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Gay and other men who have sex with men (MSM) of Asian background (GAM) are emerging as a pivotal group in efforts to eradicate HIV in Australia. Once a seemingly unassailable target, ending HIV transmission is now a realistic prospect in some Australian states. One such state is New South Wales (NSW), a region in which a robust HIV prevention strategy has led to the stabilisation of notification rates in the general population.[1] Having achieved the 90–90–90 goals set out by UNAIDS,[2] NSW Health has now targeted the virtual elimination of HIV transmission in the state by 2020.[1] There is growing recognition that if this is to be attained, a focused approach to combat HIV acquisition in high-risk populations is key.

Although MSM have long been recognised as a priority population in HIV prevention efforts, we are yet to fully characterise the impact of ethnicity on the care-seeking behaviour of this inherently heterogeneous population. This has clear relevance in NSW today, with surveillance data highlighting diverging trends in notification rates between MSM of different ethnic backgrounds.[1,3] This reflects trends seen on a national level: Australia-wide, data indicate that although the number of notifications involving Australian-born MSM is trending downward, notifications relating to overseas-born MSM continue to increase.[3] Indeed, available data from 2017 and the first quarter of 2018 indicate that the number of new HIV diagnoses in NSW pertaining to overseas-born MSM over this period exceeded that of their Australian-born counterparts for the first time.[1,4] Both local and national data suggest that MSM of Asian origin account for an increasingly large proportion of new diagnoses among overseas-born MSM, with GAM accounting for 40% of such diagnoses in NSW in the first quarter of 2018.[4] If we are to achieve the goals set out by NSW Health, the importance of a nuanced approach to the growing HIV epidemic in this group is clear.

estimated response rate of around 40–50%. For the purposes of the survey, 'frequent' HIV testing was defined as a minimum of two tests in the preceding 12 months, with 'comprehensive' STI testing defined as a minimum of one throat swab, one anal swab, one urine sample and one blood test either for syphilis or for other STIs (excluding HIV) over the same period.

Data were analysed through descriptive analysis, and bivariate analyses (i.e. cross-tabs, t

practices at the bivariate level between the two subgroups. Compared with Group 1, men in Group 2 were substantially more sexually active: they were more likely to have multiple regular or casual male partners ($P = 0.001$) and to have had more than 10 male partners in the 6 months before survey ($P < 0.001$). Group 2 participants also reported using more approaches (either online or offline) to find male partners in the previous 6 months (Group 2 median = 2 vs Group 1 median = 1; $P < 0.001$). Further, Group 2 participants were more likely to participate in condomless anal intercourse with both casual ($P < 0.001$) and regular partners ($P = 0.002$). Group 2 participants were more likely to have engaged in group sex ($P < 0.001$) and to report the use of party drugs for sex in the preceding 6 months ($P < 0.001$). Men in Group 2 were also more likely than their Group 1 counterparts to know their current regular partner's HIV status ($P = 0.008$) and to have shared information about HIV status during casual sexual encounters in the 6 months before survey ($P < 0.001$).

As indicated in Table 3, there were statistically significant differences (at $P < 0.05$) in HIV- and STI-related clinical service engagement at the bivariate level between the two subgroups. Compared with Group 1, men in Group 2 were significantly more engaged with HIV and STI testing, with Group 2 participants self-identifying more reasons to test than their Group 1 counterparts ($P < 0.001$). Although Group 2 participants most frequently reported having used sexual health clinics or associated community-based peer testing sites ($P < 0.001$) for their latest HIV test, they were also more likely than Group 1 to have multiple channels through which to obtain HIV and STI knowledge ($P < 0.001$). Group 2 participants were more likely to know about the current availability of PEP ($P < 0.001$) and PrEP ($P = 0.017$), with a higher proportion of them reporting use of PEP ($P = 0.001$) and PrEP ($P < 0.001$) in the preceding 6 months.

For the multivariable logistic regression analysis, key sociodemographic variables and variables that were statistically significant at the bivariate level were entered into the initial model. As indicated in Table 4, the final reduced

these gay-friendly sexual health services (both clinic based and community peer led) should be a priority moving forward.

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at risk of infection. It is essential that culturally appropriate

health-needs-of-culturally-diverse-men-who-have-sex-with-men/ [verified 11 November 2019].

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