Feeling Queer:
Can a Primary Health Care approach mitigate health inequity experienced by homosexually active South Australian men?

by

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A thesis submitted in fulfilment of the requirements for the degree of

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# Contents

Contents .................................................................................................... 3  
List of tables ........................................................................................... 9  
List of figures .......................................................................................... 11  
Abstract .................................................................................................. 15  
Candidate’s statement ........................................................................... 17  
Acknowledgements ................................................................................... 18  
Thesis map .............................................................................................. 20  
PART ONE Context: What do the terms in the question mean and what is known already? .............................................................................. 21  
Methodological Note ................................................................................. 22  
Chapter 1: Health inequity ...................................................................... 23  
  Preamble ............................................................................................... 23  
  Introduction ........................................................................................... 26  
  ‘Health’ ............................................................................................... 27  
  Health inequality ................................................................................ 29  
  History ............................................................................................... 29  
  The ‘Black Report’ ........................................................................... 31  
  Geographical inequality .................................................................... 36  
  Health inequality ............................................................................... 39  
How inequity influences health – multi-level models.............................. 43  
Social variables investigated to date..................................................... 50  
  Socio-economic position-related variables ....................................... 50  
  Other variables ............................................................................... 54  
Sexual identity as a basis for health inequity ......................................... 59  
Conclusion ......................................................................................... 62  
Chapter 2: A Primary Health Care approach ........................................... 63  
  Introduction ....................................................................................... 63  
  Origins .............................................................................................. 64  
  The Declaration of Alma Ata ............................................................... 66  
  Selective Primary Health Care ............................................................ 70  
  The Ottawa Charter for health promotion .......................................... 72  
  The Jakarta Declaration .................................................................... 74  
‘Health for all in the twenty-first century’ .............................................. 76  
Developments since 2000........................................................................ 76  
Primary Health Care, primary care & general practice ......................... 84  
PHC in Australia ................................................................................... 87  
  PHC and national health policy ......................................................... 87  
‘Communities’ to ‘consumers’............................................................... 96  
The problem of ‘outcomes’ in PHC .................................................... 97  
PHC & HIV in Australia ...................................................................... 99  
New South Australian PHC policy ..................................................... 112  
Conclusion ....................................................................................... 114  
Chapter 3: Homosexually Active Men .................................................... 117  
  Introduction ..................................................................................... 117  
  A brief history of homosexuality ...................................................... 117  
  Beginnings(?) ............................................................................... 117  
  Medicalisation .................................................................................. 119
### Feeling Queer: Primary Health Care & homosexually active men

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay community involvement</td>
<td>260</td>
</tr>
<tr>
<td>Male relationships</td>
<td>262</td>
</tr>
<tr>
<td>Duration of relationship</td>
<td>263</td>
</tr>
<tr>
<td>Sexual behaviour with a regular partner</td>
<td>264</td>
</tr>
<tr>
<td>Receptive oral sex with a regular partner</td>
<td>267</td>
</tr>
<tr>
<td>Any anal sex with a regular partner</td>
<td>268</td>
</tr>
<tr>
<td>Insertive anal sex with a regular partner</td>
<td>268</td>
</tr>
<tr>
<td>Receptive anal sex with a regular partner</td>
<td>269</td>
</tr>
<tr>
<td>Any unprotected anal sex with regular partner</td>
<td>269</td>
</tr>
<tr>
<td>Unprotected insertive anal sex with a regular partner</td>
<td>270</td>
</tr>
<tr>
<td>Unprotected receptive anal sex with a regular partner</td>
<td>271</td>
</tr>
<tr>
<td>‘Strategic Positioning’</td>
<td>271</td>
</tr>
<tr>
<td>General community comparison</td>
<td>272</td>
</tr>
<tr>
<td>Sexual behaviour with casual partners</td>
<td>273</td>
</tr>
<tr>
<td>Receptive oral sex with casual partners</td>
<td>273</td>
</tr>
<tr>
<td>Any anal sex with casual partners</td>
<td>274</td>
</tr>
<tr>
<td>Insertive anal sex with casual partners</td>
<td>274</td>
</tr>
<tr>
<td>Receptive anal sex with casual partners</td>
<td>274</td>
</tr>
<tr>
<td>Unprotected anal sex with casual partners</td>
<td>275</td>
</tr>
<tr>
<td>General community comparison</td>
<td>275</td>
</tr>
<tr>
<td>Anthropometrics</td>
<td>276</td>
</tr>
<tr>
<td>Height</td>
<td>276</td>
</tr>
<tr>
<td>Weight</td>
<td>277</td>
</tr>
<tr>
<td>Body mass index</td>
<td>277</td>
</tr>
<tr>
<td>Triceps skin fold</td>
<td>278</td>
</tr>
<tr>
<td>Mid-arm muscle circumference</td>
<td>278</td>
</tr>
<tr>
<td>Abdominal girth</td>
<td>279</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>280</td>
</tr>
<tr>
<td>Peak expiratory flow rate</td>
<td>281</td>
</tr>
<tr>
<td>Sexually transmitted infection history</td>
<td>282</td>
</tr>
<tr>
<td>Syphilis</td>
<td>282</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>283</td>
</tr>
<tr>
<td>Warts</td>
<td>285</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>287</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>289</td>
</tr>
<tr>
<td>Non-specific urethritis (NSU):</td>
<td>290</td>
</tr>
<tr>
<td>Any sexually transmitted infection:</td>
<td>291</td>
</tr>
<tr>
<td>Depressive disorders</td>
<td>291</td>
</tr>
<tr>
<td>Zung depression rating scale</td>
<td>295</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>295</td>
</tr>
<tr>
<td>Suicide attempt history</td>
<td>297</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>297</td>
</tr>
<tr>
<td>Recollection of childhood sexual abuse (CSA)</td>
<td>298</td>
</tr>
<tr>
<td>Substance use</td>
<td>299</td>
</tr>
<tr>
<td>Tobacco</td>
<td>299</td>
</tr>
<tr>
<td>Alcohol</td>
<td>301</td>
</tr>
<tr>
<td>Cannabis</td>
<td>303</td>
</tr>
<tr>
<td>Nitrites</td>
<td>304</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>305</td>
</tr>
<tr>
<td>Lysergic acid diethylamide (LSD)</td>
<td>306</td>
</tr>
<tr>
<td>Ecstasy (methyleneoxydimethamphetamine/MDMA)</td>
<td>307</td>
</tr>
</tbody>
</table>
Feeling Queer: Primary Health Care & homosexually active men

Heroin ..................................................................................................................308
Injecting use of any illicit drug ...............................................................................308
Function and quality of life (short form 36) ..........................................................309
Mortality ..................................................................................................................313
Completed suicide .................................................................................................316
Discussion ................................................................................................................317
PART THREE Correlates & Consequences: Was the health inequality also health
inequality, and how was this related to HIV transmission behaviours? ....321
Chapter 7: Social and Historical Correlates .............................................................323
Introduction ............................................................................................................323
Correlates of sexually transmitted diseases history ...............................................329
Correlates of depressive disorders .........................................................................330
Zung depression rating scale ..................................................................................330
Associations between depression and substance use levels ....................................331
Summary ..................................................................................................................332
Correlates of suicidal ideation ................................................................................333
Correlates of anxiety disorders ..............................................................................334
Panic Disorder .........................................................................................................334
Generalised Anxiety Disorder ................................................................................335
Correlates of substance use levels ..........................................................................335
Tobacco ...................................................................................................................336
Alcohol .....................................................................................................................336
Cannabis ..................................................................................................................337
Nitrites .......................................................................................................................337
Amphetamines .......................................................................................................337
LSD ...........................................................................................................................338
Ecstasy .....................................................................................................................338
Heroin .......................................................................................................................338
Injecting use of any illicit drug ...............................................................................339
Correlates of sf36 scores ........................................................................................340
Physical Function ..................................................................................................340
Role limitation due to physical health ('Role Physical') ........................................341
General Health .......................................................................................................342
Body Pain ...............................................................................................................342
Vitality .......................................................................................................................343
Social Function .......................................................................................................344
Role limitation due to emotional health ('Role Emotional') ................................345
Mental Health .........................................................................................................345
Summary ..................................................................................................................346
Extended sociohistorical correlates .....................................................................347
Parental relationships .............................................................................................348
Recollection of childhood sexual abuse (CSA) .......................................................350
Non-consensual sex in adulthood .........................................................................350
Recent experience of violence and verbal abuse ..................................................350
Summary ..................................................................................................................352
Discussion ................................................................................................................354
Chapter 8: Sexual behaviour correlates of health inequity ....................................359
Introduction ............................................................................................................359
Notes on particular comparisons ..........................................................................363
Age and sexual behaviour ......................................................................................363
Depressive and anxiety disorders and sexual behaviour ......................................364
Feeling Queer: Primary Health Care & homosexually active men

HIV risk behaviours and health characteristics................................. 366
HIV risk behaviours and social variables ............................................. 371
Discussion ....................................................................................... 372

PART FOUR Counter Measures: How was a Primary Health Care approach
  applied and what changed in association with its use?....................... 375
Chapter 9: Application of a Primary Health Care Approach............... 377
  Introduction.................................................................................. 377
  The operations of Care & Prevention Programme............................. 378
  Health assessment and monitoring .................................................. 379
  Care planning, coordination and facilitation ...................................... 380
  Provision of extended services......................................................... 380
  Health care worker support............................................................. 381
  Knowledge development and advice provision. ............................... 382
  Governance and strategic development............................................ 382
Discussion ..................................................................................... 383

Chapter 10: Quantitative measures of outcome ................................. 385
  Assessment of outcome ................................................................ 385
  sf36 scores .................................................................................. 389
    Physical Function ....................................................................... 389
    Role limitation due to physical health ('Role Physical') ................. 390
    General Health ......................................................................... 391
    Bodily Pain ............................................................................... 392
    Vitality ....................................................................................... 393
    Social Function.......................................................................... 394
    Role limitation due to emotional health ('Role Emotional')........... 395
    Mental Health .......................................................................... 396
    Overall sf36 profile .................................................................... 397
  Depressive disorders ..................................................................... 398
    Major Depressive Episode prevalence ......................................... 398
    Dysthymic Disorder prevalence.................................................... 399
  Suicidal ideation .......................................................................... 400
  Anxiety disorders ......................................................................... 401
    Panic Disorder .......................................................................... 401
    Generalised Anxiety Disorder ...................................................... 402
  Sexual behaviour with casual partners ......................................... 403
  HIV non-concordant UAI-R .......................................................... 405
  Substance use .............................................................................. 407
    Tobacco use ............................................................................. 408
    Alcohol use ............................................................................... 409
    Cannabis use ............................................................................ 410
    Nitrate use ................................................................................ 411
    Amphetamine use ...................................................................... 412
    LSD and related substance use ................................................... 413
    Ecstasy use ................................................................................ 414
    Heroin use ................................................................................ 415
    Injecting use of any drug ............................................................. 416
  New diagnosis of HIV infection ...................................................... 417
  Discussion ..................................................................................... 420

Chapter 11: Subjective and qualitative measures of outcome ............. 421
  Satisfaction rating and free text commentary .................................. 421
  Satisfaction with the Programme overall ....................................... 422

7
# Feeling Queer: Primary Health Care & homosexually active men

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination and nursing service</td>
<td>423</td>
</tr>
<tr>
<td>Dietetic and nutrition service</td>
<td>425</td>
</tr>
<tr>
<td>Physiotherapy service</td>
<td>427</td>
</tr>
<tr>
<td>Massage therapy service</td>
<td>429</td>
</tr>
<tr>
<td>Dental assessment service</td>
<td>431</td>
</tr>
<tr>
<td>General medical practitioner service</td>
<td>432</td>
</tr>
<tr>
<td>Psychiatry service</td>
<td>434</td>
</tr>
<tr>
<td>General and colorectal surgical service</td>
<td>436</td>
</tr>
<tr>
<td>Problems encountered with the C&amp;PP</td>
<td>437</td>
</tr>
<tr>
<td>Suggestions and comments</td>
<td>439</td>
</tr>
<tr>
<td>Reflexive practice and organisational learning</td>
<td>443</td>
</tr>
<tr>
<td>Discussion</td>
<td>444</td>
</tr>
</tbody>
</table>

## PART FIVE Conclusions: What were the findings, what are their limitations and what are their implications?

Chapter 12: Summary of Findings                                        447
- The health inequity framework                                        447
- Primary Health Care                                                  448
- Homosexually active men                                              449
- The Care and Prevention Programme                                    449
- ‘Outcomes’                                                           450

Chapter 13: Limitations of the Study                                    453
- ‘Validity’                                                           454
- Measuring health inequality                                          455
- Identifying health inequity                                          458
- Measuring the impact of the PHC programme                            459
- Summary                                                             463

Chapter 14: Implications of the Study for Future Policy, Practice and Research  465
- Policy & Practice                                                    465
- Research                                                             467
- Population health research                                           467
- Health service research                                              469

Appendices
- Appendix 1: Demographic questionnaire                                471
- Appendix 2: Health baselines form                                    477
- Appendix 3: Extended sociohistorical correlates questionnaire         481
- Appendix 4: Abbreviations                                             483
- Appendix 5: Published paper                                           485
- References                                                           491
List of tables

Table 1: Some aspects of health inequity experienced by Indigenous Australians based on data presented in (Thomson et al., 2004) .............................. 56
Table 2: Proportion of males with suicide attempt history (Mathy, 2002) .... 181
Table 3: Rates of mood disorders among Dutch men (Sandfort et al., 2001). 204
Table 5: Comparison of frequency of occupation types ............................... 252
Table 6: Cannabis use levels by HIV status ............................................... 303
Table 7: Mean sf36 scores at enrolment (n = 517) ....................................... 309
Table 8: Mean sf36 scores compared with SA population norms for males (Behavioural Epidemiology Unit, 1995) ....................................... 310
Table 9: Comparison of mean sf36 scores, C&PP vs Lin & Ward (Lin et al., 1998) .............................................................................................. 312
Table 10: Observed and expected deaths by age in C&PP cohort, based on SA population data. (Australian Bureau of Statistics, 2002b) ................. 315
Table 11: Observed and expected suicide deaths by age in C&PP cohort based on Australian population data. (Australian Bureau of Statistics, 2002c).. 316
Table 12: Dimensions of health inequality experienced by homosexually active men ................................................................................................ 319
Table 13: Correlation matrix for relationships between reported substance use levels at enrolment ................................................................. 326
Table 14: Statistical methods used according to data forms .......................... 327
Table 15: Social correlates of sexually transmitted infection history ............ 329
Table 16: Social correlates of depressive disorders and effective Zung score 330
Table 17: Univariate association of depression markers with substance use levels by comparison of medians with Mann Whitney Test for presence or absence of disorders and Spearman’s correlation for EZS .......................... 331
Table 18: Association of depression markers with substance use levels in multivariate regression models including all dependent variables ............. 332
Table 19: Participant choice of descriptor for early childhood relationship with father .................................................................................................. 349
Table 20: Participant choice of descriptor for early childhood relationship with mother ................................................................................................... 349
Table 21: Relationships between health characteristics and extended sociohistorical correlates (univariate analyses) ............................................. 352
Table 22: Odds ratio of reporting UAI-C in prior six months for men with health characteristic compared with those without ................................. 367
Table 23: Odds ratio of reporting UAI-Rnc in prior six months for men with health characteristic compared with those without ............................. 368
Table 24: P values for associations between UAI-C/UAI-Rnc and substance use levels ........................................................................................................369

Table 25: P values for association between UAI-C/UAI-Rnc and sf36 scales ........................................................................................................370

Table 26: P values for association between UAI-C/UAI-Rnc and social characteristics.................................................................................................371

Table 27: P values (and odds ratios for dichotomous characteristics) for association between UAI-C/UAI-Rnc and extended sociohistorical variables ........................................................................................................371
List of figures

Figure 1: Fractal image.................................................................47
Figure 2: Participants in the Care & Prevention Programme...........237
Figure 3: Age of participants at enrolment......................................243
Figure 4: Country of birth of participants.....................................246
Figure 5: Place of current residence of participants.......................248
Figure 6: Place of raising of men born in Australia.........................248
Figure 7: Accommodation arrangements of cohort members.............249
Figure 8: Accommodation arrangements of SA men in Census.............249
Figure 9: Employment rate of HIV+ participants..............................251
Figure 10: Employment rate of HIV-/? participants..........................251
Figure 11: Employment rate of SA men in 2001 Census......................251
Figure 12: Comparison of income distribution.................................254
Figure 13: Comparison of rates of religious belief............................255
Figure 14: Proportion of men in cohort ever married........................256
Figure 15: Portion of SA males in Census ever married......................256
Figure 16: Comparison of proportion of gay friends..........................261
Figure 17: Comparison of time spent with gay friends.......................261
Figure 18: Proportion with regular male partner in cohort...............265
Figure 19: Proportion with regular male partner in Periodic picnic sample..265
Figure 20: Proportion with regular male partner in Periodic venues sample...265
Figure 21: HIV status of participants and regular partners.................266
Figure 22: Proportion reporting any UAI-R by seroconcordance...........270
Figure 23: ‘Strategic positioning’ between regular partners..............272
Figure 24: Proportion reporting UAI-C in last six months by HIV status...276
Figure 25: Body mass index distribution by HIV status......................278
Figure 26: Blood pressure by HIV status.......................................280
Figure 27: Distribution of peak expiratory flow rate by HIV status......281
Figure 28: Prevalence of clinical herpes by HIV status.....................284
Figure 29: Anogenital wart history by HIV status.............................286
Figure 30: Gonorrhoea history by HIV status..................................287
Figure 31: Prevalence of Major Depressive Episode by HIV status and in comparison groups.........................293
Figure 32: Prevalence of Dysthymic Disorder by HIV status and in comparison groups.........................294
Figure 33: Suicidal ideation in last two weeks by HIV status and comparison with ideation in prior year in a population sample of Australian heterosexually-identified men.

Figure 34: Cross-sectional prevalence of anxiety disorders by Prime-MD in cohort.

Figure 35: Rates of current smoking by HIV status and comparison with males in NDSHS98.

Figure 36: Probable alcohol use disorder by HIV status and compared with rate (by CIDI) in SA males.

Figure 37: Cannabis use in last year by HIV status and comparison with males in NDSHS98.

Figure 38: Nitrite Use in Last Year by HIV status and comparison with males in NDSHS98.

Figure 39: Amphetamine use in last year by HIV status and compared with rate (by CIDI) in SA males.

Figure 40: LSD use ever by HIV status and comparison with males in NDSHS98.

Figure 41: Ecstasy use in last year by HIV status and comparison with males in NDSHS98.

Figure 42: sf36 profile for cohort on enrolment compared with SA population norms for men.

Figure 43: sf36 profile for cohort on enrolment compared with SA population norms and Lin & Ward study (1998).

Figure 44: Likely cause of death in cohort members.

Figure 45: Homosexually active at all in last six months by Major Depressive Episode.

Figure 46: Proportion reporting UAI-C, men with DD but not MDE vs remainder of cohort.

Figure 47: Follow up of C&PP participants to June 30th, 2003.

Figure 48: Major Depressive Episode prevalence, all participants.

Figure 49: Major Depressive Episode prevalence, repeated measures.

Figure 50: sf36 Physical Function score.

Figure 51: sf36 Role Physical score.

Figure 52: sf36 General Health score.

Figure 53: sf36 Bodily Pain score.

Figure 54: sf36 Vitality score.

Figure 55: sf36 Social Function score.

Figure 56: sf36 Role Emotional score.

Figure 57: sf36 Mental Health score.

Figure 58: Change in overall sf36 profile.
Feeling Queer: Primary Health Care & homosexually active men

Figure 59: Major Depressive Episode prevalence........................................398
Figure 60: Dysthymic Disorder prevalence..............................................399
Figure 61: Suicidal ideation in prior two weeks.........................................400
Figure 62: Panic Disorder prevalence.........................................................401
Figure 63: Generalised Anxiety Disorder prevalence..................................402
Figure 64: Proportion reporting UAI-C in prior six months (all participants) and comparison with 1999 and 2001 Periodic Surveys...........404
Figure 65: Proportion reporting UAI-C in prior six months (repeated measures) and comparison with 1999 and 2001 Periodic Surveys.....404
Figure 66: HIV non-concordant UAI-R..........................................................406
Figure 67: HIV discordant UAI-R...............................................................406
Figure 68: Change in tobacco use level.......................................................408
Figure 69: Change in alcohol use level........................................................409
Figure 70: Change in cannabis use level.....................................................410
Figure 71: Change in nitrite use level...........................................................411
Figure 72: Change in amphetamine use level.............................................412
Figure 73: Change in LSD & related substance use level.............................413
Figure 74: Change in ecstasy use level.......................................................414
Figure 75: Change in heroin use level.......................................................415
Figure 76: Change in injecting drug use level.............................................416
Figure 77: Overall satisfaction with Programme at each review....................422
Figure 78: Satisfaction with care coordination at each review......................423
Figure 79: Satisfaction with dietetic service at each review........................425
Figure 80: Satisfaction with physiotherapy service at each review..............427
Figure 81: Satisfaction with massage therapy at each review......................429
Figure 82: Satisfaction with dental assessment service at each review.........431
Figure 83: Satisfaction with GP service at each review..............................432
Figure 84: Satisfaction with psychiatry service at each review....................434
Figure 85: Satisfaction with surgical service at each review.......................436
Abstract

Feeling Queer:

Can a Primary Health Care approach mitigate health inequity experienced by homosexually active South Australian men?

by Gary Rogers MB, BS, MGPPsych(Clinical)

Supervised by:

Professor Justin Beilby, Professor Deborah Turnbull,

(and formerly by Professor David Wilkinson)

Health inequity refers to differences in health status between populations (health inequalities) that are unnecessary and avoidable and, additionally, are considered unfair or unjust.

The history of the concept is reviewed and the mechanisms by which inequity affects health surveyed, with a focus on multi-level models of health production. The origins and development of the Primary Health Care approach is then considered with an emphasis on the Australian setting and on HIV/AIDS policy.

The construct of homosexuality is then explored and concepts of sexual attraction, ‘orientation’, identity and behaviour differentiated. What is known about the health characteristics of homosexually active men in the First World is then surveyed by means of a systematic literature review. It is concluded that there is evidence that they are affected by substantial health inequality in a range of areas including mortality, suicidality, depressive disorders, anxiety disorders, report of childhood sexual abuse and problematic substance use. Few of these inequalities have been confirmed in the Australian context, however, and almost none have been confirmed specifically in South Australia.

The background to the development of a Primary Health Care programme focused on homosexually active men, is then described. The baseline health characteristics of the programme’s cohort of 542 homosexually active South Australian men (including their sexual behaviour in the context of HIV transmission) are described and compared with other samples of men to identify inequalities. It is concluded that men in the cohort were subject to health inequality in a wide range of health parameters including mortality, suicidality, sexually transmitted infections, depressive and anxiety disorders, levels of substance use and self-rated health on the short-form 36 (sf36) instrument.
The relationships between these characteristics and factors indicative of disadvantage and victimisation are then explored. It is concluded that many of the health inequalities identified were related to sociohistorical factors such as emotional withdrawal by one’s father, low income, unemployment, reduced educational attainment, and recent experience of violence and abuse from strangers. It is argued that some of these factors can be considered to be examples of unfairness and injustice and that, as a consequence, at least some of the health inequality experienced by this population is also health inequity.

The elements of the Primary Health Care programme devised to meet the needs of homosexually active men is described and the trajectory of health characteristics of its participants over three time points is examined.

210 homosexually active men had reached Second Review, an average of thirty-six months after enrolment, by the time of analysis. Among this group, significant sustained improvement in a range of health outcomes, including prevalence of depressive disorders, sf36 scores and rate of recent suicidal ideation, is reported in association with involvement in the programme.

Participant’s subjective satisfaction with the programme is then described and their beliefs about the causes of their improved health explored using a qualitative methodology. It is concluded that the programme had largely met the needs of participants and they believed that it had been responsible for their improved health.

Limitations of the study are considered and discussed. Limitations of the investigation to identify health inequality include questions of external validity arising from the absence of a perfect comparator group and concerns with construct validity related to the possibility of geographical and cultural variation in definitions of ‘homosexually active men’. In the investigation to determine the extent to which health inequalities were also examples of inequity, issues of conclusion validity are discussed particularly in relation to multiple comparisons and the balance between Type I and Type II errors.

In the evaluation of the impact of the Primary Health Care programme, there are concerns about internal validity resulting from the absence of randomisation and an uncontrolled design. The components of this issue are discussed and some support for internal validity is found in the reported subjective beliefs of participants about the cause of their health improvement and the outcomes of critical reflection by the programme team.

The implications of the findings for policy, practice and further research are explored. It is argued that the health inequity experienced by people of sexual diversity will require profound social change for complete resolution. In the meantime, however, focused Primary Health Care with a community of sexual diversity has the potential to mitigate the health inequity its members experience and to help them to survive and function while they wait for a fairer and kinder society.
Candidate’s statement

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

__________________________________ Date: ___________________
Gary Rogers

Date: 1st May, 2006
Acknowledgements

This thesis was written, and the research to which it refers was conducted, on the land of the Kaurna people.

The thesis is informed by data collected in the course of the operation of a coordinated Primary Health Care service focussed on homosexually-active men in South Australia, between 1998 and 2003.

The service, which is now known as The Care and Prevention Programme, began operating at the start of 1998 as a project of the Adelaide Central and Eastern Division of General Practice funded by the (then) Commonwealth Department of Health and Family Services. In 2000 it was transferred to the Department of General Practice at the University of Adelaide and has been funded since that year by what is now the South Australian Department of Health. Small additional grants have been received from several pharmaceutical companies to assist with the provision of extended allied health services to participants.

The author conceived the Programme in consultation with members of the communities it serves, and has managed it since it began.

He devised its protocols, questionnaires and database and has undertaken all of the data analysis.

He is indebted to the participants in the Care and Prevention Programme for their inspiration, patience and generosity.

He also expresses deepest thanks to the other members of the Programme team for their assistance with the gathering of data and provision of care, as well as their wise counsel and advice, namely:

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Feeling Queer: Primary Health Care & homosexually active men

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Thesis map

PART ONE
Context:
What do the terms in the question mean and what is known already?

PART TWO
Characteristics of health:
Were homosexually active men enrolling in a Primary Health Care programme subject to health inequality?

PART THREE
Correlates & Consequences:
Was the health inequality also health inequity, and how was this related to HIV transmission behaviours?

PART FOUR
Counter Measures:
How was a Primary Health Care approach applied and what changed in association with its use?

PART FIVE
Conclusions:
What were the findings, what are their limitations and what more needs to be done?

Chapter 1: Health Inequity
What are the origins and meanings of this concept?

Chapter 2: A Primary Health Care Approach
What is the history and the elements of this approach?

Chapter 3: Homosexually Active Men
What is meant by this term, and what is already known about the group's health and social

Chapter 4: Background to the establishment of the Care and Prevention Programme
How did the Programme come to be established?

Chapter 5: The Care & Prevention Program Cohort
What methods were used for recruitment, assessment, comparison with other populations and analysis?

Chapter 6: Health Characteristics of the Cohort and Comparators
What were the results of the comparison for health inequality?

Chapter 7: Social and Historical Correlates
Did the social and historical correlates of the characteristics suggest the health inequality was also health inequity?

Chapter 8: Sexual Behaviour Correlates
How were the health characteristics related to sexual behaviours with the potential for HIV transmission?

Chapter 9: Application of a Primary Health Care Approach
How was the Primary Health Care Approach applied in the Care and Prevention Programme?

Chapter 10: Quantitative Measures of Outcome
How had the health characteristics changed in reviewed participants?

Chapter 11: Subjective and Qualitative Measures of Outcome
What other outcome were observed and how?

Chapter 12: Summary of Findings
How has the study contributed to knowledge?

Chapter 13: Limitations of Study
What issues need to be born in mind in assessing this contribution?

Chapter 14: Implications of the Study for Future Policy, Practice and Future Research