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Place and practice: Sexual risk behaviour while travelling abroad among Swedish men who have sex with men

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ABSTRACT

Background: The proportion of newly diagnosed HIV and STI cases among men who have sex with men (MSM) that were contracted abroad has been increasing in Sweden. The present study explored factors associated with casual unprotected anal intercourse (UAI) and travelling abroad among MSM.

Methods: A cross-sectional stratified survey with 2751 MSM was conducted. The frequency of sexual practices among men who had casual UAI abroad (< 12 months) with that of men who had casual UAI only in Sweden were compared and factors associated with casual UAI abroad were identified through regression analysis.

Results: Factors associated with casual UAI abroad within the previous 12 months were: visit a gay sauna (OR 6.15, 95% CI 3.43–11.06), visit gay café/bar/pub (OR 3.24, 95% CI 1.62–6.48), experience of UAI with a foreign visitor (OR 4.80, 95% CI 2.37–9.75), living with HIV (OR 2.73, 95% CI 1.15–6.48), reporting poor overall health (OR 2.24, 95% CI 1.13–4.44), being born outside Sweden (OR 2.21, 95% CI 1.08–4.53), and being vaccinated against hepatitis A, hepatitis B, or both (OR 1.92, 95% CI 1.13–3.27).

Conclusion: MSM who engage in casual UAI abroad need to increase their understanding of related risks and that risk varies with place and practice. Health care professionals should address the preventive needs of traveling MSM and offer counselling and STI-preventive measures.

1. Introduction

Transnational travel is steadily increasing in both Europe and the rest of the world [1]. Travel within Europe has been facilitated by the Schengen agreement, and over a ten year period from 1996 to 2006 all foreign travel grew by over 50% among Swedish residents [2]. Leisure travel has increased the most, accounting for more than half of the trips abroad, with 60% of Swedish residents claiming they travel at least one week per year [2,3].

Ease of travel is particularly valuable for minorities such as men who have sex with men (MSM) because it broadens opportunities for visiting social and sexual environments that cater to their interests [4]. Hughes [5] argues that travelling abroad is a way for MSM to be able to construct identity, be openly gay, and be anonymous. Recently, a Swedish gay magazine encouraged readers to take a last-minute day trip to Berlin to buy an outfit for an upcoming gay leather party in Stockholm [6]. Stockholm, the capital of Sweden, is officially promoted as an LGBT destination by the city's Visitors Board; hotels, museums, and even the royal court collaborate to attract LGBT tourists from around the world. Therefore, the global community of MSM 'is defined less by geographic boundaries and linked more by shared interests and social and sexual networks' [4].

Previous research has observed an association between travel and behavioural disinhibition [7,8]. It has been suggested that casual sex while travelling triples the risk of becoming infected with a sexually transmitted infection (STI) MSM in particular have sex abroad more often, and have a larger number of sexual partners abroad, than other travellers [9]. A high prevalence of HIV among MSM residing in places to which MSM commonly travel, such as Berlin and London, is hypothesized to increase the risk of acquiring HIV or other STIs abroad for MSM [4]. HIV/STIs testing and treatment varies among countries mainly by availability and cost, sampling routines, and treatment

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options (i.e., use of pre- and post-exposure prophylaxis and antiretroviral therapy for HIV), which contributes to geographical differences in the transmission risk of HIV and STIs [10].

Previous studies have shown that condom use abroad is inconsistent and risk behaviour in general may increase while one is abroad and [9,11]. Several studies of risk behaviour among travelling MSM have used non-probability methods and recruited participants in party-oriented destinations, potentially skewing the samples towards men who are more interested in risky practices and who have higher incomes than average [7,12,13]. Other studies have shown that MSM engage in unprotected anal intercourse (UAI) less often when travelling abroad than when travelling domestically or staying at home [14,15]. Moreover, it has been hypothesized that persons engaging in risky behaviour at home are also doing it while abroad, implying that place in itself is not the decisive factor [12,16,17]. Factors such as place and partner preferences, or number of partners are not decisive for transmission of infection because HIV and STIs require sexual risk behaviour in order to be transmitted onwards. Among MSM, UAI is the foremost route of transmission of HIV, with receptive UAI carrying the largest estimated transmission risk at 1.4% (95% CI 0.2–2.5) per act and per partner [18,19].

HIV is a notifiable disease in the Swedish Communicable Disease Prevention Act (2004:168). Physicians and laboratories that diagnose a new case of HIV are obliged to report the case with anonymized code to the national electronic surveillance system SmiNet [20]. The patient and the physician are both obliged to conduct contact tracing in order to identify the transmission route and hinder further transmission of HIV. It is recommended, but not obliged, that physicians contact previous sexual partners residing abroad [21]. From 2010 to 2014, 52% of all reported HIV cases among MSM were reported as contracted abroad (Table 1), an 11% increase compared with the previous 5-year period. A substantial increase has also been observed for other STIs among MSM in Sweden. The number of reported cases of gonorrhoea, syphilis, and chlamydia trachomatis increased between 2005–2009 and 2010–2014, and the proportion of cases reported as contracted abroad increased by 6–10% for each of these STIs (Table 1).

The European MSM internet survey (EMIS), conducted in 2010, showed that 26% of the respondents reported having sex abroad within the previous 12 months [22]. Older age, higher education, residing in a large city, and living with HIV were all associated with having sex abroad in the previous 12 months. Spain and Germany were the most common destinations where the respondents reported having sexual contacts, and 62% of the men who reported having sex with a man abroad had anal intercourse at their most recent sexual encounter abroad. Among these, a quarter reported not using a condom. UAI was more commonly reported by men living with HIV and men with less education. The analysis of the Swedish EMIS data showed similar results with 30% reporting having sex abroad within the previous 12 months. A third of the 57% of Swedish participants who had anal intercourse at their most recent sexual contact abroad reported not using a condom.

The available data suggest that MSM having casual sex while travelling abroad are exposed to a higher risk of contracting an STI or HIV than when at home. Improved knowledge of risk behaviour among MSM having casual sex abroad is needed to strengthen and direct HIV and STI preventive measures. The aims of this study were: 1) to assess differences in sexual practices between men having casual sex abroad and men having it at home and 2) to explore the factors associated with having casual UAI abroad.

2. Method

2.1. Study setting, recruitment, and sample

All analyses were conducted on data from MSM2013, a nationwide anonymous cross-sectional web survey undertaken October 1–31, 2013, via Qruiser, a Scandinavian LGBT internet community. Non-female web community members listed as Swedish residents 15 years or older were eligible for participation. No personal identification data were collected, and informed consent to participate was given by actively clicking the link to participate at the end of the invitation message. Out of 52,979 eligible members, 14,514 were selected using stratified random sampling by age and county of residence to provide a sample that was representative of the community population. The selected members were invited to participate via a Qruiser inbox message with an individual link to the survey. A total of 2751 participants answered the questionnaire. A detailed description of the methods and questionnaire has been published elsewhere [23]. The dataset used in the present study consisted of 2373 participants who reported ever having sex with a man, who were Swedish residents, and who replied to more than just the socio-demographic questions. Fig. 1 provides an overview of the inclusion process for the present study. Ethical approval was obtained from the Regional Ethical Review Board, Stockholm, Sweden (2013/248-31/3).

2.2. Variables

The respondents were categorized based on sexual practices. Respondents reporting having had UAI with casual male sex partners only within Sweden within the previous 12 months were categorized as ‘not abroad’. Respondents having had UAI with male casual sex partners abroad or both abroad and in Sweden were categorized as ‘abroad’ (Fig. 1). The latter could indicate in what countries they had sex from a list of all countries. In addition, they could indicate the country of origin of their sex partners and whether they had receptive and/or insertive UAI. They could also specify if they had engaged in other sexual practices when having UAI including insertive oral sex, receptive oral sex, masturbation to someone else, receptive masturbation, rimming, being rimmed, sharing sex toys, insertive fisting, receptive fisting, urine/faeces sex, threesome, group sex, giving money/compensation for sex, receiving money/compensation for sex, agreeing beforehand to not use a condom (barebacking), binge drinking, poppers use, drug use, and erectile dysfunction medication use.

Several independent variables were examined for association with

Table 1
Reported cases of male-to-male sexually transmitted HIV and other STIs in Sweden by reported place of exposure in 2005–2009 compared to 2010–2014.[a]

	HIV		Gonorrhoea		Syphilis		Chlamydia trachomatis	
	2005–2009	2010–2014	2005–2009	2010–2014	2005–2009	2010–2014	2005–2009	2010–2014
Reported cases	2222	2308	3347	5341	873	1120	192,462	183,805
Numbers and proportions of cases reported to be male-to-male sexually transmitted	590 (27%)	635 (33%)	1148 (34%)	1918 (36%)	387 (44%)	608 (54%)	1846 (1%)	2924 (2%)
Transmitted within Sweden	333 (56%)	295 (46%)	921 (80%)	1496 (78%)	261 (67%)	355 (58%)	1501 (81%)	2208 (76%)
Transmitted abroad	240 (41%)	328 (52%)	182 (16%)	404 (21%)	114 (30%)	240 (40%)	209 (11%)	499 (17%)
Place of transmission unknown	17 (3%)	12 (2%)	45 (4%)	18 (1%)	12 (3%)	13 (2%)	136 (8%)	217 (7%)

[a] Source: SmiNet, The Public Health Agency of Sweden.