a sample size drawn from openly gay MSM where Asians are under-represented (Azariah & Perkins, 2010). This research will potentially fill existing knowledge gaps in research on the under-represented sample of Asian MSM in New Zealand. It specifically concerns itself with the question of **what is the impact of communication within in social groups and communities on attitudes and perceptions of HIV risk in Asian men who have sex with men?**

The focus of the study is on Asian MSM's perception of risk, community and sexuality and the related factors that impact on low levels of testing for HIV and STIs. It is pertinent to note that the research question relates to all Asian MSM and is not solely focused on Asian MSM living with HIV. Thus, testing as a health seeking behaviour is of interest.

When this is combined with findings of international research that reveal that ethnic minorities experience a range of issues in accessing healthcare, despite adequate health communication or infrastructure, research that aims to provide further insight is both relevant and timely. As new tools of HIV prevention and medications are likely to be included in New Zealand's HIV prevention approach, knowledge around testing for HIV is more important than ever before. Researchers place a high importance on HIV testing to fully realize the public health benefits of HIV prevention (Saxton, Hughes & Massimo Giola, 2015).

Research has shown that amongst Asian MSM in New Zealand, there is high message recognition of condom use as a primary HIV prevention method promoted as a safe sex practice. However, this does not result in health seeking behaviour, for example testing for HIV and health-care seeking outcomes (Adams and Neville, 2014). Similar research overseas (Elford, et al 2012 and Guy et al, 2009) points to a need for targeted or modified messaging. There are limited insights into the social practices within communities and communication amongst Asian MSM in New Zealand and the resulting impact on testing behaviour.

The need to study Asian MSM as a separate subgroup is further highlighted by overseas research findings that indicate that despite adequate presence and capacity of healthcare infrastructure and robust health communication to mainstream communities, ethnic minorities experience a range of issues or disenfranchisement in accessing healthcare (Margolis, et al., 2012); (Holt, et al. 2012); (Choi, et al. 2006); (Cohall et al. 2010); (Ramirez-Valles, Molina & Dirkes, 2013); (Tobin KE, 2014); (Korner, H. 2007) and (Savidson, 2013).

Research conducted overseas of 736 Asian and Pacific Island MSM through serial, cross-sectional surveys annually from 1999 to 2002 in San Diego, California and Seattle, Washington found that sexual and ethnic identity were intertwined and mutually influential (Vu, Choi & Do, 2011). 'Having a positive attitude toward one's own sexual and ethnic identity can improve psychological well-being and self-efficacy and may reduce vulnerability to HIV infection and higher likelihood of testing' (Vu, Choi & Do, 2011). This points to the relevance of focusing on articulation of sexuality of Asian MSM in New Zealand and its impact on their sexual health and behaviour.

It is the aim of this research to inform policy and practice, particularly health communication, and to positively impact the experience of Asian MSM. This research will inform guidelines that seek to support culturally relevant health promotion for Asian MSM (Tri D et al., 2006)) who may have low attachment to and involvement with the openly gay community (Guy et al., 2009); or may not respond well to general social marketing campaigns (Erausquin et al., 2009); (Gardner et al., 2011); (Baytop et al., 2014).

Asian MSM's high risk to HIV and STIs, low testing likelihood and low attachment to and involvement with the openly gay community in New Zealand are further compounded by the effect of sexual networks as mentioned before.

Additionally, segregation on the basis of ethnicity in New Zealand's increasingly diverse population is not necessarily simple. Khawaja, Boddington and Didham in their report (Statistics New Zealand, 2007) state that the respondents in their study did not necessarily wish to identify with a single socio-cultural affiliations. As a result public interest or social marketing campaigns to promote health seeking behaviour may be more challenging without a better understanding of what it means to be an Asian MSM new to New Zealand.

Asian men who may have migrated to New Zealand from overseas would be challenged in specific ways when accessing healthcare and receiving health communication.

Research examining testing and counseling in migrant populations and ethnic minorities

is relevant (European Centre for Disease Prevention and Control, 2011). Health practitioners and those working in the field of HIV prevention will find value in understanding Asian MSM's social position, their reasons for taking a HIV tests, community ties and health beliefs. In the Centre for Disease Prevention and Control (2011) report, in Europe, with an equivalent health care system to New Zealand and commitment to public health, migrant populations represent a significant proportion of HIV and AIDS diagnoses. This could be because of the already high prevalence of HIV in the home countries from where the migrating population belonged to prior to migrating in to Europe. HIV prevalence among some groups of migrants in the general population is attributed to epidemiological patterns of the HIV epidemic in home countries and this subsequently increases their vulnerability in countries of destination in Europe. This, is due to a range of social, economic, cultural and legal issues that the most at risk groups face. These most at risk groups are identified in the report to be migrant women, migrant and ethnic minority men who have sex with men, and heterosexual migrant and ethnic minority men who engage in high-risk behaviours. Additionally, the report recommends testing in a community setting for high-risk migrant MSM (European Centre for Disease Prevention and Control, 2011).

A targeted approach to HIV testing specifically directed at migrant and ethnic minority populations (European Centre for Disease Prevention and Control, 2011). This includes promoting and providing testing in community settings. In New Zealand, this is carried out through rapid testing for HIV at sex on site venues or Universities. However, the drop-in population is often one where Asian MSM are under-represented. With weak ties and low involvement with the over-all gay community, the usefulness of testing in community settings for Asian MSM can be questioned and highlights the need for research that would identify the factors that would encourage Asian MSM to proactively access health seeking behaviours like HIV testing, when the testing facilities are made available in a community setting.

To be able to effectively monitor and prevent HIV among the Asian migrant sub-group, understanding their behaviour, social ties and understanding of safe sex messages, is important.

Definitions

For this research, the category 'Asian' as is commonly used in health and social research is referred to. However the term Asian does not have a natural, fixed, uncontested meaning (Rasanathan, Craig, & Perkins, 2006, p. 211). Asian people as a

group are very heterogeneous and often have self-identifiers along a number of lines (Rasanathan, Ameratunga, & Tse, 2006) and within the Asian category, health needs may vastly vary (Rasanathan, Craig, et al., 2006). Nonetheless, as scholars state, ‘the Asian category provides a political platform to advocate for resources and enable research into the previously ignored health status of the diverse ‘Asian’ population” (Rasanathan, Craig, et al., 2006, p. 211)’. A very broad definition of Asian is applied and any participant who identifies with the descriptor is eligible to take part in this study.

Health Belief Model (HBM) and HIV testing in Asian MSM in New Zealand

The Health Belief Model (HBM) (Aidsmap, n.d.) is used to theorize this research and is one of the first theories developed to explain the process of change in relation to health behaviour (Dennill, King, Lock, and Swanepoel, 1999). It is a popular model that is frequently used by health practitioners currently (Brink, 1999). This model is an appropriate one for this research as it contextualizes Asian MSM’s lives in New Zealand and provides the appropriate lens to study Asian MSM’s beliefs and perception (Polit, and Hungler, 1999).

In 1950, well before the start of the HIV epidemic in the 1980s (Rosenstock, Victor, Strecher and Becker, 1996) , the Health Belief Model (HBM) was developed by social psychologists in America to understand people’s behaviour to and participation in public health programmes (Hochbaum, 1958; Rosenstock, 1960, 1966, 1974). Over the years, the model was adapted to study a range of health related behaviour like response to symptoms and response to diagnosed illness Kirscht, 1974) (Becker, 1974). The HBM is based on how individuals value preventing illness and the actions they take to avoid illness as well as their perception of risks to their health.

HBM provides a framework for analysing the factors that motivate people to act in certain ways in order to prevent illness. At the start of the global HIV epidemic, researchers largely studied sexual behaviour in order to design HIV prevention programmes and campaigns. This was on the assumption that at the population level, individuals would adapt and amend their sexual behaviour once they were made aware of HIV transmission and risks (Walker, Reid and Cornnel, 2004).

According to Tarkang and Zotor (2015) the Health Belief Model is divided into three major components:

1. The individual’s perceptions about health.

2. The modifying factors which include demographic, socio-psychological and structural variables.
3. The benefits of taking preventive measures

Additionally, the authors (Tarkang and Zotor, 2015) provide an explanation for each aspect of the model. This pilot study is organized around these themes:

1. How strongly do participants believe that they are susceptible to the disease in question?
2. Whether the disease would have serious effects on their lives if they should contract it.
3. The suggested health intervention is of value.
4. Whether the effectiveness of the treatment is worth the cost.
5. Which barriers people must overcome to institute and maintain specific behaviours.
6. Influence by another person close by, who may have been susceptible to the same disease, signalling the need for action.

Studying Asian MSM's perception of HIV risk to them, attitudes towards their sexual risk taking, their articulation of sexuality to their family, friends and community as well as their experiences of adapting to change their behaviour to New Zealand's health care system and benefits of taking action for good health (preventing HIV) would be helpful in developing a nuanced understanding of the reasons for low levels of HIV testing amongst this group.

The HBM (Hochbaum, 1958; Rosenstock 1966; Becker, 1974; Sharma and Romas, 2012) is a cognitive model and is a tool that has been used to understand people's motivation to take positive health action. Researchers who have used this model to predict behaviour have explained that behaviour is determined by beliefs held by individuals about what constitutes a harm or a threat to their well-being; the perceptions of the effectiveness of their actions and effect the of the outcomes of their actions on their wellbeing; and this model also incorporates the cues which prompt positive action. HBM makes it an appropriate fit for public health's commitment to health equity and positive health outcomes for communities and with Asian MSM's knowledge of HIV risk, their feelings on their susceptibility to the virus, consequences of risk taking and their motivations to test for HIV (Rosenstock, 1996).

Behaviour factors strongly influence HIV transmission, and the way in which people adapt and change their behaviour has provided a foundation for HIV prevention efforts (Abraham, Sheeran, and Orbell, 1998). It is also pertinent to note that, in particular, Asian MSM care more intensely about how their social relationships and network perceive them as individuals. They are also far more dependent on their social network as research on aging has shown (Guo et al., 2014). Thus, this research takes into account the Asian MSM who have been interviewed for this study in terms of their social ties to communities in New Zealand, their social location and the cues they would receive to influence and adopt HIV testing vis-à-vis their perceptions of HIV risk and risk taking. The reality of Asian MSM's experience of migration and race is an element of this research that has not been thus far sufficiently understood. This understanding may not find its way into public policy or public health messages. Though the Health Belief Model provides a useful theoretical framework, this research additionally acknowledges that the decision to test for HIV may not be linear and in fact, may be influenced by a combination of experiences of Asian MSM new to New Zealand. Their social location within communities, ties within communities, perception of sexual risk taking and risk of HIV have a bearing on communication, relationships to social groups like family, kin or society as they bear the risk of exclusion from their social networks. The health belief model is an appropriate framework that aligns well to this research's core questions.

A study done elsewhere using the HBM (Oyekale and Oyekale, 2010) amongst a sample of men in Nigeria, Africa, analyzed the factors influencing participants taking an HIV test and risky behaviour change and showed that a high level of awareness of HIV did not translate into a high level of HIV testing. The study noted that a high level of abstinence and a change in risky behaviour was observed when factors like age, access to media and education came into play.

While applying the HBM for the purpose of the sample in this research is appropriate to gain a nuanced understanding of factors of influence, it would be pertinent to formulate factors relevant to this sample – for example, participant's migrant status, race in the context of European MSM, cultural implications for Asian MSM with respect to their sexuality and perceptions of risk.

A research paper on African new settlers in New Zealand by Henrickson, Fisher, Ludlam and Mhlanga (2016) focused on 'What do African new settlers in New Zealand 'know' about HIV?' stated that black African migrants reported good levels of basic HIV knowledge in the survey, however the respondents demonstrated a range of culturally constructed beliefs and operational knowledge in focus groups. The study

findings suggested that objective knowledge assessment is not sufficient, and that a contextual approach to understanding what people 'know' is essential, not only for HIV, but for the delivery of all health care education and interventions to Black African new settlers. Routine HIV education and testing, together with staff education, may increase acceptance of these interventions.

For this study, it would be relevant to spend time on understanding the range of diverse contextual approaches Asian MSM may have to their understanding of HIV and negotiating their sexuality. For instance, if an Asian MSM is not yet openly gay, this would potentially impact on his social ties to the openly gay community on one hand and his relationship and social ties to the Asian community generally. Loss of social relationships is a cost he would need to consider carefully and his health seeking behaviour is likely to be impacted as a result.

Research has shown that social ties and their strength have influence over actions of individuals and their behaviour (Putnam, n.d.). While knowledge of how HIV may be transmitted may be known, its likelihood of it being present in the Asian community may be underestimated partly due to beliefs around monogamy, hetero-normative attitudes, homophobia etc.

The suitability of the HBM for this study is further supported by research done with similar sample of Chinese MSM (Li X, Lei Y, Wang H, He G & Williams, 2016) where it was confirmed that the HBM could be applied to Chinese MSM to explain their rationale for health risk-taking behaviours.

Similarly it would be important to first elaborate on Asian MSM's rationale for risk taking as a precursor to developing a further understanding of their HIV testing behaviour. As this is a pilot study, it presents an opportunity to accurately define what is of value to Asian MSM and what constitutes expected outcomes of mitigating risk for Asian MSM.

It is hoped that the data from the Asian MSM interviews paves the way for future research and makes a contribution to building a questionnaire, which may further probe the HIV testing behaviour of this sample group.

HBM has been used in other studies of samples drawn where participants are immigrants from Asia, like the paper from to glean insights into sexual behaviours and HIV risk among Taiwanese immigrants. Similar to other research cited here, a study by Lin, Simoni and Zemon (2005) too asserts that culturally sensitive measures that promote self-efficacy need to be incorporated along with a focus on acculturation need to be incorporated into the HBM. It would be useful for this sample to glean if the HBM

constructs, as a set, reliably predicted participants' sexual behaviours, or any other insights which might provide deeper understanding of risk taking among the sample of Asian MSM interviewed for this research.

A point of difference to note between my study and other studies using the HBM in relation to HIV behaviour and risk is that the model has been less frequently used with qualitative data collection (Downing-Matibag and Geisinger, 2009).

The role of community, social connection, social position and communication on HIV testing

In this research, the semi-structured interviews investigated the perceptions that Asian MSM hold of their own social position, their attitudes and social ties to their own Asian communities as well as the gay community, and the implications (if any) of their perceptions and beliefs on Asian MSM's HIV testing. This is relevant because research done with ethnic minority populations shows the impact that ethnicity has on sexual partnering, social location and its subsequent impact on HIV testing behaviour.

Race and ethnicity are said to play a part in forming partnerships in their sample of participants. The scholars note the role of homophobic attitudes within participant's own community, subsequent social isolation experienced by participants, and how that would then play out in sexual networks (Gregory II, Michelle, Sydney and Brian, 2016). In research done in New Zealand by Neville, S., & Adams, J. (2016)

Massey University, it is known that Asian MSM are selective about to whom they disclose their sexual identity. The strength of a social tie can be defined as the linear combination of the amount of time, the emotional intensity, the intimacy (mutual confiding) and the reciprocal services that characterize the tie (Granovetter, 1973). Granovetter (1973) highlight the significance and paradox of social tie in the context of health care and wellbeing of individuals in communities - that small-scale interaction becomes large-scale action. Personal experiences of individuals in communities are particularly relevant to social structures. Therefore, it is important in this pilot to begin reflecting on Asian MSM's perception of social ties and their sense of their own social position as well as their experience of community in New Zealand and their countries of origin.

Robert Putnam further highlights the importance of social ties for this research in a separate work - that when individuals feel a part of a group, they are more likely to contribute to group behaviour. Individuals in categories such as gays and lesbians (Minkoff, 1995) due to a lack of infrastructure that encourages social ties, mobilization

of these groups produced social ties and subsequently, a sense of identity. It is in this context that Asian MSM in this study are placed, as they are also migrants forging a new life for themselves in New Zealand.

The importance of friendship is highlighted in research by Kelly, Carpiano, Easterbrook and Parsons (2012) particularly for men who may have faced homophobia (Banks 2003), such as Asian MSM and who acknowledged that they have lived in environments where homosexuality was not openly accepted or is criminalized. The concept of community can also include wider interactions with friends and people with shared attitudes. Any action that individuals take would to some degree be bound to be influenced by the social context in which individuals reside Granovetter's (1985: 487). Researchers assert that the more intensely an individual feels embedded in a community the higher the likelihood of the individual engaging in behaviour normal to that community, including sexual risk taking.

The meaning of what constitutes community and potential social divisions within the gay community is useful for this research as public awareness of HIV has declined from the 1980s and, the acceptance of sexual minority communities seem to be increasing (NZAF, nd). At the same time, migration and technology are vital components of this research as a lens through which Asian MSM's experiences are filtered.

When Asian MSM were asked about their thoughts on socializing in this research, their inclusion of technology like dating apps as well as physical spaces where MSM can meet in New Zealand indicate that community is not confined to physical spaces and socializing can be virtual. Scholars (Holt, 2011; Wilkinson et al., 2011) state in their research that MSM may associate with a variety of mixed personal communities based on sociability rather than sexual identity alone.

While some studies point to the positive influence of constructive social ties to communities, equally others point to aspects such as higher risk taking (Buttram & Kurtz, 2013) which would naturally be detrimental to the health of individuals when it comes to HIV transmission. When this is seen from the lens of migrant's experience, race and gender, it becomes less simplified as an understanding of health behaviour.

Summary

New HIV transmissions are rising in New Zealand. Men who have sex with men are the population group most at risk of acquiring the virus. This is due to scientific reasons and the biology of anal sex. Condomless anal sex carries the highest risk of transmission.

While a high use of condom use has kept the epidemic at relatively low levels in the

country, new combination prevention methods including early testing and immediate access to treatment for newly diagnosed people, and pre-exposure prophylaxis are being proposed by experts. The issues of HIV related stigma amongst health care professionals and the wider New Zealand society needs to be noted as a key barrier to HIV prevention initiatives.

At the same time the number of new diagnoses amongst Asian MSM is seen to be rising. The population level context for policy and practice are also that the New Zealand's population is increasingly becoming diverse and this will have implications for health communication.

Asian MSM's health access behaviour is understudied. This is a population group that is under-represented in research samples. Research suggests that belonging to multiple minority groups puts Asian MSM at a further risk of acquiring HIV as they face a number of barriers while accessing healthcare or HIV testing.

The Health Belief Model is the theoretical framework used to study the health seeking behaviour and HIV testing of Asian MSM for this pilot study.

Chapter 3: Methodology

Methodology

A qualitative research approach was proposed to answer the research question. This is primarily because the research question seeks to gain insights into thoughts, beliefs and social existence of Asian MSM which are subjective in nature (Family Health International, n.d.).

Participants were drawn from the Asian MSM community in New Zealand and semi-structured interviews were carried out with them. The interviews were recorded and transcribed and along with additional interview (or field) notes were appropriately filed. The data was viewed, reflected upon and analyzed. A first level of analysis involved making descriptive and detailed notes about the data. It helped tremendously to map the data in this way to see clear connections in the themes as well as of the data to the theoretical framework. This helped in classifying data into similar themes and sifting out any dissimilarities. The next level of analysis involved more reflection and interpretation of the data including categorizing it.

Emerging data was organized into themes and analyzed to find connecting or common aspects between each participants' interviews, similar or different perspectives or patterns of thinking or points of difference within the context of HIV testing.

Any propositions or trends emerging from the data analysis that answered the research question were reported.

The answers to the research question combine the different perspectives through multiple lenses, for instance – gender, race, culture and the status of participants as new migrants and their access to health care (HIV testing). To do justice to the complexity of issues to be addressed in this project, a range of qualitative questions were drawn on to determine why Asian MSM have low levels of HIV and STIs testing. This methodology is proposed as it will be beneficial understanding how Asian MSM would prefer to engage with health promotion programmes (and messages) and understand their communication within social groups, and what would motivate them to test for HIV.

Overall research strategy

Articulation of sexuality, health beliefs and attitudes of Asian MSM to health are central to this research. The research employed the Health Belief Model (HBM) (1950) as the framework for narratives, understanding and investigating the experiences of Asian MSM and to explain connected (and potentially complex) testing behaviour as well as responses to health messages. More specifically, the experiences of Asian MSM reveal

their beliefs about risk taking, and their ability to take ownership of their health and well-being. As the HBM frames these experiences to understand the health behaviour and likelihood of participants engaging in particular behaviour, it was seen as an appropriate and meaningful framework for this pilot study. Studying Asian MSM from the prism of culture, gender, ethnicity and sexuality, and then further gaining insight into their everyday community interactions and communication would allow for a more nuanced and holistic understanding of Asian MSM's access to HIV testing, rather than focusing solely on one particular aspect of their behaviour alone.

The Health Belief Model is a suitable theoretical framework for this research (Rosenstock, 1966) as it focuses on an individual's perception of risk and their beliefs on controlling variables through their health choices to avoid a negative health outcome. Public health's commitment to social justice and the ability of individuals to respond to health communication makes it a natural fit with the Health Belief Models' focus on health seeking behaviour.

Data

The sample in this pilot research has been drawn from MSM networks and groups in New Zealand. The technique of tapping into networks to access and recruit from hard to reach, suppressed or populations vulnerable to HIV is common (Amirkhanian and McAuliffe, 2005). This method is also utilized in delivering community level interventions for HIV prevention in networks (Ezo, Morooka, Noda, et al. 2012).

Data collection and analysis

Data were collected by carrying out semi-structured qualitative interviews. The interviews were transcribed and organized into themes.

A purposive sample (Bryman, 2012) of 4 Asian MSM living in New Zealand was interviewed face to face using a semi-structured, qualitative questionnaire. In the context of this research, a purposive sample is considered appropriate as Asian MSM may not be open about their sexuality and the usual channels of recruiting participants would not be considered effective. Connections in the gay community were helpful in recruiting the sample for this pilot research. Asian MSM's concern around confidentiality was addressed through providing them with sufficient information about the research and consent forms. Participants were made aware of their rights and their ability to withdraw from the research at any time. Additionally, one concern

raised was that as the researcher was not an Asian MSM, she would have limited understanding and shared knowledge of the community. This concern was addressed by acknowledging the researcher's limitation, and by articulating that the research was based on addressing the needs of Asian MSM. Asian MSM also expressed fears around being a part of research not presenting issues accurately. These concerns were sufficiently addressed during the course of the research through following procedures required by the AUT's Ethic's approval procedure and with the support of organisations working with the LGBTIQ community.

Specific Asian MSM networks (EquAsian, Rainbow Youth and University LGBTI groups) were solicited for support. New Zealand AIDS Foundation's community engagement coordinators were approached for their assistance as key partners in recruiting Asian MSM for this study. Participants were recruited through word of mouth. Participation was voluntary and participants were appropriately briefed about the aim and purpose of the research and their consent was taken prior to the interviews as per best practice. Participants were told they could withdraw from the research at any time they wish.

Interviews were recorded and transcribed. Detailed notes were taken to account for nuance and meaning of participant's spoken word and facial expressions, and where possible, non-verbal expressions or body language cues were appropriately clarified during the interview so that accurate meanings were clearly communicated and recorded. Interviews lasted for approximately 60-90 minutes. They were conducted at New Zealand AIDS Foundation (NZAF)'s office where the interviewees and the interviewer felt comfortable enough to articulate themselves without fear or apprehension. Data was treated in the strictest confidence.

Explanation on the sample and sample size selected for this pilot study

When embarking on this pilot research, the difficulty faced at the outset was getting eligible subjects. In spite of the support from organisations that work in the LGBTIQ communities in New Zealand, Asian MSM who were living in New Zealand for under 5 years (as required by the eligibility criteria for this pilot study), found it challenging to be a part of a research that potentially asked them for deeply personal information. Therefore, this challenge guided and influenced the sample size of the research. In saying so, for a pilot study, a sample of four participants was sufficient as this pilot study's objective is to establish a questionnaire which may then potentially be administered to a larger sample size of Asian MSM. A small sample suitable for a

pilot study such as this ensured that available resources such as participant's and researcher's availability, time and relationships were utilized appropriately to meaningfully achieve in-depth insights in each interview. In the qualitative framework of the Health Belief Model, the face to face interviews sought to go beyond the surface into Asian MSM's social and sexual lives (Crouch and McKenzie, 2006).

By first conducting the pilot with a smaller and focused purposive sample aligned to best practice (Fossey, Harvey, Mcdermott and Davidson, 2002), the research was able to ascertain feasibility of any future, larger research and gain insights which would add value to future research in making it highly relevant to Asian MSM's health and well-being.

Selection criteria

Participant eligibility is that the participants should be 18 or older, identifies as Asian an man who has sex with other men, and lives in New Zealand.

Participants' identities and any information shared by them were treated in strictest confidence. Data were kept secure and destroyed at the appropriate time as per AUT's policy. Participants will be emailed a summary of the research findings if this was indicated by them at the beginning of the interview process.

Participants were asked questions around sexuality, community, feelings and understanding of HIV, experiences of homosexuality in the Asian community, connections within Asian community overall in New Zealand, Asian MSM and New Zealand society, attitudes towards HIV testing and HIV itself as an issue of concern (or not). Narratives of the experiences of HIV testing, health beliefs, values, opinions, perceptions and concepts of meaningful interaction of Asian MSM in New Zealand produced data that were analysed to answer the research questions.

The questions asked were open ended, and focused on participant's experiences, stories, opinions, feelings and knowledge and seeking their own input into health behaviour.

Questions encourage reflection from participants and this was important in order to gain authentic insights into their experiences, lived experience and narratives.

The questionnaire administered to the four participants in the pilot asked them questions around their HIV knowledge, their sexual life and perceived health beliefs. The number of participants at four were deemed suitable as a sample size considering this is a pilot study that is scaled up to a larger sample size in the future.

The questions aimed to begin future lines of enquiry and to provide a foundation for building a questionnaire, which focuses on Asian MSM's perception, health beliefs and attitude towards HIV testing.

These are the categories and questions administered to the participants:

Schedule of questions

Introductory/ background/ice-breaker questions

Where are you from?

How long have you been in New Zealand?

How did you come to settle in New Zealand?

Health access questions

Are you registered with a GP?

Did you know about HIV prior to coming to New Zealand or did you find out about it in New Zealand?

What do you know about HIV?

Have you considered taking an HIV test?

Have you ever been offered or taken an HIV test in New Zealand?

What do you think will happen if you were to test or ask for a test?

What are your feelings about getting tested?

How do you think you would go about asking for help if you thought you were exposed to HIV?

What would stop you from getting yourself tested?

What and who would encourage you to get tested?

Would you take an HIV test if it were free?

Sexuality, family and culture questions

How would you identify your sexual preference and sexual orientation?

Are your family/friends aware of your sexuality?

What members of your family are aware of your sexuality?

How is your relationship with your family?

Is being Asian and gay different here in New Zealand than in your country? In what way?

What do you think the Asian community in New Zealand think about HIV?

What are your experiences of being gay in the New Zealand/ Asian community?

Do you think this (being open or not of your sexuality) has an impact on being tested for HIV?

Gay community and communication questions

Where and with whom do you socialize?

How do you socially identify to others in the community?

The suitability of conducting a pilot study for this research

This pilot study is conducted to test the feasibility of and identify the limitations of a larger scale study of this nature (Thabane and Jinhui, et al 2010). Conducting a pilot study was decided in order to determine the best questions to ask and in preparation for a larger study on Asian's MSM health beliefs in the future.

Another reason for conducting a pilot study is that there is limited research that focuses exclusively on Asian MSM's HIV testing behaviour. Asian MSM are a hard to reach and often a hidden population group. Reaching and accessing such a population group is challenging to researchers. A pilot study such as this offers preliminary insights into how best to approach a larger research project and its potential focus.

Many Asian MSM are highly selective about disclosing their sexual orientation and therefore, it poses a challenge in uncovering the specific barriers they may have when testing for HIV. Given these considerations, conducting a pilot study was decided as the most appropriate way to research Asian MSM's attitudes and health beliefs towards HIV testing.

Initial contact and relationship building with Asian MSM made it possible to recruit the sample of Asian MSM and to understand to some degree the context and dynamics of Asian MSM in the gay community. Conducting a pilot has the advantage of the network effect of relationships in this pilot (Hendricks, Blanken and Adriaans, 1992).

It is important to acknowledge the sample selected for this pilot study are not randomly drawn and are based on subjective criteria for this research. Scholars have identified this as one of the limitations of purposive sampling (Van Meter, 1990; Kaplan et al, 1987). As this research deals with the impact of communication within social groups and communities on attitudes and perception of HIV risk in Asian men who have sex with men, the pilot study also seeks to understand issues of the process of conducting a larger survey. This includes the most appropriate method of questioning Asian MSM in the future, reflecting on sampling and the role of gate-keepers or those among the Asian MSM who would enable access to participants (Teijlingen, Rennie, Hundley and Phil, 2001).

A small sample size of four participants was appropriate for this research as it was sufficient to conduct a pilot and fulfil the objectives of this research.

To summarize, this pilot study is necessary for conducting future research because the sample is drawn exclusively of Asian MSM. This is more likely to increase the success for research planned or conducted in the future on the health behaviour of Asian MSM. The specific criteria for success of this pilot study is to refine and review questions to produce a questionnaire that can be scaled up to a larger sample of Asian MSM to investigate their health beliefs, attitudes and perceptions when accessing HIV testing.

About the participants

All the participants of this pilot research were articulate and able to communicate their thoughts, beliefs and emotions in detail during the interviews. The age of the participants ranged from mid 20s to late 30s and they all self-identified as homosexual. Two of the participants were from China and two from India. Only one participant was in a long term relationship. The other three participants reported to being single and enjoying their sex lives and sexual encounters in Auckland where they all now lived. All the participants spoke fondly of their countries of origin in Asia and recalled memories of a vibrant and rich social life in MSM communities. All participants lived on their own in New Zealand, with their parents and families living in the country of origin. Two participants reported to have a very good relationship with their families with regular phone and video conferencing as part of their routine life in New Zealand. These participants spoke of the affection and acceptance they received from their families. Two of the sample of participants reported that they had a strained relationship with their parents and families with sporadic or infrequent contact or communication. The participants completed their tertiary education (first degrees) in their countries of origin and travelled to New Zealand for further education or employment opportunities. Economically, the participants were not in any hardship and were in some form of stable employment. This, they said, allowed them to fully explore opportunities for socializing and leisure in New Zealand. All the participants in this study self-reported that their health was in good condition and they felt well.

Methods of data collection

Participants were interviewed in an informal but safe professional setting. The first preference was to conduct the interviews at the University (AUT) or at the NZAF. However, NZAF was finalized and agreed as an appropriate space for the interviews by the participants. NZAF was considered as an informal but safe professional setting as the organisation has a long history of working in the LGBTI community and

specifically in the area of HIV prevention. The Auckland office of NZAF hosts volunteers from the LGBTIQ community each week for a routine ‘condom packing’ activity. Concerted effort was and is continually made to ensure that the space is free of stigma (negative attitudes towards homosexuality, discrimination and HIV stigma). These are the specific ways in which the NZAF Auckland office where the interviews were conducted is considered to be a safe space for the research and the participants. The participants expressed that by interviewing at NZAF, they were not concerned about disclosing their sexual orientation or identity in a public setting.

Research instruments

Individual, face to face qualitative, semi-structured, in-depth interviews were conducted, audio recorded and then transcribed into text documents in English. Researcher’s notes and observation of participants’ body language and non-verbal cues in unstructured notes are included as data where relevant.

The questionnaire contained open-ended questions with the aim of producing answers that gave vivid narratives including meaning, experience and views of the participants. Microsoft word was used to generate the transcripts of the interviews. The interviews were recorded using an Apple iPhone recorder.

Method of data analysis

Once interviews were transcribed (word documents), the material (narratives or data) was appropriately filed and stored with individual filenames in digital formats (.doc). The file names of individual documents were: date and pseudonym of the participants. This was stored in a folder with the research title. The individual transcripts contained details of the place of interview, date and time.

The data were organized according to themes around nature of communication, social ties, sexuality and HIV. Narratives were checked for points of similarity, difference, recurring ideas. Particularly, any recurring behaviour, thoughts, communication elements or social ties that would predict HIV testing were noted.

The data was helpful in understanding the context and world view of the participants (John Hopkins Bloomberg School of Public Health, 2008). The analysis sought to gain an understanding of Asian MSM’s beliefs as well as perceptions and elements in public health care interact in the world of Asian MSM and what implications did this have on their health.

A three step process was used for analysing data (Miles, Huberman and Saldana, 2014). Data was first consolidated and understood fully through re-reading of the transcripts.

Themes from interviews were assigned labels or categories to keep a track of similarities and connection to HIV testing or any distinct features. Next, the data were analysed according to the categories of the Health Belief Model:

1. Perceived Susceptibility
2. Perceived Severity
3. Perceived Benefits
4. Perceived Barriers
5. Cues to Action
6. Self-Efficacy

Any emerging patterns were noted. In time, analysis of the data was organized into a set of findings and conclusions regarding Asian MSM and their HIV testing behaviour.

The Health Belief Model as a framework was used further develop the findings into a descriptive analysis and propose further questions for future research.

Summary

This research uses a qualitative approach within the framework of the Health Belief Model to seek answers to the research question. With ever increasing diversity in New Zealand, this research aims to gain insight and understanding from Asian MSM on how they would like to access healthcare and their perception of HIV risk. The pilot research aims to gain insight into what type of communication among Asian MSM's social groups and communities will impact on their attitudes and perceptions of HIV risk.

The research is designed with the intention of obtaining authentic representation of voices from Asian MSM. These are used to generate a questionnaire for future research to gain a deeper and more meaningful understanding of Asian MSM's HIV testing behaviour. Any research in this topic can also be ultimately used to inform policy and programmes aimed at improving Asian MSM's access to HIV testing.

Acknowledgement

The researcher acknowledges her position as currently employed by NZAF (at the time of data collection) and a heterosexual female. She may most likely be viewed as an outsider by the participants. However, over the course of employment and through participation in events organized by the Asian LGBTIQ community, she may be considered an ally. A level of trust has been built between the researcher and Asian MSM. This was experienced intuitively by the researcher and additionally as she was welcomed by Asian MSM outside the context of the research and called a friend on

multiple occasions. Her research was well received when she spoke about it to Asian MSM and it was openly acknowledged by individual Asian MSM that there was certainly a need for the research for the well-being of Asian MSM in the community.

Chapter 4: Findings

Description of pilot study

Four participants were asked questions in qualitative, face-to-face interviews for the purpose of answering the research question. The data have been analysed and through this, a questionnaire is formulated as an outcome of the pilot study. The interviews took place at the New Zealand AIDS Foundation (NZAF) in Auckland.

NZAF is New Zealand's leading organization that provides HIV prevention, support and care for anyone who is affected by HIV and their friends, family or whānau. Due to the fact that NZAF is considered as an expert provider of information and HIV prevention support, participants were assured of confidentiality and safety in the environment in which the interviews were conducted. This venue provided a professional setting for the interviews.

Conducting the pilot is also sufficient as a first step to developing a questionnaire for a larger study in the future. There is insufficient research into Asian MSM's HIV testing behaviour and before a larger study can be undertaken, it was necessary to conduct a smaller scale pilot to assess the population.

Description of participants

Asian MSM interviewed for this research were fluent English speakers with the ability to clearly and precisely communicate their thoughts and feelings. While they described themselves as gay or specifically homosexual, that did not seem to be the sole identity they preferred to use. They clearly communicated their social life outside of the 'gay community' in New Zealand, which is the openly gay MSM and socialization within gay safe and gay friendly spaces. Participants conceded that they had to be selective when disclosing their sexual orientation to people. They reported that prior to coming to New Zealand, they found it harder to interact with other MSM in their countries of origin. This was largely due to the underground or secret nature of the gay communities in Asian countries as well as the gay unfriendly environment. However, the participants did not necessarily see this aspect in their countries of origin as an issue or barrier that impacted their socializing, sexual risk taking, sexual partnering or sexual encounters in general. Sexual partnering and sexuality are distinctly separate issues according to them. For instance, even though they identified as homosexuals, they were clear that this did not mean they necessarily conformed to the stereotype that they would be promiscuous or have non-traditional, non-heteronormative sexual partnering. The participants

asserted that the risk of HIV is mitigated through ‘good’ sexual conduct, that is, low levels of promiscuity and fidelity to sexual partners.

The individuals interviewed for this research reported to have a high level of well-being in New Zealand. They reported to having few friends and not necessarily only from the openly gay community. All participants had close family members overseas who were either aware (through disclosure) or had a very good idea of the participant’s sexuality. Most had acceptance and support from their family. However, the participants were clear that acceptance of their sexual preference and support from their family were not factors that would impact their ability or actions in protecting themselves from HIV or encouraging them to get tested.

Participants did not specifically prefer to get tested at a General Practitioner (GP) and the responses to being asked to get tested for HIV by their GP were mixed. The practice of registering with a GP was not something participants felt familiar with. Participants asserted that they would go to a GP only if they fell sick and most importantly, would wait to fall sick before they would register with a GP. HIV being asymptomatic in many cases, similar to STIs, this is a worrying finding.

HIV was also seen as ‘normal’ or ‘normalized’ here in New Zealand according to the participants. By that, they meant that there is much more discussion around HIV in the communities and therefore, a contrast from Asian countries where there is much less open discussion of HIV.

Ironically, Asian MSM perceived a higher risk of HIV in New Zealand than in their countries of origin precisely because of homosexuality being legal and of the openly gay community. They perceived promiscuity as directly increasing the risk of HIV. There is deep stigma attached to HIV both from the Asian community as well as the Asian MSM themselves attached to HIV. However, participants were comfortable about being asked about their sexuality now, relative to years ago.

Data Analysis

Data has been organized and generalized into the following 6 themes which are:

1. Perceived Susceptibility
2. Perceived Severity
3. Perceived Benefits
4. Perceived Barriers
5. Cues to Action
6. Self-Efficacy

These themes are aligned with the constructs presented in the HBM. Each theme has been assigned numerical – 1 – 6 and beyond.

Those codes or themes that fall outside of these constructs are included in the summary.

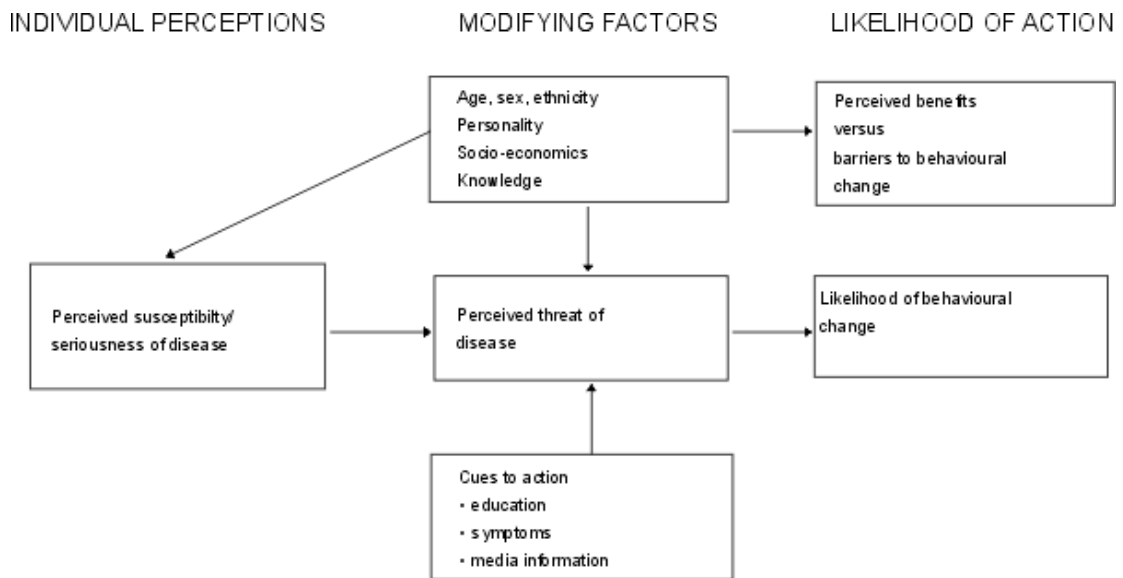
The applicability of the Health Belief Model is also examined to a certain degree (Li, Lei, Wang, He & Williams, 2015). This is to ensure that the framework of HBM fits well with this research and to be aware of the limitations of the model. Categories or themes from the analysis have been linked to components of the HBM

Health Belief Model – 6 constructs from the HBM under which themes emerging from data are organised

(Source: Table and infographic from University of Twente)

Concept and components of the HBM	Definition as per University of Twente	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behaviour; heighten perceived susceptibility if too low.
Perceived Severity	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.

Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action.



Note: Diagram and table reproduced from Explaining Health Behaviours (2017) from https://www.utwente.nl/en/bms/communication-theories/sorted-by-cluster/Health%20Communication/Health_Belief_Model/

Introduction to themes of the Health Belief Model in relation to this pilot

Researchers have explained the health belief model (HBM) (Hochbaum, 1958; Rosenstock 1966; Becker, 1974; Sharma and Romas, 2012) and its application. The model focuses on health beliefs of participants and on what would motivate them to act in ways that benefit their health. Behaviour is guided and governed by a number of beliefs about what is harmful to people. Beliefs are supported by internal and external

stimuli (health messages, in the case of this research, the cues to test and threat of unprotected sex leading to the outcome of HIV infection). Costs are weighed against benefits of certain actions (for example HIV testing). From the findings of this pilot, the benefits gained from behaviour mitigating risks (such as using condoms for anal sex or not having sex outside of a relationship and only with one partner) out-weigh the perceived risks and costs (such as fear of finding out a HIV positive result, experiencing stigma or being perceived as irresponsible) attached to actual health seeking behaviour like HIV testing. Participants, due to their high knowledge of HIV, are mitigating the risks by adopting protected sex or having sex with only one partner in monogamous and sexually exclusive relationships. Thus they perceive the benefits of HIV testing are low and the costs are relatively high – in this case, confusing knowledge of health care in New Zealand, negotiating visa status, homophobic attitudes of the Asian community, low and poor quality social connections to the openly gay community and persistent HIV stigma in healthcare settings and the general Kiwi society. (Jackson, 2005: 133) clearly explains this latter as a rational choice or an approach which he claims is inadequate as a basis for understanding and intervening in human behaviours for a number of reasons. In particular it pays insufficient attention to the social norms and expectations that govern human choice and to the habitual and routine nature of much human behaviour. It also fails to recognize how consumers are locked into specific behaviour patterns through institutional factors outside their control.

Perceived susceptibility:

Every health condition is perceived in a certain way by individuals including the condition's negative impact on them. How susceptible individuals may think they are to the condition or to what degree people think an adverse health condition will impact them varies from person to person. The spectrum of perceptions can range from denial that they may experience the adverse health condition to admitting that they may well be susceptible to the risk. At the higher end of the spectrum, individuals may believe that they may be at extreme risk of contracting the adverse condition.

Participants were asked questions about their risk of a negative health outcome, that is, a positive result of an HIV test.

Participants were aware of MSM being more vulnerable to HIV than other population groups. However, participants also stressed that they were aware that HIV also existed in people who were heterosexual and did not identify as MSM.

“I’m not so sure... because I do believe straight also have that issue as well. It’s just that in our community we have, actually I know someone who is straight has [HIV] as well. So for me I wouldn’t say we’re high risk, but I would say it is everywhere. Just because our proportion is smaller, that is why we kinda like, closer to that statistic.”
Jerry

In identifying as MSM, all four participants in the pilot acknowledged and concurred on the risk of HIV carried by unprotected anal sex. All participants, while not actively averse to condom use, used alternative risk mitigation tactics, mainly, avoiding sex with multiple partners in addition to avoiding unprotected sex as their primary method of avoiding a negative health outcome, in this case, acquiring HIV.

Participants stressed that if they had a partner or were in a steady relationship, then they saw no need for HIV testing because in their perception this presented no risk of acquiring HIV.

Participants also stressed not adopting the risky behaviours of those in the gay community in New Zealand. One participant stated that he found it unnecessary to adopt the promiscuous behaviours of MSM of European ethnicity simply because he identified as MSM. One participant said that he felt that in New Zealand the likelihood of unprotected sex was less as most MSM, especially openly gay MSM of European ethnicity would not engage in condom-less sex.

Participants also said that they avoided risk to acquiring HIV because they did not visit gay bars, venues and saunas which may be frequented or preferred by other MSM.

Perceived Severity:

The perceived severity is a belief a person holds regarding the effects a disease or an adverse health condition will have on him or her. The view individuals can take can be in terms of the difficulties experiencing the disease or adverse health condition will create in their lives. This can range from pain, discomfort, time off from work, financial strain, stress experienced in relationships and the emotional toll the disease or the adverse health condition will have on them. The seriousness of the impact of the adverse health condition can include a range of spiritual, emotional, financial and social costs to the individual’s beliefs.

Participants were asked their views on how severe the consequences of a negative health outcome be if they acquired HIV and received a positive result to a HIV test

In a scenario hypothetically presented to the participants, in case of knowledge of having acquired HIV or an HIV positive diagnosis, all four participants said that their reaction would be of shock and denial.

“So I would think like, for the first time, that would be the end of the world. It’s still incurable, the disease, and people always like, saying bad stuff about getting HIV and you are just going to die and you won’t get cured. So it’s kinda like it’s not the best. It’s like depressed. Yeah, kinda, after the result, I was like – ah, yes (sighs), I’m negative... personally, I would not. I will never come out to my family, to be honest, it would be a huge shock to them. It would be much much bigger than I am being gay, so I won’t tell family or seek any help.” Owen

All participants also impassionately spoke of the impact it would have on their family and friends. The belief that HIV is an incurable illness was acutely expressed by all the participants. In addition, all participants concurred that potentially living with HIV is something that would impact their lives significantly. Potential disclosure to future partners and relationships was mentioned by participants as an important consequence of potentially having HIV) as a result of risky sexual behaviour or condom-less sex. Participants also expressed that the idea of being diagnosed with HIV “is depressing”. Acquiring HIV would also mean according to the participants, that Asian MSM would be further distanced from the Asian community generally. The perception that “Knowledge of HIV low in many Asians. So Asian people would never be in touch again with you” was voiced by most of the participants.

“Ok, if I come to know I have been exposed, I would need to come to know by a test and obviously, it would be a big shock because coming from an Indian family when you’ve got these set of expectations from studying and staying abroad, it would be a big shocker. But then I would also be assured that there are measures that can be taken to, I mean, not all is lost because there are measures that you can still take and be reasonably well. So, I guess, it would be a major set-back, but there are still steps and there are centers you can go to in New Zealand.... so let’s say, I’m not sure, let’s say again, I’m tested positive, my current partner would be with me. And whenever I go out and seeking, I’m ready to go in to another relationship there will always be, like I would definitely not hide I’m HIV positive. It’s all out in the open, I’m HIV positive, so maybe, maybe I think the chances of finding a partner who might stay with you might be difficult. So, that way, I just want to keep it a secret.” Donald.

“Asians are still not well educated about HIV. So once you are HIV positive, in my opinion, people from Asia would think, ok, I would never be in touch with you because you are HIV positive, it means you can me HIV. The rumor, about HIV. People [here] would be more educated [non-Asians].” Owen

Perceived benefits:

Once individuals have accepted their vulnerability or susceptibility to a disease or an adverse condition, taking steps towards preventing the condition is the next step in the HBM. The individuals recognize the potential risks posed by the illness and chooses to take preventive action. Their actions will be guided and influenced by the beliefs they hold connected to the action.

Participants were asked about the benefit of the health behaviour (testing for HIV) in order to determine whether it would out-weigh the cost of not testing for HIV. Essentially, the question examines what would the participants gain by changing behaviour or adopting health seeking behaviours, which included testing for HIV.

All participants stressed that their health and maintaining good health were of high importance to them. Having said this, they felt that they did not need an HIV test as they modelled monogamous relationships and sexual fidelity. This strategy of avoiding multiple partnered relationships mitigated their risk of HIV. As such, non-risky behaviour carried implicit benefits for the participants according to the participants.

While participants assumed they had ‘no need’ for an HIV test, a sense of responsibility would prompt them to test for HIV. One of the key benefits of getting themselves tested for HIV, should they expose themselves to risky behaviour (such as condomless sex or having sex outside of their primary relationship), was to reduce the stress of not knowing if they had HIV or not. According to the participants this was especially more important when starting a new relationship, as this would impact their decision of sexual partnering with a potential new partner.

“There was a sexual encounter and I mean, obviously I always prefer safe sex, but during the act I found out that the condom broke, so when I realized that I said, ok let’s stop, let’s not go any further. But even though I was assured by the person that he is not, that he has been tested and he is all good and even though there is this thing in the mind, let’s get tested what’s the deal, so that prompted me to go ahead and get tested.” Donald.

Perceived barriers:

Even if a person may understand and acknowledge the benefits of taking actions to prevent an illness, they may be unable to take the action due to several barriers. These barriers may be due to a number of reasons, for example the inaccessibility of the treatment, costs of treatment, stigma or other non-tangible barriers and unpleasant or painful elements of treatment. This is not an exhaustive list of reasons and any other

reason may present as a barrier to individuals taking action to prevent an illness or adverse health condition.

This category of questions examined what, according to the participants are the perceived barriers to HIV testing?

Participants exhibited a very low level of proactiveness when it came to their overall health seeking behaviour. This was indicated by none of the participants in this pilot study being registered at a GP. Waiting for their first illness from the day they moved to New Zealand is the only catalyst for the participants to register with a GP or a doctor.

Knowledge of the New Zealand health system was low with no clarity about patient rights or services available. Additionally a GP was not perceived as an HIV expert and participants vehemently indicated that they would not prefer to be tested at their GP. HIV testing was seen as low priority and only perceived as an appropriate health action in the case of engaging in risky or promiscuous sexual behaviour or encounters. Testing equated to having done something wrong.

“I didn’t have boyfriend in Taiwan... I have a partner now so I don’t have risky behaviour.” Jerry

All participants indicated they were not closely connected with the gay community and did not frequent gay bar, venues or places where HIV testing would be available. The concept of community was not limited to the openly gay community but also to the general New Zealand and Asian community and people.

As participants demonstrated a high level of awareness of condom use for protection against HIV transmission, they stressed that as long as they protected themselves using a condom, they would not test.

“As long as I protect myself well, I think I won’t get tested. Yes, I think that’s the right opinion or idea, for myself, yes, I won’t. And by that ... meaning using a condom. Yes, it’s all about the blood thing. Come to my mind, it’s all about the blood. As long as I’m not exposed to the blood, I think it should be fine.” Owen.

Participants’ knowledge and experiences of the New Zealand’s health care system varied.

“...Before I came here I actually didn’t have any idea. I ... health system, we just know welfare system, their welfare system is much better than in Asia and then the health system we know we have to register with GP which is we know different from what have in Taiwan. In Taiwan, no matter is what happens, you can go everywhere to

see anyone. So the system here is really different. We know that the system here is different from Taiwan.” Jerry.

“I’m not registered with a GP as of now, although I am covered by life insurance policy which is paid by our employer. So, I’m on that plan, but other than that, there is nothing I’ve done, I’ve not been to a GP yet in any case. Yeah, but definitely if I find out I’m ill, it would mean I should go to.” Donald.

“I find that the healthcare system is much slower here. As in well even if they call it an emergency they make you wait for an hour or two hours. Then they take up your case. And health care too is much better than in India though it’s slower. Also the ratio of doctors to patients compared to here and back home is, you have less number of people so you need less doctors, but still, I don’t think we have enough doctors for the number of people in New Zealand.” Daniel.

HIV stigma and fear of being ostracized by the community posed a significant barrier to HIV testing.

“Yes, it is [stigma]. You cannot really talk about sexual health in India. Not even to your parents because of cultural how do I put it? Cultural manacles. So that part of why unprotected sex may lead to HIV and they think Sexually Transmitted Disease, AIDS to be precise, is transmitted by sex and they fail to see that it can be through blood transfusion too. There is stigma attached to it.” Daniel.

Self-efficacy:

Self-efficacy is an individual’s belief in their ability to overcome barriers and take action to prevent the adverse health condition or illness. This can range from lifestyle choices to adherence to medication.

This section asks the participants if they believe they can overcome barriers to make changes to their behaviour to access HIV testing. Essentially, would they be able to overcome barriers such as their perceptions or health beliefs and test for HIV?

Participants remained steady and unchanging in their beliefs that they did not need an HIV test if they modelled monogamous relationships and if they did not engage in condom-less anal sex. The participants’ sense of responsibility presented with a high level of self-efficacy and control of their own health to protect themselves and their sexual partners.

All the participants pointed to a high level of self-efficacy in accessing support, but not from family or friends, but for organisations or individuals they perceived as experts on HIV and related services. Participants mentioned that the reason for this was their fear

of losing intimate partners or friends. They mentioned that they can access support but would not prefer not to reach out to friends or family for the fear of losing relationships with them.

“Ok – that’s a good question, I never thought about that. What would encourage me? To be honest, I don’t know. Encourage by the others, if my partner told me I think we need to take a test, I think that should be the reason, unless he encourages me to take a test, I couldn’t think of any other reason. Yes, coz I know what I am exposed to, so I know the risks that I would get HIV so I don’t think any kind of like meaningless encouragement would work. I know myself well.” Owen.

“It was monogamous, well, we didn’t exactly consummate it because he wanted to be careful, I wanted to be careful and safe sex is better than unprotected sex.” Daniel.

“...for me, still at same level [HIV knowledge after moving to New Zealand and compared to country of origin in Asia]. I also know that I have to protect myself. Other than that, I don’t think I have any changes to make to be honest.” Owen.

Cues to action:

Behind the individual’s action are the motivating factors from their perception of how susceptible or at risk they may be to the adverse health condition or illness as well as the benefits of overcoming the barriers to act. However, individuals may need a cue to action for the preferred health behaviour to take place. These cues may be internal or external (like social health campaigns or counselling).

This category sheds light on what will give participants the motivational support needed to make the final push to change their behaviour from not testing for HIV to seeking HIV tests.

Contradictory to their previous preference of not getting an HIV test at the GP, participants said that if a GP asked them for an HIV test, they would opt for it. They also mentioned that they would not mind if the GP asked them direct questions regarding their sex life, sexual preference or sexual orientation to assess their risk to HIV.

The key cue to action according to the participants was their own perceived and actual risky sexual behaviour or a sexual encounter without condoms that would motivate them to test for HIV. The next plausible cue to action that would motivate participants was the fear of having HIV or potential exposure.

“We were thinking of, I was with a partner then, and we were thinking, before we consummated it, we had to go get a sexual health check up before we actually consummated it. That was part of why.” Daniel.

Subsequent to this motivational cue to action, participants said that they would test for HIV if their partner insisted on it. One participant was certain that encouragement from friends would only have limited success in getting them to test for HIV. If their partner insisted, they would get tested and encouragement from friends would not result in them getting tested for HIV.

“So for me, I’m currently in a relationship. And we are thinking of having unprotected sex... so, I was like before we even go there, let’s get tested first. Just so that we’re safe, you’re safe, I’m safe, both of us are all good. So that is what prompted me to do the test.” Donald.

“Well, two timing is one reason [partner having sex outside of the relationship] or the other is if I notice any symptoms. The second time I went for the test the doctor was very helpful in explaining the symptoms that come with a few sexually transmitted diseases. And I noticed symptoms that came about a few diseases, and that’s how ... that is what would motivate me, any symptoms that you see, go check up. Do a sexual health check up because I think I have a healthy sexual appetite.” Daniel.

“I don’t think I would call a helpline, I would call someone at NZAF. That might have been my first choice. Ya coz I have heard instances that NZAF has helped. But I don’t know of any such place otherwise for support. I would seek support from my friends... if you cannot be honest with a doctor, how are they going to treat you better? So, I would just take it as a question, like him asking me ... do you have headaches. That’s the kind of a question this is as well. So that he can know me better to treat me.” Daniel.

All participants reported that the presence of organizations like NZAF and the use of communication are reported to encourage participants to test according to the participants.

Specific themes emerging from the findings reveal that Asian MSM are risk averse and mitigate their risk of acquiring HIV. Additionally, findings also suggest that Asian MSM do not necessarily want to associate or immerse themselves in a stereotype of gay and bisexual men as highly sexualised or promiscuous. Combined with the preference for monogamy, this is used to mitigate the risk of HIV infection by Asian MSM. However, data analysis suggests that we do not know the effect of this on their over-all wellbeing and social integration. This is also a contributing factor or barrier to Asian MSM’s low levels of accessing HIV testing as it is deemed as unnecessary by them.

Chapter 5: Discussion

This research explores Asian Men Who have Sex with Men (MSM)'s perception of risk behaviour and attitudes towards HIV testing in New Zealand. In doing so, it sets to:

- Identify existing knowledge gaps in the current literature specific to Asian MSM and their access to HIV testing
- Better inform policy and practice and to positively impact the experience of Asian MSM in their access to healthcare
- Develop a questionnaire that sheds more light on the reasons for Asian MSM's sexual risk taking and their low levels of HIV testing.
- Identify the reasons behind the low levels of HIV testing among the Asian MSM in New Zealand.

Identify existing knowledge gaps in the literature specific to Asian MSM and their access to HIV testing

One of the objectives of this research is to fill any existing knowledge gaps and in some ways, address the current invisibility of Asian MSM in research and prevention programmes.

Through focusing on Asian MSM and their attitudes, perceptions and beliefs about HIV and health care, this pilot study sheds light on existing knowledge gaps in New Zealand literature. The outcome is to develop a questionnaire to reveal the existing knowledge gaps as well as gain insight into the HIV testing behaviour of Asian MSM. The sub-group of Asian MSM has largely been invisible from research and prevention programmes. This has an impact on any HIV prevention or health outreach programmes designed for the MSM community. Asian MSM are ill served due to lack of insights or appropriate observation and analysis of their attitude and perceptions towards accessing healthcare generally and HIV prevention specifically.

Not much in depth research is available to HIV researchers, those working in HIV prevention, clinicians or health practitioners about Asian MSM or the barriers they experience in accessing health care in New Zealand. This pilot research found that Asian MSM are reluctant to share their sexuality or sexual practices to their GPs or clinicians. This makes it harder for GPs and clinicians to gauge Asian MSM's risk of HIV and prescribe HIV tests. It also makes Asian MSM more disadvantaged and

vulnerable to HIV than compared to other MSM. Any new knowledge such as the findings from this pilot and any future research work gives Asian MSM visibility in research. As mentioned earlier, with increasing diversity in population, it is essential that the diversity of views are visible and reflected in research as well as policy that is built on research.

In New Zealand, there is surveillance of the HIV epidemic by the AIDS Epidemiology Group at the University of Otago. Aside from this, there are the two national behavioural surveys (now no longer funded by the Government and unlikely to be repeated in 2017), known as GAPSS and GOSS that capture the largest sample of MSM in New Zealand for analysis. HIV prevention programmes are guided by the findings of GAPSS and GOSS. Asian MSM remain under represented in this research.

This makes it necessary to conduct different types of research, in addition to epidemiological and behavioural alone, and both qualitative and quantitative with different samples of the diverse population of MSM to gain a fuller picture of the diverse MSM community and its health needs. Research helps and serves as a tool to obtaining pieces of the puzzle that's specific. Research that goes beyond behavioural or epidemiological has the potential to add depth, meaning and perspective to existing data and this can help refine existing prevention programmes or even design specific HIV prevention models that best serve the needs of Asian MSM in New Zealand. This pilot research makes a contribution to the wider research body in New Zealand by presenting different perspectives on Asian MSM that are usually not included in larger research on MSM in the country.

Better inform policy and practice and to positively impact the experience of Asian MSM in their access to healthcare

At the outset, this research outlined the significance of research that would inform policy and practice and to positively impact the experience of Asian MSM in their access to healthcare. This research will inform guidelines that seek to support socio-culturally relevant health promotion for Asian MSM.

Government reports and policy are outdated in serving HIV prevention in New Zealand. In addition, research is underfunded with recent budget cuts to the critical GAPSS and GOSS surveys, the largest behavioural surveys of MSM in the country. This presents a two-fold challenge to those working in the field of HIV prevention, public health and clinicians. However, it also presents an opportunity for scholars and researchers to

inform new policy that would potentially shape future HIV prevention programmes in the country.

HIV prevention programmes rely on behaviour change campaigns to be able to successfully prevent HIV in communities most at risk of the virus. In New Zealand, MSM are the community most at risk of the epidemic and unprotected sex is the main way HIV is transmitted.

The success of HIV prevention programmes depends on effective communication and social marketing campaigns that target behaviour change in MSM and populations most at risk of HIV. Given the diversity of New Zealand's population and the specific needs of Asian MSM, a 'one size fits all' communication solution or communication campaigns that serve only European MSM are not likely to effectively prevent HIV transmission among Asian MSM. This pilot research recognizes and establishes from its findings that Asian MSM perceive and access health care (HIV testing) as well as HIV differently from other MSM. Any outcomes that positively impact Asian MSM's health and health seeking behaviour such as HIV testing, will depend on effective and accurate research that focuses on the specific needs of Asian MSM. This pilot research is a step towards developing further research that seeks information and findings on HIV risk, health beliefs, attitudes and perceptions of Asian MSM. The findings from analyzing interviews of Asian MSM in this pilot show that there are areas that remain not fully understood such as Asian MSM's patterns of socialization, sexual partnering, perceptions about HIV risk, barriers to accessing healthcare in New Zealand and dealing with stigma.

It follows that any research that may be conducted in the future would require adequate support and funding from funding bodies and the Government for programmes and benefits to reach and benefit Asian MSM and to fully realize the cumulative positive impact of effective HIV prevention. For practitioners – social marketers, clinicians and health workers – lack of accurate research or research that is not reflective of the populations most at risk of the HIV epidemic means not being able to design programmes that appropriately serve the needs of these populations. However, if there are focused insights, this can make a positive impact on the work of practitioners working in the field of HIV prevention. Findings from this pilot give an indication from this pilot of how the needs of Asian MSM are different from other MSM. It can help practitioners adapt and upskill to be able to ensure this population group is served in an appropriate, efficient and effective manner.

Based on the findings a questionnaire that aims to shed more light on the reasons for Asian MSM's sexual risk taking and their low levels of HIV testing was designed. The proposed questions are presented below:

I. Participant insights

1. How long have you been in New Zealand?
2. Where do you live – In Auckland/outside Auckland?
3. Employment status – Do you work full time/part time/ unemployed
4. Are you registered with a GP – Yes/No

II. HIV testing and health access

1. Have you ever been tested for HIV?
2. When was your last HIV test?
3. How frequently do you test for HIV?
4. Where would you prefer to be tested for HIV - GP, Sexual Health, University, NZAF
5. Did you know that you can get an HIV test at no cost in New Zealand?
6. What will motivate you to test for HIV?
7. Which of the following reasons make it less likely for you to test for HIV?
 - a. I'm scared of getting tested
 - b. I don't need it because I always use condoms
 - c. I am in a monogamous relationship
 - d. I am not sure if I have to pay for the HIV test
 - e. I don't like dealing with the healthcare system
 - f. I feel judged by the community if I take the HIV test
 - g. I don't like discussing my sexuality or sexual practices with doctors or nurses
 - h. I don't like my blood taken
 - i. I am scared of the results
 - j. Other

III. Sexuality and sexual partnering

1. Do you have sex with casual partners? Yes/no/sometimes
2. How many men have you had sex with in the last three, six and 12 months?
3. Let us know about your current sexual partners:

- a. I have no current regular male partner
- b. We are monogamous – neither of us has casual sex
- c. Both my partner and I have casual sex with other men
- d. I have casual sex with other men but my partner doesn't
- e. My partner has casual sex with other men but I do not
- f. I have several regular male partners
- g. Other

IV. HIV knowledge, primary prevention and risk perception

1. Do you discuss HIV with your partners? Yes/no/sometimes
2. Do you think HIV is an issue for Asians in New Zealand? In what way?
3. Do you engage in anal sex?
4. Do you use condoms for anal sex: always, sometimes, never
 - a) In your view, what is the risk of HIV to Asian MSM in New Zealand? High, medium, low.
 - b) What are the reasons for your answer?
5. How do you think HIV transmission risk can be mitigated or controlled among Asian MSM?
6. What are the consequences in your view of being diagnosed with HIV?
7. What are your reasons for not getting tested for HIV?
8. Have you tested for HIV? Yes, no, Can't remember
 - a. I was not sure where to test
 - b. I was not sure if my visa status would mean that I will have to leave New Zealand if I was diagnosed
 - c. I was unsure if I could get the test for free
 - d. I am worried that I will be seen as irresponsible if I test
 - e. I am worried that no other Asians will want to keep contact with me,
 - f. I was afraid of being diagnosed with HIV
 - g. I think my sex life would suffer if I have HIV
 - h. I am worried I'll feel like a failure for not protecting myself better
 - i. I am worried I'll have to face legal or criminal charges if I'm diagnosed with HIV
 - j. I am afraid that my partner will leave me if I am diagnosed with HIV
 - k. I don't want to know the results for the fear of testing HIV positive
 - l. The place I could get a test is very inconvenient for me to travel to

- m. I don't like feeling judged by the clinical staff and the idea of counselling pre and post testing
- n. I am afraid of losing my job
- o. Someone might recognize me at the testing site
- p. Other

V. Cultural belief, community and wider family questions

1. What does family mean to you?
2. Does your family know of your sexual orientation?
3. Does your family have an opinion on HIV
4. Does your family have an opinion on your risk levels of acquiring HIV?
5. Are there any beliefs or customs about your health that your family follows?
6. Do you discuss your health with your family?
Would you confide in your family members if you took an HIV test?
7. Would your family help you make decisions around your health care?
8. Who would help you and support you if you decided to go for an HIV test?
9. Do you access any support from your family when you're ill?
10. Do you access any support from your community when you are ill?
11. What do you think your family would think if you opted to test for HIV?

VI. Communication questions

1. If you were asked to get tested for HIV, in what language would you prefer this to be done?
2. Do you think the current HIV messages you see are relevant to you or speak to you?
3. Do you think it is necessary to test for HIV?

VII. Perception of health

1. What does the word healthy mean to you?
2. What do you think causes HIV?
3. Do you think it is relevant to test for HIV for your health?
4. Do you think it is necessary to access healthcare if you feel ill?
5. What are the aspects of community that contribute to your health and well-being?
6. Do you have any concerns about going for HIV tests?

The importance of identifying the reasons behind low levels of HIV testing among Asian MSM

This research attempts to identify the reasons behind the low levels of HIV testing among the Asian MSM sub-population in New Zealand. While previous research has looked into this from an epidemiological perspective, this research looks at the question through the prism of cultural norms, perceptions of what constitutes risky behaviour and health beliefs.

Some key barriers that the findings of this pilot research reveal

HIV testing is not considered necessary by the participants or beneficial for health, well-being or as a means of HIV prevention by Asian MSM. This is reflected in the overall attitude to the health care of Asian MSM where importance is placed on personal responsibility for their own health and well-being. Health care is accessed only when there are evident symptoms of ill health or an episode of illness. Other than that, visits to GP are not common or deemed as a necessary part of looking after themselves or a routine aspect of maintaining good health by Asian MSM.

Given that the participants of this pilot study have been in New Zealand for less than 5 years, issues that new migrants face present as barriers such as negotiating the New Zealand health care system, settling into a new country and getting appropriate visas and employment. This may also be why Asian MSM do not prioritize their health.

Social ties and Asian MSM's integration in communities – either the openly MSM community or the general Asian community – present a complex landscape for them to be open and 'out' with their sexuality or access HIV testing due to homophobia and risk of social isolation.

The complexity of Asian MSM negotiating their access to HIV testing is explained by the participants as not being at risk of HIV because they do not frequent places such as gay bars, clubs or saunas where the openly gay and bi men go. Ironically, this is in fact where HIV testing may be available and where messages about HIV prevention may be promoted. Their perception and behaviour point to a need for appropriate communication regarding HIV testing and prevention aimed at Asian MSM. The participants also actively avoided multiple partners or unprotected sex. However, Asian MSM's weak ties to the openly gay and bi community and fear of homophobia from the Asian community are significant barrier to Asian MSM accessing HIV testing. Any knowledge of an individual's HIV status of them accessing HIV testing would be seen with suspicion, stigma and in the extreme, social ostracization. Asian MSM report that

due to this danger, they would rather not test for HIV and take other measures instead to mitigate the risk of illness.

The prospect of a positive test result and the fear of an HIV diagnosis is another significant barrier. The participants feared not just having a lifelong serious illness but also the fear of being ostracized from the Asian community.

Thus a combination of low involvement in the openly gay and bi community (and therefore low exposure to HIV prevention messages and opportunities to test) and the consequences of not belonging to the general Asian community at large if tested positive for HIV present as barriers to Asian MSM accessing HIV testing.

Additional barriers are Asian MSM's perception of HIV tests and what it may imply if they access an HIV test. Accessing an HIV test is perceived as an indication of 'having done something wrong' or for example, it could mean an indication any number of social norms were breached such as varied sexual practices, not being monogamous, having had unprotected sex or being under the influence of drugs. HIV testing is also perceived as something that is unnecessary if there is condom use during sex or in the case of monogamous relationships. However, condomless sex or risky sexual behaviour are considered a powerful motivators for HIV testing.

Summary

Communicating HIV prevention messages to an increasingly diverse population poses a significant challenge to those working in HIV prevention, policy makers and practitioners. Any additional insights into what could encourage and increase health seeking behaviour or testing for HIV would prove helpful to policy and practice.

As illustrated in the literature, the sample in New Zealand's largest surveys focusing on HIV and sexual behaviour is under-representative of Asian MSM. In addition, the barriers that Asian MSM face in migrating to New Zealand are supported by and impact their access to health care and HIV testing.

This study analysed the factors influencing HIV testing amongst Asian MSM in New Zealand using the Health Belief Model. The findings of this research suggest that though adequate motivation to health seeking behaviour and cues to action as well as high knowledge of HIV exist amongst the small sample of Asian MSM used in this research, their perception of risk and what constitutes enough reason to test for HIV present as key barriers. The regular venues of testing for the gay community – that is, saunas and sex on site venues and generally, a GP setting are not preferred by Asian MSM and this also present a barrier to testing.

A multitude of factors act in conjunction to impact HIV testing behaviour and risky behaviour amongst Asian MSM in New Zealand. This is similar to the study by Oyekale and Oyekale (2010) that identified the factors that influence the conduct of HIV testing and risky behaviour change of Nigerian youth using the Health Belief Model. According to the authors (Oyekale and Oyekale, 2010), certain factors such as age, access to media and per capita expenditure increased the likelihood of getting tested for HIV while testing significantly decreased among those with no formal education. Similarly, living in urban areas significantly increased the probability of HIV testing and significantly reduced the chances of reduced risky behaviours.

Practical implications of the analysis of the findings from the pilot study

Participants had an in-depth and scientific knowledge of HIV including how HIV is transmitted and the importance of prevention. They also demonstrated a very good understanding of the implications of risk taking and lack of testing. However, there was low motivation for testing due to several factors.

One of the key factors as per the data analysis is that participants in the sample for this pilot study report that they mitigate their risk of HIV through modelling monogamy and avoiding multiple partners and report to never risking unprotected sex. Testing for HIV is therefore deemed unnecessary or irrelevant to them. However, a deeper insight is offered by their perceptions of community in New Zealand, social ties and knowledge of the country's health care system. Asian MSM perceive sexual partnering in the openly gay community as risky because they assume that openly gay men are more promiscuous than them. This is in spite of them stating that there is high message recognition amongst the openly gay community. This perception about sexual partnering is one of the factors that distances Asian MSM from the openly gay community including from community spaces such as gay bars or saunas where targeted health care support is easily accessible. Asian MSM in this pilot also reported to not particularly perceiving themselves as belonging to the openly gay community and still were selective about disclosing their sexual preferences to people in general. They attributed this to the stigma attached to being gay by Asian or straight people.

Being migrants to New Zealand and having lived here for less than 5 years, the Asian MSM interviewed in this pilot study also exhibited varied and diverse views of knowledge of New Zealand's health care system and processes. Not registering with a primary health care provider or GP until the first episode of illness was common to all the participants. In addition, the GP was not a preferred venue for HIV testing by the

participants and general health practitioners were not looked upon as experts in the field to whom the participants would feel comfortable being tested for HIV. However, participants reported that after residing in New Zealand over time they felt comfortable being asked about their sexuality in a GP setting. The influence of migration and geographical and social location emerged as significant to participants' perception of risk taking and HIV knowledge.

The findings point to a lesser likelihood of Asian MSM being openly gay and testing for HIV due to fear of exclusion and associated stigma of homosexuality. Participants also reported that though sexual promiscuity was frowned upon in places they were from, that is Asian countries of origin (India and China in this sample of participants), it was no predictor of sexual promiscuity in New Zealand in what the participants perceived as 'more open'. In fact, the resulting behaviour was lesser likelihood of sexual risk taking on account of mitigating the risk of acquiring HIV.

There is the potential for sexual risk taking to be under reported by the participants. In such a scenario, further questioning would be necessary in any future research.

Additionally, contrary to stereotypical perceptions of Asian culture to be constrictive when it concerns homosexuality, participants from this pilot study reported that they enjoyed a full and thriving social life in Asian countries of origin. They did acknowledge that the environment may not have been as open and welcoming to gay and bisexual men, however, even in places where homosexuality is a criminal offence or generally frowned upon, participant enjoyed robust contact and solidarity with the gay community (Prakash, 2016). In comparison, their connection and quality of connection with the openly gay community in New Zealand were of lower quality and frequency, in spite of the environment in New Zealand being generally accepting of the gay community. Participants reported a cultural gap in their social interactions in terms of missing shared understanding of social skills and understanding of culture.

Participants reported to missing simple social contact with other gay and bisexual men and felt that the expectation of 'hooking up' was ever present.

In terms of Asian MSM's social ties with the general Asian communities in New Zealand, participants reported to being extremely selective to whom they disclosed their sexual preferences. A belief that disclosure of sexuality or any hypothetical HIV diagnosis would cost them relationships was voiced by all participants. This pointed to the need for more education to reduce the stigma around homosexuality and HIV in Asian communities. This also tied in with Asian MSM in this sample reiterating that they

would be unlikely to seek support from peers or friends and would instead prefer to go to who they perceived as experts in HIV should they feel the need.

Limitations

The Asian MSM interviewed in this study had high knowledge of HIV and arguably, this posed a limitation to studying testing behaviour. This is because a sample well versed in HIV knowledge and exposed to health messages are more likely to be conversant in what constitutes HIV risk and therefore motivated to mitigate risk and consider HIV testing irrelevant. Sexual risk taking may be under-reported by participants in similar a sample of participants in any future research.

Recommendations

This pilot study reveals some practical recommendations that hopefully will make a positive impact on the health and wellbeing of Asian MSM migrants in New Zealand. It is likely that sexual risk taking is being under-reported by Asian MSM. As such, health workers and clinicians working with Asian MSM would potentially need to factor this in when addressing the issue of under-reported sexual risk taking with their Asian MSM clients.

Specific research into the sub population of Asian MSM is recommended as HIV prevention in New Zealand becomes complex with new biomedical prevention method such as Pre-exposure Prophylaxis (PrEP) become readily available in New Zealand.

This is equally true as the population becomes increasingly diverse generally in the country. Any HIV prevention policy or programme would be incomplete if it does not have specific insights on the health needs of Asian MSM.

While it is true that many Asian MSM who are new migrants may be from countries where homosexuality is criminalized, it would be misleading to assume that their social connections would be lacking in depth, strength or be limited in their countries of origin. In fact, Asian MSM in this sample reported that they experienced a thriving social life in gay communities, although underground and hidden in their countries of origin. Counter intuitively, Asian MSM reported that they missed social contact and simple social connections with other MSM without the pressure of 'hooking up' or having a sexual relationship in New Zealand. It is recommended for gay community advocates to be mindful of this when reaching out to Asian MSM.

The study also indicates that Asian MSM do not consider primary prevention communication messages as necessarily relevant to them. This insight is relevant to

social marketers and those working in primary prevention outreach work in the community. It would be helpful for those working in HIV prevention and social marketing to tailor campaigns and messages that specifically serve the needs of Asian MSM in New Zealand.

Asian MSM in this research reported that being new migrants, accessing healthcare remains low on their list of priorities. Process mapping, the steps that migrants go through in their journey in making New Zealand their home from navigating government paperwork to social and psychological adapting, for migrants is highly recommended as this will help practitioners and policy makers to plan effective HIV prevention interventions. This would also offer Asian MSM who are migrants to obtain up to date knowledge of the health system in New Zealand which they may be unfamiliar with. Timely information is likely to go a long way in preventing illness generally as well as HIV, which would have cost savings for New Zealand's health care system in the long term.

These recommendations provide an input into any research that can be conducted in the future for the health and wellbeing of Asian MSM.

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