School of Public Health

Collaboration for Evidence, Research and Impact in Public Health

Investigating Australian Male Expatriate, Longer-Term and Frequent Traveller Social Networks in Thailand to Determine Their Potential to Influence HIV and Other STI Risk Behaviour

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Doctor of Philosophy
of
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Declaration

I declare that to the best of knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis is my own account of my research and contains no material which has been accepted for the award of any other degree or diploma in any other university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated 2018. Prior to the commencement of this research, ethical approval was received from the Curtin University Human Research Ethics Committee, Approval Number: SPH – 13 – 2012.

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The original work presented for examination was undertaken by the author. Development of study design, obtaining ethical approval, data collection and analysis, development of manuscripts for publication and thesis writing was conducted under the supervision of Professor Bruce Maycock, Dr Roanna Lobo and Associate Professor Graham Brown.

Gemma Crawford

24/10/2019

What men call gallantry, and gods adultery, is much more common where the climate's sultry.

- Don Juan, G.G. Byron, 1818–1824 -

Abstract

Background

Notifications of Human Immunodeficiency Virus (HIV) infections acquired overseas have increased in Western Australia (WA) over the last decade amongst men travelling, living and working in Thailand and Southeast Asia (SEA). This grounded theory study sought firstly to understand social network processes of Australian male expatriates, longer-term or frequent travellers (ELoFTs) to Thailand. Secondly the research sought to explore how ELoFT social networks may be harnessed for public health intervention, particularly via peer education and social influence; a cornerstone of Australia's historical HIV response.

Methods

Symbolic interaction provided the theoretical lens for this study. Data were collected via a systematic literature review; in-depth interviews (n=25) with heterosexual men and men who have sex with men; five users of an online forum and the analysis of posts (n=500); fieldwork visits to Thailand (n=3) including setting and venue observations (120 hours) and informal conversations with stakeholders (n=8). An explanatory conceptual model was developed to support the grounded theory.

Results

For ELoFTs to flourish in the liminal space, strong networks were important social survival strategies. *Identity, adjustment, support, pathways, motivation, risk, home and place* were the processes and context through which the ELoFT's sense of self was shaped, how social norms were communicated and how *community and communitas* were formed. ELoFTs indicated a small core network of strong ties, bonding together ELoFTs with similar interests and values. A wider peripheral network was also evident comprising weak ties with looser, less frequent connections; a bridge to a diverse group with a broader set of attitudes and experiences. Both components of the network had instrumentality to strengthen or diminish health harming or enhancing knowledge, attitudes or practices. Key features which suggested utility from a public health perspective were: *influential people, influential places* and *influential points*.

Conclusion

Findings from this study shed light on future public health intervention and policy design. Australian ELoFTs in Thailand have strong social networks comprising key actors and assets which can be used for intervention to reduce HIV and other STI risk. In the context of population mobility, reducing overseas acquired HIV notifications in WA requires close examination of the connection between local and global, and consequent complexity of networks, settings, behaviours, norms and contexts for risk and for prevention.

Dedication

The moment you doubt whether you can fly, you cease for ever to be able to do it.

- Peter Pan, J.M. Barrie, 1904 -

To Marcia and Ian for always telling me I could

and to Gavin for never telling me I couldn't.

I dedicate this thesis to the participants in this study and to those living with HIV in Australia and Southeast Asia. I am grateful for your generosity, for sharing your knowledge and stories and for continuing to inspire me to work in this area of public health.

Thank you.

Acknowledgements

Curiouser and curiouser!

- Alice's Adventures in Wonderland, L. Carroll, 1865 -

A PhD is a curious journey; it tests your resolve. It is not a spectator sport, not for the faint of heart. It kicks you when you're down. In the dark but beautiful way only he could, Anthony Bourdain wrote of travel in the way I have thought about my PhD, "*Travel isn't always pretty. It isn't always comfortable. Sometimes it hurts, it even breaks your heart. But that's okay. The journey changes you; it should change you. It leaves marks on your memory, on your consciousness, on your heart, and on your body. You take something with you. Hopefully, you leave something good behind*"[1].

For those like me who have taken a little time to complete, the PhD sits on your shoulder, hanging on with grim determination as you stumble to the end. At times, it had a tendency to make me feel hopeless. But the words of Rebecca Solnit gave pause*, "power comes from the shadows and the margins…our hope is in the dark around the edges, not the limelight of centre stage. Our hope and often our power"*[2]*.* I gave to this work my hope, and found in it my power. To that end, I would like to take this opportunity to thank those who nurtured that hope and power and who celebrated my choice to take on this challenge.

Trish and my former colleagues at the Western Australian AIDS Council, particularly Mark and Sally, your steadfast determination, wit and ability to see the light and shade has been formative in showing me what it takes. To Lisa, Sue and the team at SHBBVP and to the agencies and organisations that provided support for this project, thank you for helping the world take notice of HIV and for working to show that WA is a little bit different.

My appreciation to the examiners and reviewers for your constructive feedback. Jenny, I received your encouragement gratefully. Sarah and Tina, you calmly stepped in just at the right moment-thank you. I am indebted to the staff who have supported this research particularly Nicole, Rochelle, Kahlia, Chloe and Hannah. Thank you for smoothing the path. Rochelle and Kahlia - I hope to return the love. Corie - for carrying on with the HIV mobility journey I wish you all good things for your research.

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[1] Bourdain A. 2007. *No Reservations: Around the World on an Empty Stomach*. London, UK: Bloomsbury USA.
[2] Solnit R. 2016. *Hope In The Dark: Untold Histories, Wild Possibilities.* Edinburgh, UK**:** Canongate Books Ltd

Thank you SoPH colleagues, particularly Ann, Gary, Toni, Helen, Caroline, Deb and my former Head, Sue for your encouragement. To those in health promotion and public health, particularly AHPA (the Board, specifically Michele, Suzanne and Melinda), my gratitude for picking up the slack, for an empathetic ear and your belief I would get there, in the end.

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To Sharyn, my Chair who has been there from the beginning, thank you for your warm encouragement, sensible suggestions and interest in my work.

To the people of Thailand who played host to me across the span of this PhD but whose voices are quiet in this research. I hope for your understanding of the work that I have done and the contribution it might make, in some small way towards reducing HIV transmission amongst mobile and migrant populations in your country and mine.

It was Ralph Waldo Emerson who said that *"our chief want in life is somebody who will make us do what we can".* To Bruce, to Roanna and to Graham – thank you for your mentorship and for impelling me forward especially when I would have happily given up.

Graham, without your encouragement I would never have set out on this journey. Your advocacy, your commitment and endeavours in this area of public health are in part what have sparked mine. Your influence is greater than you could know.

Roanna, my gratitude for your grace and consideration and for your faith in me. You have pressed me to make the final product reflective of work that was undertaken. Your friendship has been an unexpected and joyous bonus.

Bruce, my appreciation for your levity and for talking me down my ladder when the going got tough. Thank you for creating the space to PhD student from time to time. I have valued your steady hand in steering the ship and have learned both as a student and an academic and surely this is the definition of research training.

I am grateful to you all for coming with me on this long journey, much longer than you should have had to bear, for putting up with the bad days and for celebrating the good. From Perth to Phuket and back again, I thank you.

To Justine - one of the best people I know. I admire your work ethic, sense of fun and your willingness to roll up your sleeves. Marcel Proust encouraged us to be grateful to those who make us happy, describing them as "*the charming gardeners who make our souls blossom"*. How fortunate then that I am to have met you (and the Professor) – you charming gardeners. Much love for leading my cheer squad, for being my Endnote guru, for letting me vent and for shouldering the load when the going got tough. I look forward to more adventures, high teas, flower-arranging, elf duties, cocktails and rounds of ging gang goolie.

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In The Little Prince, Antoine de Saint-Exupéry wrote, "*it is the time you have wasted for your rose that makes your rose so important"*[3]. So, for those who were there at the beginning and who have stood with me to the end, it has certainly been a longer than expected journey. To my family and friends, your support and interest (even when it bored you silly) has sustained me. Thank you for all the times you asked and all the times you knew not to. Thank you for inspiring curiosity and a desire to ask why, for editing and reading my work, for the dinners and cups of tea, for always showing up, and for loving me, no matter what.

As Robert Louis Stevenson once noted, *"perpetual devotion to what a (wo)man calls (her)his business, is only to be sustained by perpetual neglect of many other things".* For that which lay neglected while assembling this bricolage - I am coming for you.

Finally, to all those who choose to embark on this journey - I wish you calm seas and swift winds.

Nolite te bastardes carborundorum.

The world is better for your curiosity.

[3] de Saint-Exupéry A. 1943. *The Little Prince.* New York, US: Reynal & Hitchcock.

Peer Reviewed Publications

Publications included as part of this thesis

1. **Crawford G,** Lobo R, Brown G and Maycock B. The influence of population mobility on changing patterns of HIV acquisition: lessons for and from Australia. *Health Promotion Journal of Australia.* 2016; 27(2), 153-154. doi:https://doi.org/10.1071/HE15042 (Impact Factor: 1.333)

2. Brown G, Ellard J, Mooney-Somers J, Prestage G, **Crawford G*** and Langdon T. 'Living a life less ordinary': exploring the experiences of Australian men who have acquired HIV overseas. *Sexual Health*. 2014; 11(6), 547-555. doi:https://doi.org/10.1071/SH13155 (Impact Factor: 1.421) *corresponding author

3. **Crawford G,** Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV and STIs amongst expatriates and travellers to low and middle income countries: A systematic review. *International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249 (Impact Factor: 2.468)

4. **Crawford G,** Bowser N, Brown G and Maycock B. 2013. Exploring the potential of expatriate social networks to reduce HIV and STI transmission: a protocol for a qualitative study. *BMJ Open.* 2013; 3 (2):e002581. doi:10.1136/bmjopen-2013-002581 (Impact Factor: 2.376)

5. **Crawford G,** Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research.* 2018; 20(9):e10787. doi:10.2196/10787 (Impact Factor: 4.945)

Statement of Contribution

This study was conducted through the Collaboration for Evidence, Research and Impact at Curtin University and part funded by the WA Department of Health, the WA AIDS Council, NT Health and La Trobe University. The author managed the project which involved: conceptualising the study design; developing and implementing the intervention; and the collection, analysis and interpretation of data. Publications 1, 3, 4 and 5 were written by the thesis author with input from co-authors as outlined below. Publication 2 was conceptualised by a thesis supervisor with drafting, critical revision and intellectual contribution from the thesis author who was also the corresponding author for this paper. The following individuals were directly involved as supervisors and/or co-authors for publications arising from this study.

Professor Bruce Maycock: contributed as primary supervisor. He had an ongoing close involvement with the research, including contributing to the project proposal, providing feedback on research findings, discussing the structure of publications, the reading of drafts and making suggestions for improvements to Publications 1, 3-5.

Dr Roanna Lobo: contributed as a co-supervisor. She had an ongoing close involvement with the research, including providing feedback on research findings, discussing the structure of publications, the reading of drafts and making suggestions for improvements to Publications 1, 3 and 5.

Associate Professor Graham Brown: contributed as a co-supervisor. He had an ongoing close involvement with the research, including contributing to the project proposal, discussing the structure of publications, the reading of drafts and making suggestions for improvements to all publications. He conceptualised and co-drafted Publication 2.

Nicole Bowser: provided research support, read and approved the draft for Publication 4.

Rochelle Tobin: provided assistance with recruitment and data collection, read and approved the draft for Publication 5.

Chloe Macri and Hannah Smith: provided research support, read and approved the draft for Publication 3.

Signed statements of contribution are included in Appendix B.

Abbreviations

ABS	Australian Bureau of Statistics
ACON	AIDS Council of New South Wales
AFAO	Australian Federation of AIDS Organisations
AIDS	Acquired Immune Deficiency Syndrome
AIVL	Australian Injecting & Illicit Drug Users League
ARCSHS	Australian Research Centre in Sex, Health and Society
ART	Antiretroviral treatment
ASHM	Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine
BBV	blood-borne virus
COREQ	consolidated criteria for reporting qualitative research
DoHA	Department of Health (Commonwealth)
DoHWA	Department of Health (Western Australia)
DoI	Diffusion of Innovation
ELoFT	expatriate, longer-term and frequent traveller
EMPOWER	Education Means Protection Of Women Engaged in Recreation
FIFO	Fly-in fly-out
GMSM	Gay men and other men who have sex with men
GP	General Practitioner
HBV	hepatitis B
HIC	high-income country
HIV	Human Immunodeficiency Virus
HIVST	HIV self-testing
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LHIV	Living with HIV
LOS	Land of Smiles (slang for Thailand)
NAPWHA	National Association of People Living with HIV and AIDS
NSW	New South Wales
NT	Northern Territory
OECD	Organization for Economic Co-operation and Development
PEP	Post-exposure Prophylaxis
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RSAT	Rainbow Sky Association of Thailand

SA	South Australia
SEA	Southeast Asia
SiREN	Sexual Health and Blood-Borne Virus Applied Research and Evaluation Network
SSA	sub-Saharan Africa
STIs	sexually transmitted infections
SWING	Service Workers In Group
TaSP	Treatment as Prevention
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
USA	United States of America
VIC	Victoria
WA	Western Australia
WAAC	Western Australian AIDS Council
WHO	World Health Organization

Definitions

Asia-Pacific region	"A geographical scope that stretches from Turkey in the west to the Pacific island nation of Kiribati in the east, and from the Russian Federation in the north to New Zealand in the south. The Asia and the Pacific region is home to 4.1 billion people, or two thirds of the world's population" (United Nations n.d.).
Australian	Being born in Australia or having long-term residency in Australia
CD4	"A type of white blood cell that protects the body from infection. CD4 cells are the primary target of HIV, and CD4 cell numbers decline during HIV disease" (Pepin 2011).
Combination prevention	Combination prevention is a framework used in HIV prevention, incorporating behavioural, biomedical and structural strategies.
"Communification"	Connecting an individual to a community involving a process of meaning making through communication of symbols that can arouse strong attachments (Chen 2016; Cavusoglu and Demirbag-Kaplan 2017).
Communitas	Communitas is the shared, ritual experience that takes shape when like–minded people come together in groups that emerge in liminal places where pre-existing social structure, is absent (Turner 1969).
Concentrated epidemic	The HIV prevalence rate is 5% in at least one high-risk subpopulation, such as GMSM, PWID, sex workers or the clients of sex workers (International Organization for Migration 2011; World Health Organization 2013).
Constructionist epistemology	Meaning is created through an interaction of the interpreter and the interpreted (Levers 2013).
Contain and control	Traditional approach to public health and disease outbreak.
Country of destination	Thailand (or other Southeast Asian countries)
Country of origin	Australia
Culture	The concept of culture used in this study is taken from the Symbolic Interaction perspective as used by Charon and includes use of significant symbols and ritual (Blumer 1969; Charon 2001).
Diaspora	Populations outside their country of origin usually sustaining ties and developing links both with that country of origin and across countries of settlement/residence (THP Foundation 2008). Dispersion or spread of any people from their original homeland (Oxford Dictionary 2017).
Dramaturgy	Dramaturgy refers to a metaphorical perspective on social life that sees interaction as a performance for an audience (Manning 2016).
Endemic	When a disease occurs frequently and at a predictable rate in a specific location or population (US Department of Health and Human Services 2019).
Epidemic	"A widespread outbreak of a disease in a large number of individuals over a particular period of time either in a given area or among a specific group of people" (US Department of Health and Human Services 2019).

Epidemiology	"Deals with incidence, distribution and possible control of disease" (Oxford Dictionary 2017).
Epistemology	"concerned with the nature and forms of knowledge. Epistemological assumptions are concerned with how knowledge can be created, acquired and communicated, in other words what it means to know. Guba and Lincoln (1994, p 108) explain that epistemology asks the question, what is the nature of the relationship between the would-be knower and what can be known?" (Scotland 2012).
Expatriate	Someone who has taken up a paid work position within an organisation in Southeast Asia for a period of more than 6 months or who may be broadly defined as a lifestyle retiree or migrant.
Expatriate, longer-term or frequent traveller (ELoFT)	**Expatriate** - someone who has taken up a paid work position within an organisation in SEA for a period of more than six months or who may be broadly defined as a lifestyle retiree or migrant. **Longer-term or frequent traveller** - someone who has spent more than six months within a 12-month period in SEA. The abbreviation ELoFT is used when referring to these as a collective group. ELOFT is male, Australian-born or long term Australian resident.
Farang	A word used in Southeast Asia, particularly Thailand to describe a European or 'Westerner'.
FIFO worker	People who work away from home for an extended period of time on rotational work schedules. Workers receive accommodation and food. FIFO workers spend a fixed number of days working, followed by a fixed number of days off.
Gay men and other men who have sex with men	We use this term to describe men who are engaging in sexual contact with other men. This encompasses men who identify as gay or bisexual. We acknowledge that this classification may not be the preferred terminology for all people, however, in this study not all men self-identified as being either gay or bisexual.
Generalised HIV epidemic	The HIV prevalence rate is >1% in the general population (International Organization for Migration 2011; World Health Organization 2013).
Geopolitical borders	Borders as determined by a combination of geographical and political factors; "neither entirely fixed nor impenetrable, but are constructed and operate as relational sites of power, (re)negotiation, and struggle" (Spurlin 2016).
Globalisation	Globalisation, or the increased interconnectedness and interdependence of peoples and countries, is generally understood to include two inter-related elements: the opening of international borders to increasingly fast flows of goods, services, finance, people and ideas; and the changes in institutions and policies at national and international levels that facilitate or promote such flows (World Health Organization n.d.)
"going native"	Often used colloquially to describe the adoption of the lifestyle or outlook of local inhabitants, especially when dwelling in a colonial region (O'Reilly 2009; Collins Dictionary n.d.).

Grounded theory	"Emphasis is on process, theoretical sensitivity and the centrality of a storyline around which analysis can coalesce" (Dey 2007).
Habitus	"The way in which actors calculate and determine future actions based on existing norms, rules, and values representing existing conditions" (Eisenberg 2007).
Harmonised surveillance	Surveillance refers to the routine tracking of diseases (disease surveillance) or behaviours (behaviour surveillance), using the same data collection system over time (Southern African Development Community 2010). Harmonising surveillance thus means achieving consistency in systems across a defined area or region.
Heterosexual contact	The reported sexual intercourse between people of different sex.
High HIV prevalence country	High HIV prevalence countries include those with ≥ 1% estimated prevalence in at least one year of the last ten year period (Kirby Institute 2016).
HIV rapid testing	Rapid testing uses a pinprick of the finger (or oral fluid, depending on the test) and returns results within 10 to 20 minutes. Most rapid HIV tests detect HIV antibodies; however, some can also test for the presence of the virus itself.
HIV self-collection testing	Self-collection (or home sampling) involves taking a mouth swab or finger prick and mailing it to a laboratory, which makes the results available either by phone, text message, or online.
HIV self-testing	HIV self-testing (also known as home-based testing) is HIV testing conducted in the home or similar environment by a community member and individuals interpret the result. It uses the same technology as HIV rapid tests.
Kathoey	A term commonly used in Thailand to refer to someone identifying as male-to-female transgender (Saisuwan 2016).
Key informant	Select experts chosen because they are believed to have the most knowledge of the subject matter (Parsons 2008)
Late HIV diagnosis	Measured by a CD4 cell count of fewer than 350 cells/µl at diagnosis. CD4 cells are a type of white blood cell that fights infection. A normal CD4 count is from 500- 1,500 cells per cubic millimetre (µl) of blood (Kirby Institute 2016).
LGBTI	Lesbian, gay, bisexual, transgender and intersex
Liminality	Described by van Gennep and Turner as transition, a sense of being "being betwixt and between", as reviewed by Thomassen within and between environments, raising issues of identity and belonging (Thomassen 2009).
Longer-term or frequent traveller	Someone who has spent more than 6 months within a 12-month period in Southeast Asia.
Low HIV prevalence rate	"Low HIV prevalence rate <1% in the general population, but >5% in at least one high-risk subpopulation, such as gay or other homosexually active men, people who inject drugs, sex workers or clients of sex workers" (World Health Organization 2013).

Low, middle and high income countries	Gross Net Income per capita: Low-income, $1,025 or less; Lower middle income, $1,026 - $4,035; Upper middle income, $4,036 - $12,475; and High-income, $12,475 or more (World Bank 2017).
Medicare	"the Commonwealth funded health insurance scheme that provides free or subsidised health care services to the Australian population" (Biggs 2004).
Memo	Written records of analysis (Corbin and Strauss 2008).
Migrant	"Any person who is moving or has moved across an international border or away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) the reasons for the movement; or (4) the length of the stay" (International Organization for Migration n.d.).
Migration	A process of moving, either across an international border, or within a state which results in a temporary or (semi-) permanent change of residence (THP Foundation 2008).
Mobile populations	People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons (King 2010).
Mobile workers	People who work away from their permanent residence. Someone who works in more than one place or travels as part of their job.
Mobility and movement	Human geographic mobility, which encompasses any kind of movement of people, regardless of length, composition and causes.
Neverland	Neverland is an island featured in the fictional works of J.M. Barrie. It is a place described as a place of fantasy often used as a metaphor for escape or remaining child-like (Fox 2007).
'newbies'	An inexperienced newcomer to a particular activity.
Online community	As operationalized by Herring: "(1) active participation, (2) shared culture and norms, (3) roles, rituals and hierarchies, (4) a distinct identity, (5) solidarity, and (6) support and conflict resolution" (Herring 2004).
Ontology	"Ontology is the study of being. Ontological assumptions are concerned with what constitutes reality, in other words what is. Researchers need to take a position regarding their perceptions of how things really are and how things really work."(Scotland 2012).
Overseas-acquired HIV	HIV acquired while the individual was outside of Australia.
P4P	A term used to describe pay for pleasure, sexual services provided for money.
Pandemic	"An epidemic of disease, or other health condition, that occurs over a widespread area (multiple countries or continents) and usually affects a sizeable part of the population" (US Department of Health and Human Services 2019).
Peer	In the case of this research, peer is used to describe Australian men who may share characterises with ELoFTs in Southeast Asia.

Permanent residency	An Australian permanent resident "(permanent resident) is a non-citizen who holds an Australian permanent visa, or is usually resident in Australia and holds a permanent visa. Generally, permanent residents can live, work and study with much fewer restrictions than temporary visa holders in Australia. Permanent residents cannot vote unless they were enrolled to vote as a British subject prior to 1984" (Australian Government Department of Home Affairs 2019).
Pharmaceutical Benefits Scheme	"A program of the Australian government that provides subsidized prescription medications to Australian residents" (Commonwealth of Australia 2019).
Posts	"A message written in the online community forum" (Arsal, Woosnam et al. 2010).
Post exposure prophylaxis (PEP)	"PEP (post-exposure prophylaxis) means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected" (Centers for Disease Control and Prevention 2018).
Pre exposure prophylaxis (PrEP)	"Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day" (Centers for Disease Control and Prevention 2018).
Priority population	A group identified as being vulnerable to a health condition.
Priority populations/ populations at-risk of HIV	Populations considered vulnerable to HIV acquisition. Examples of priority populations are GMSM, sex workers, PWID, mobile populations and migrants.
Push and pull factors	Factors that "both drives and enables people to move to another country - "push" represents the state of things at home, such as the strength of the economy; the "pull" is the situation in the migrant's target country, such as the prospects of finding a decent job" (Organisation for Economic Co-Operation and Development 2009).
Re-domestication	An individual returning to their country of origin (i.e. Australia).
Relativist ontology	"Relativist ontology is the belief that reality is a finite subjective experience" (Levers 2013).
Reflexivity	"Reflexivity is the process of becoming self-aware through a researcher's ongoing critique and critical reflection of their own biases" (Mills, Durepos et al. 2010).
Safe-to-fail risks	Those risks that in a context of change, uncertainty, and adaptability can be deemed 'safe-to-fail' by anticipating failures and designing strategically so that failure is contained and minimised (Ahern 2011).
Seed	"Snowball sampling entails identifying an initial number of subgroup members from whom the desired data are gathered and who then serve as 'seeds', or study staff recruited respondents, to help identify other subgroup members (i.e. individuals who engage in the same types of behaviors) to be included in the sample" (Magnani, Sabin et al. 2005).
Self-actualisation	"The desire for self-fulfillment, namely to the tendency for him to become actualized in what he is potentially" (Maslow 1943).

Seroconversion	"The transition from infection with HIV to the detectable presence of HIV antibodies in the blood. When seroconversion occurs (usually within a few weeks of infection), the result of an HIV antibody test changes from HIV negative to HIV positive" (US Department of Health and Human Services 2019).
Sexual health hardware	"Health hardware for STI/HIV control includes condoms, sterile needles and other injecting equipment, and single-use sharps equipment" (Department of Health WA 2011).
Sex tourism	"Trips organized from within the tourism sector, or from outside this sector but using its structures and networks, with the primary purpose of effecting a commercial sexual relationship by the tourist with residents at the destination" (World Tourism Organization 1995).
Sex work/sex worker	The term sex worker "focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male and transgender adults—over the age of 18 years—who regularly or occasionally receive money or goods in exchange for sexual services" (UNAIDS 2015). In the case of this research it generally refers to female adults. Sex may be viewed as more or less transactional or commercial depending on the context. Formal sex workers may include those working in brothels. Informal sex workers may include bar girls who act as sex workers. In some instances this may be referred to as informal sex work or transactional sex. It is acknowledged that in SEA context (particularly in Thailand) it may be the case that women working in bars (often referred to as bar girls) may provide sexual services for financial or other support. "Men may seek to reinforce the non-commercial and non-sexual aspects of the relationship (support, companionship). The characteristics of a private rather than commercial transaction may be preserved in such situations by the exchange of gifts and other resources in place of cash" (WHO 2002).
Situational disinhibition	"The feeling of being a 'different person' while on holiday" (Clift and Carter 2000).
Social capital	Described variously, but by Putnam (1993: 167) as, "features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions" (Putnam 1993).
Sociation	"Stable and patterned forms of reciprocal interaction between individuals who are 'with-one-another, for-one-another, in-one-another, against-one-another, and through-one-another, in state and commune, in church and economic association, in family and in clubs'" (Simmel 1971 quoted by Law 2011).
Sois	A Thai term for side streets and backstreets.
Southeast Asia	"Countries included in this region as per the Australian Bureau of Statistics Standard Classification of Countries" (SACC), 2016.
sub-Saharan Africa	"Countries included in this region as per the Australian Bureau of Statistics Standard Classification of Countries" (SACC), 2016.

Symbolic interactionism	Explores how individuals interact meaningfully with their social and natural environments, and how humans socially construct their concept of self (Mead 1934; Blumer 1969; Charon 2001).
Threads	"Hierarchically organized postings" (Arsal, Woosnam et al. 2010).
Transmission dynamics	Forces that produce or affect changes in the patterns of HIV acquisition (Cassels, Clark et al. 2008; Rothenberg 2009).
Transmission networks	Interconnected relationships between individuals through which HIV is acquired (Rothenberg 2009).
Transmission pathways	Ways in which HIV may be transmitted from person-to person or through networks.
Transnational identity	A social and cultural identity that recognises and incorporates a migrant's cross-cultural and cross-border experiences.
Treatment as prevention (TasP)	Used to describe HIV prevention methods that use antiretroviral therapy in PLHIV to decrease the chance of HIV transmission independent of CD4 cell count (World Health Organization 2012).
Wanderlust	"The wish to travel far away and to many different places" (Cambridge Dictionary 2019).
Viral load	"The amount of HIV in a sample of blood. Viral load (VL) is reported as the number of HIV RNA copies per milliliter of blood. An important goal of ART is to suppress a person's VL to an undetectable level—a level too low for the virus to be detected by a VL test" (US Department of Health and Human Services 2019).

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1. Introduction

As the HIV pandemic surely should have taught us, in the context of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected.

- Emerging Infections, International Organization for Migration, 1992 -

PRELUDE

This thesis describes a grounded theory study, considered from the perspective of Symbolic Interaction. It explores 1) social network development, amongst Australian expatriates, longer-term or frequent travellers (ELoFTs) to Thailand and Southeast Asia (SEA), and 2) the capacity of networks for intervention to reduce the risk of HIV and other STI transmission amongst this population. This chapter offers an overview of the thesis contents. The background explains the study context and purpose. The chapter then outlines the research aim and objectives, significance of the research and organisation of the thesis.

1.1 Background

The transmission of HIV continues to present a major challenge for public health globally. Almost 40 years since the first cases of HIV were reported, more than 70 million people have been infected (UNAIDS 2018). While significant advances have been made in many countries, transmission of the virus coalesces where ignorance and stigma remain, where there are significant disparities in the social determinants of health equity and where laws and policies exist that penalise people for being human (Dean and Fenton 2010). HIV remains a focus for global health institutions such as the World Health Organization (2019), which named HIV one of ten global health threats. Mechanisms for HIV transmission are rooted in a panoply of social, political, economic and gender inequalities (Auerbach, Parkhurst et al. 2011; World Health Organization 2018a), amplified by rapid globalisation and increasing population mobility (Gushulak 2010; International Organization for Migration 2018).

With recent estimates suggesting that more than 3% of the world's population (approximately 258 million people) have migrated from their country of origin (United Nations 2017), populations on the move are increasingly vulnerable to HIV acquisition (Gupta, Parkhurst et al. 2008; Haour-Knipe 2013). Drivers for transmission amongst mobile and migrant populations include HIV prevalence in countries of origin and destination, lack of access to testing, treatment and health services, poor health literacy and myriad sociocultural, political, economic and labour factors (Deane 2010; Haour-Knipe 2013; International Organization for Migration 2018). Consequently, increasing acquisition of HIV amongst mobile and migrant populations can be seen across the world in low, middle and high-income contexts including Australia (Crawford, Lobo et al. 2014).

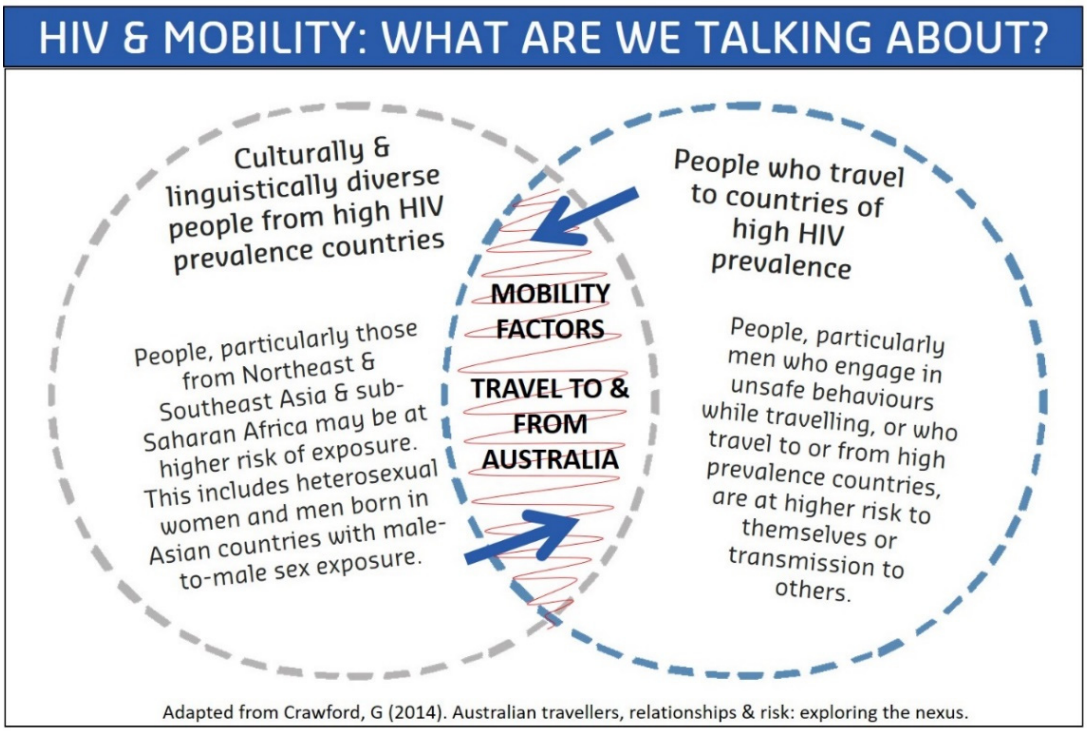
Characterised by strong partnerships, involvement of affected peoples, bi-partisanship and collection and access to quality data, the HIV response in Australia has been an exemplar for many countries with similar profiles (Brown, O'Donnell et al. 2014; Crawford, Lobo et al. 2014; Crawford, Lobo et al. 2016a). In Australia, to the end of 2017 there had been 38,172 HIV notifications and 27,545 people were living with HIV (Kirby Institute 2018). Historically, Australia has experienced a low-prevalence, concentrated epidemic with infections mostly amongst gay men and other men who have sex with men (GMSM) (Mcdonald, Crofts et al. 1994; Brown, O'Donnell et al. 2014; Kirby Institute 2018). HIV transmission amongst people who inject drugs, sex workers, and transmission from mother to child or amongst those who identify as heterosexual was relatively uncommon.

The profile of HIV infections in Australia is changing. An Increasing number of HIV infections have been recorded amongst those travelling to and from countries of high HIV prevalence and amongst those who identify as heterosexual (Guy, Mcdonald et al. 2007; Combs and Giele 2009; Crawford, Lobo et al. 2014; Persson, Brown et al. 2014) (see Figure 1). National data suggest around 20% of newly diagnosed Australian-born men likely acquired HIV overseas, though this may be an underrepresentation (Kirby Institute 2018). In Victoria, estimates suggest that from 1996 to 2014, there were 821 new non-GMSM HIV diagnoses. Among 348 Australian-born people, around one quarter (n=81, 23%) reported likely overseas exposure; the majority of these were men who reported exposure in SEA. Specifically, of the 348 diagnoses among those born in Australia, two-thirds (n=233, 66%) were men. Of these, around one quarter (n=57, 24%) likely acquired HIV in SEA (Peach, Lemoh et al. 2018).

The NT recorded 13 HIV notifications in 2017, seven amongst males. Of five cases amongst Australian born individuals, four were acquired overseas (and one unknown) (NT Health 2018). In SA, there were seven HIV notifications in 2018 amongst MSM which were reported as acquired overseas (35%). There were 11 (34%) males diagnosed with HIV in 2018 who reported heterosexual contact. Six of these notifications were amongst Australian-born men (n=6). Six of the notifications were acquired overseas (SA Health 2018). Of 88 notifications of HIV recorded in NSW in 2019 amongst Australian-born MSM in, seven were likely acquired overseas (17.2%). Amongst Australian-born heterosexual people, 22 HIV notifications were recorded, 19 of these were amongst men. Of all notifications reported as heterosexually acquired, six were likely acquired overseas (at least three men) (five cases were unknown) (NSW Health 2019).

This increase in overseas-acquired HIV is addressed in the Australian Government's Eighth National HIV Strategy which recognises mobile and migrant populations as priority groups, specifically *"culturally and linguistically diverse (CaLD) people from high HIV prevalence countries and people who travel to high prevalence countries"* (Commonwealth of Australia 2018, p.21).

Figure 1: HIV and Mobility in Australia



WA was one of the first states in Australia to report on this changing epidemiology (Combs and Giele 2009). At the time (around 2009), it was posited that the change may have been in part attributed to a rapidly expanding local economy and 'mining boom' (Combs and Giele 2009). Approximately 40% of all HIV infections in WA are now acquired overseas (Department of Health Western Australia 2017). The evolving nature of the epidemic requires rethinking traditional approaches for different groups and in different contexts. One of the groups of particular interest in WA is Australian-born men who have acquired HIV overseas.

WA Department of Health data suggest that of the 1199 WA notifications since 2004, 160 notifications have been recorded amongst Australian-born men who have acquired HIV overseas (13%), ranging from 10-20% of total cases annually. Of these, 69% (n=110) were acquired in SEA. Two-thirds (63%) reported their exposure category as heterosexual (n=100). Age was relatively evenly split with one-quarter (n=40) aged 40-49 years, around one fifth (22%; n=35) aged 30-39 years, a further one-fifth aged between 50 and 59 years (21%; n=34) and just under a fifth (18%; n=28) aged over 60 years. A further 14% (n=23) were 19-29 years of age. Of concern, around one-third (36%) of those Australian-born men who acquired HIV overseas were diagnosed late (n=57) (Department of Health Western

Australia 2019). Late diagnosis has implications for subsequent treatment, prognosis and onward infection, particularly if an individual is unaware of their HIV status.

Population estimates of those who form part of the Australian diaspora are inconsistent. Current figures suggest there may be as many as one million Australians living overseas (Advance and PWC Australia 2018), while 2008 estimates suggested the number of Australian expatriates in Thailand to be around 20, 000 (The Hon. Stephen Smith Australian Minister for Foreign Affairs and Trade 2008). Little is known about Australian-born men who acquired HIV overseas in terms of how they access health services or the contexts in which their transmission occurred. The modest body of research that is available points to ELoFTs as highly connected groups with particular norms and practices which may make them vulnerable to HIV and other STI acquisition (Brown, Ellard et al. 2014). The context of transmission and risk for HIV and other STIs amongst this group is linked not only to the prevalence of HIV in the country of destination but to the mores of the social networks to which they belong, as well as the meanings they associate with the country of destination and country of origin (Brown, Ellard et al. 2012).

If Australia, and indeed the world, is to see an end to HIV transmission in this generation, bold action is required. Recent advances in biomedical prevention suggest that better access to testing and treatment could result in meeting global targets of 30 million people receiving HIV treatment by 2020 (UNAIDS 2019). This would mean that 90% of people living with HIV know their HIV status, 90% of those diagnosed with HIV infection receive treatment and 90% of those receiving treatment will have suppressed virus (UNAIDS 2019). The Eighth National HIV Strategy suggests Australia is on-track to meet and exceed these targets (Commonwealth of Australia 2018). Yet, what we have learned from past successes in HIV prevention, and in public health more broadly, is that a one-size-fits-all approach is unlikely to be effective. Sustained and directed action is needed to *"reach our goal of virtual elimination of HIV transmission, achieve longer and healthier lives for people with HIV and eliminate stigma and discrimination"* (Commonwealth of Australia 2018, p.6).

The HIV and Mobility in Australia: Road Map for Action (Crawford, Lobo et al. 2014) suggested five key areas for action to respond to HIV acquisition amongst mobile and migrant populations in Australia: (1) International leadership and global health governance; (2) Commonwealth and state leadership; (3) Community mobilisation; (4) Development of services for mobile or migrant people and groups; and (5) Surveillance, research and evaluation (Crawford, Lobo et al. 2014). The report and associated research stressed the

need for tailored and targeted strategies, an empathetic policy context that does not reify difference and that reduces stigma, and policy and practice that recognises the heterogeneity of priority populations (Crawford, Lobo et al. 2016).

The change in HIV epidemiology, my experience working in the HIV sector, discussions with the peak WA HIV agency and Department of Health in WA, and findings from previous research were the motivation for this study. A more sophisticated understanding of the behavioural and cultural contexts, meanings and practices of overseas acquired HIV is critical for prevention (Deane 2010). This means better knowledge about the individual, their knowledge, social and environmental contexts, networks, attitudes and practices in country of origin and destination (Cassels 2014). Such knowledge would influence intervention planning in WA, and have resonance for other jurisdictions both locally and internationally with similar epidemiological profiles of HIV transmission.

1.2 Research Aim and Objectives

The aim of the study was to determine whether social network processes of Australian male expatriates,[4] longer-term or frequent travellers in Thailand and SEA[5] have the **potential** to support peer education and social influence interventions to reduce transmission of HIV and, more broadly, other STIs.[6] To achieve this aim, the study had the following objectives:

1. To build a deeper contextual understanding of culture and personal behaviour amongst Australian ELOFTs in Thailand and SEA. [Publications 1, 2, 3 and 5] [Chapters 2, 4, 5 and 6]

2. To describe the socialisation process and pathways experienced by Australians (potential new ELoFTs) interacting with Australian ELoFTs in Thailand and SEA. [Publications 2 and 5] [Chapters 2, 4, 5, 6]

3. To investigate the roles of Australian ELoFTs as mentors and potential change agents within ELoFT social networks in Thailand and SEA. [Chapters 2, 4, 5, 6]

4. To construct a theory and conceptual model explaining the development of social networks amongst Australian ELoFTs, and their capacity to support peer education and social influence interventions to reduce sexual health harms specifically HIV but also other STIs. [Chapter 7]

5. To make recommendations for further research including intervention research targeting ELoFTs. [Publications 1, 2, 3, 5] [Chapter 8]

[4] For the purposes of this research an **expatriate** is defined as someone who has taken up a paid work position within an organisation in Thailand and SEA for a period of more than six months or who may be broadly defined as a lifestyle retiree. A **longer-term or frequent traveller** is defined as someone who has spent more than six months within a 12-month period in Thailand or SEA. The abbreviation ELoFT is used when referring to these as a collective group.

[5] The study is primarily motivated by increasing notifications of HIV and the related impact of mobility to SEA, but specifically Thailand. Broadly, findings and context have applicability to SEA, but the primary focus of data collection was in Thailand.

[6] The study is primarily motivated by increasing notifications of HIV and the related impact of mobility. Broadly, findings and context have applicability to transmission pathways for STIs and synergies for subsequent intervention opportunities particularly where there may be risk for co-infection. HIV is the focus throughout the thesis.

1.3 Significance of the Research

Over the past three decades, Australia's national HIV strategies have identified mobile and migrant populations as priority groups (Commonwealth of Australia 2018). Despite this, there is limited evidence of effective interventions for these groups, including Australian born ELoFTs (Crawford, Bowser et al. 2013; Brown, Ellard et al. 2014; Crawford, Lobo et al. 2014; Crawford, Lobo et al. 2016a;). Greater understanding of these groups and the mechanisms for HIV transmission can facilitate more targeted public health interventions. This would contribute to achieving targets in the Australian HIV response of no new infections by 2022 (Commonwealth of Australia 2018).

At the commencement of this research and to date, there has been little published about the nature of overseas acquired HIV amongst those living in high income countries, specifically Australia (Brown, Ellard et al. 2012; Brown, Ellard et al. 2014). This study was the first to explore the formation and maintenance of social networks amongst male Australian ELoFTs in Thailand and SEA with specific reference to HIV and other STI risk. Findings offer insight into the personal, social and contextual factors that influence risk, identity development and social network formation. Further, the research has illustrated how to locate key influencers as change agents to address key health and social issues experienced by ELoFTs.

Understanding the social context of risk behaviours and network formation provides theoretical insight for other health conditions and behaviours amongst this group such as mental health, alcohol and other drug use, general health and wellbeing, use of health services and uptake of health screening. Investigating the social networks of Australian male ELoFTs has led to knowledge about a range practices amongst this group, and some understanding of the impact of belonging to ELoFT social networks on health outcomes. Understanding the social context of network formation in this group may provide insight into similar practices in other hard-to-reach groups and populations.

I conducted an in-depth, systematic review providing a 15-year snapshot of the literature with an explicit focus on male ELoFTs, travelling from high to low- and middle-income countries regarding HIV, other bloodborne viruses (BBVs) or STIs (see Publication 3). To my knowledge, it is the only such study. The review facilitated in-depth analysis of a priority population which can assist the sexual health sector to support or refute a range of assumptions about the behavioural contexts in which acquisition of HIV, other BBVs or STIs

occurs amongst ELoFTs to low- and middle-income countries. Exploration of online forums, (see Publication 5) provided a valuable opportunity to examine characteristics of online social networks for potential intervention. Again to my knowledge, this was the first such study.

Knowledge translation was a strong focus. Findings were disseminated to policy, practice and research stakeholders along with the ELoFT community via research and evaluation networks, conference presentations and online forums (see Appendices I-P). The study published five peer reviewed journal articles (see Front Matter) and received media coverage (see Appendix M). It developed recommendations for government, non-government and research organisations regarding intervention methods and contextual factors for ELoFTs as a priority population. Final results will inform the development of interventions for HIV and STI risk reduction programs in WA with applicability to other jurisdictions that experience overseas acquired HIV.

This research is part of a growing corpus of work I am conducting with colleagues regarding HIV and mobility (see Front Matter and Appendices I-P). The work has informed policy and advocacy work both locally and nationally, including the development of a national Road Map for Action on HIV and Mobility (Crawford, Lobo et al. 2014) and subsequent Community of Practice for Action on HIV and Mobility.[7] Via these mechanisms, the work has contributed to a more cohesive and harmonised national response to HIV and mobility. The study has facilitated knowledge and skills amongst emerging researchers via the supervision of nine students at Honours, Masters and PhD level (see Appendix N), aiding the development of critical mass for work in HIV and mobility. Further, it has contributed to the development of 10 grants for further research (see Appendix K).

The research has established an explanatory conceptual model for the formation and development of social networks amongst an at-risk group and provided greater understanding of the profile of ELoFTs including their personal behaviours, knowledge and attitudes and how they form and maintain social networks. This knowledge will support those working in public health to pinpoint strategies most likely to succeed in effectively addressing HIV and other STI risk with this group, particularly strategies that focus on peer and social influence which have been a cornerstone of Australia's HIV response.

[7] See https://siren.org.au/hiv-mobility/community-of-practice-for-action-on-hiv-and-mobility/

1.4 Thesis Organisation

This thesis contains both peer-reviewed publications by the author and additional supporting content. It is organised into eight chapters, preceded by front matter and followed by back matter. Content and chapters are described briefly below.

Front Matter

Front matter includes the author declaration, abstract, acknowledgements, dedication, list of related peer-reviewed publications, statement of contribution, table of contents, list of figures and tables, list of abbreviations and definitions.

Chapter One: Introduction

The introduction (this chapter) orients the reader to the study, outlining its background, the research aims and objectives, brief overview, and the significance of the research.

Chapter Two: Study Context, Rationale and Review of the Literature

The literature review explores the problem in relation to what is known and what the gaps are. It includes three peer-reviewed publications [Publications 1, 2 and 3]:

1. **Crawford G,** Lobo R, Brown G and Maycock B. The influence of population mobility on changing patterns of HIV acquisition: lessons for and from Australia. *Health Promotion Journal of Australia.* 2016; 27(2), 153-154. doi:https://doi.org/10.1071/HE15042 (Impact Factor: 1.333)
2. Brown G, Ellard J, Mooney-Somers J, Prestage G, **Crawford G*** and Langdon T. 'Living a life less ordinary': exploring the experiences of Australian men who have acquired HIV overseas. *Sexual Health*. 2014; 11(6), 547-555. doi:https://doi.org/10.1071/SH13155 (Impact Factor: 1.421) *corresponding author
3. **Crawford G,** Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV and STIs amongst expatriates and travellers to low and middle income countries: A systematic review. *International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249 (Impact Factor: 2.468)

Chapter Three: Research Methods

Methods employed in the research project are described in two parts. The first is a peer-reviewed journal article which briefly describes the research protocol [Publication 4]:

1. **Crawford G,** Bowser N, Brown G and Maycock B. 2013. Exploring the potential of expatriate social networks to reduce HIV and STI transmission: a protocol for a qualitative study. *BMJ Open.* 2013; 3 (2):e002581. doi:10.1136/bmjopen-2013-002581 (Impact Factor: 2.376)

The second section describes how the study adhered to the protocol and gives details not provided within the brevity of the published paper. Information is provided on sources of data, sampling, data collection, analysis, rigour and ethical considerations of the research.

Chapter Four: In-situ Observations

Results are presented in three chapters. In this first results chapter, an overview of the observational fieldwork is presented.

Chapter Five: In-depth Interviews

The second results chapter presents data from in-depth interviews via major themes uncovered in the research process.

Chapter Six: Online Forums

Chapter five is the final results chapter which presents data from the analysis of the online forums in the form of the following peer-reviewed paper [Publication 5]:

1. **Crawford G,** Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research.* 2018; 20(9):e10787. doi:10.2196/10787 (Impact Factor: 4.945)

Chapter Seven: ELoFT Social Networks in SEA: A Grounded Theory and Conceptual Model

This chapter presents the grounded theory and explanatory conceptual model, 1) as it relates to the development of social networks, and 2) as it relates to the use of the networks for intervention with reference to the broader literature.

Chapter Eight: Implications and Conclusions

A study summary is presented along with strengths and limitations, implications and recommendations for public health policy, practice and research and concluding remarks.

Back Matter

Back matter contains the bibliography and Appendices A – P which includes copyright, ethical information, declarations, supplemental interview information, and a list of related reports, conference presentations, grants, media and supervision undertaken during the PhD.

2. Study Context, Rationale and Review of the Literature

One night in Bangkok and the world's your oyster
The bars are temples but the pearls ain't free
You'll find a god in every golden cloister
A little flesh, a little history
I can feel an angel sliding up to me
One night in Bangkok makes a hard man humble
Not much between despair and ecstasy
One night in Bangkok and the tough guys tumble
Can't be too careful with your company
I can feel the devil walking next to me

- One Night in Bangkok, T. Rice, B. Andersson, B. K. Ulvaeus, 1984 -

PRELUDE

Three published papers comprise the study context, rationale and review of the literature. The following provides an overview of the papers and their findings. A complete copy of each published manuscript follows. The following objectives are addressed:

1. To build a deeper contextual understanding of culture and personal behaviour amongst Australian ELOFTs in Thailand and SEA.

2. To describe the socialisation process and pathways experienced by Australians (potential new ELoFTs) interacting with Australian ELoFTs in Thailand and SEA.

3. To investigate the roles of Australian ELoFTs as mentors and potential change agents within ELoFT social networks in Thailand and SEA.

4. To make recommendations for further research including intervention research targeting ELoFTs.

A note on this chapter. This chapter focuses on the context and rationale for the review and to some extent on what little is known about the target group and their knowledge, attitude and practices which may increase vulnerability for acquisition of HIV and other STIs. Broader literature and terminology relevant to the thesis is embedded within the backgrounds and discussions of the five published papers as well as the thesis background, results and discussion (particularly Chapter Seven).

2.1 HIV and population mobility: setting the scene

Publication One: The influence of population mobility on changing patterns of HIV acquisition: lessons for and from Australia

Citation: Crawford G, Lobo R, Brown G and Maycock B. The influence of population mobility on changing patterns of HIV acquisition: lessons for and from Australia. *Health Promotion Journal of Australia.* 2016; 27(2), 153-154. doi:https://doi.org/10.1071/HE15042 (Impact Factor: 1.333)

Health Promotion Journal of Australia, 2016, **27**, 153–154
http://dx.doi.org/10.1071/HE15042

Commentary

The influence of population mobility on changing patterns of HIV acquisition: lessons for and from Australia

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Abstract. Investment, bipartisan support and involvement from affected communities have characterised Australia's HIV response, and helped maintain a low prevalence epidemic. Patterns of HIV acquisition are changing, with an increasing number of infections acquired overseas by migrant and mobile populations. A coordinated national response is required to address HIV acquisition in the context of population mobility.

Received 20 May 2015, accepted 1 December 2015, published online 4 April 2016

The changing patterns of HIV in Australia

Australia has experienced a low prevalence HIV epidemic* concentrated primarily among gay and other homosexually active men.[1] Over the last decade, an increasing proportion of infections have been acquired overseas by migrant and mobile populations travelling to and from countries with high HIV prevalence (particularly in sub-Saharan Africa and South East Asia).[2] In Western Australia (WA) for example, an 85% increase was recorded in the number of infections acquired overseas ($n = 307$ *v.* $n = 166$) between the 5-year periods 2004 2008 and 2009 2013. HIV infections acquired overseas now make up half of all new infections in WA.[3]

Historically, Australia's HIV response has been a public health exemplar, characterised by investment, bipartisan government support, and significant involvement by affected groups.[1] However, changing patterns of acquisition require previously used strategies to be re-examined in the context of a more globalised world. 'People from high HIV prevalence countries and their partners' and 'travellers and mobile workers' (migrant and mobile populations) were identified as priority populations in the Australian *7th National HIV Strategy (2014 2017)*.[4] Leadership is lacking to effectively implement and evaluate the response to address overseas-acquired HIV within migrant and mobile populations. A coordinated, whole-of-government effort is now critical.

Thinking and responding differently

A recently released discussion paper, *HIV and mobility in Australia: Road Map for Action*[5] called for: (1) better research, surveillance and evaluation; (2) public health policies reflecting a human rights approach; (3) a nationally coordinated, sustained response with commitment to ongoing investment and evidence-informed prevention strategies; and (4) cross-jurisdictional responses. A national Community of Practice for Action on HIV and Mobility (CoPAHM) has been established to take action on these issues. CoPAHM recently conducted an audit to determine how national momentum measured up against the strategies outlined in the *Road Map*. The audit found a range of actions were in place, but little momentum in the strategies that required Commonwealth government leadership, and inconsistent action between states and territories.

For many years, UNAIDS advised that we must know our epidemic(s) to know our responses.[6] There is a note of caution here for Australia in the way that we respond to HIV transmission in the context of HIV and migrant and mobile populations. Current prevention efforts should continue and, where effective, be scaled up. However, where there are gaps in knowledge and action, safe-to-fail risks must be taken to create strategies that are responsive, ethical and informed by the best available evidence. This is not easily achieved in short cycles of funding or in isolated projects. Within- and between-jurisdiction collaboration and resources are needed to

*Low HIV prevalence rate <1% in the general population, but >5% in at least one high-risk subpopulation, such as gay or other homosexually active men, people who inject drugs, sex workers or clients of sex workers (see http://www.who.int/hiv/pub/guidelines/arv2013/intro/keyterms/en/).

share findings and transition pilot to full scale programs. Harmonised surveillance of HIV and migrant and mobile populations would also assist to tailor strategies and provide a rationale for government resourcing.[5,6]

Supporting people travelling to and from high prevalence countries

For mobile populations such as Australian residents travelling to and from countries of high HIV prevalence, there is little evidence for the effectiveness of single strategy interventions (for example media campaigns for all travellers). Targeted interventions are needed to educate and support mobile populations who may engage in high-risk behaviours or be unaware of their heightened vulnerability to HIV acquisition in some countries.[5] Strategies may include: exploring transmission networks in destination countries to better understand risk; international partnerships to trial interventions in destination countries; enhanced pre- and post-travel screening and advice; and online engagement strategies.[5]

For migrants to Australia, barriers to accessing health services or experiences of stigma and discrimination may exacerbate vulnerability to HIV transmission and lead to late diagnosis.[5,7,8] Universal access to HIV testing and treatment is required for all Australian residents, including temporary visa holders.[‡] Petoumenos and Cogle suggest that current policy is inconsistent with the aims of the current national strategy leading to confusion for service providers and consumers.[8] For example, the WA Department of Health has a directive to provide HIV treatment and clinical services to people living with HIV including those ineligible for Medicare.[9] However research by Hermann and colleagues found considerable anxiety regarding nonrenewal or failure of visa applications for permanent residency relating to HIV status.[10] HIV screening of migrants to Australia[§] should not be a condition of entry, but undertaken to ensure appropriate access to treatment and care.[5,7,8]

Call to action

Mobility will continue to affect the characteristics of global HIV epidemics including those in the Asia-Pacific region. Where there is reduced access to healthcare, including prevention, diagnosis and treatment, there are increased cross-border transmission risks.[5] Within Australia and the region, individual vulnerability to HIV is amplified by a range of determinants beyond the bounds of health. This includes a lack of antidiscrimination reforms and laws that do not protect human rights, which reduces access to services and criminalises behaviours such as sex between men. Responses should be developed that seek to reduce antipathy and stigma and do not reify difference.[5,7,8] Closer collaboration is needed between Australia and public health sectors in countries of origin and destination of migrant and mobile populations.[5]

Australia has a recipe for a public health approach to HIV prevention: resourcing and support from government; sector mobilisation; effective testing and treatment; and ongoing surveillance, evaluation and research.[1] This is the legacy of Australia's original HIV response. Failing to apply what we have learned from this approach to the context of HIV and mobility risks further infections. Pursuing a coordinated response for migrant and mobile populations is crucial to meet Australia's goal of no new HIV infections by 2020.

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[‡]People living with HIV without a Medicare card cannot formally access subsidised antiretroviral treatment.
[§]Required for permanent visas and some other types.

2.2 What does previous research reveal about the experiences of Australian men who have acquired HIV overseas?

Publication Two: 'Living a life less ordinary': exploring the experiences of Australian men who have acquired HIV overseas

Citation: Brown G, Ellard J, Mooney-Somers J, Prestage G, **Crawford G*** and Langdon T. 'Living a life less ordinary': exploring the experiences of Australian men who have acquired HIV overseas. *Sexual Health*. 2014; 11(6), 547-555. doi:https://doi.org/10.1071/SH13155 (Impact Factor: 1.421) ***corresponding author**

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'Living a life less ordinary': exploring the experiences of Australian men who have acquired HIV overseas

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Abstract. ***Background*:** Increasing international mobility has led to a growth of cross-border HIV transmission around the world. In Australia, increasing rates of HIV infections acquired overseas have been reported, particularly among men. This qualitative study explored experiences and risk perceptions of 14 Australian men who acquired HIV while living or travelling overseas from the year 2000. ***Methods*:** Symbolic interaction provided the study's theoretical perspective and analytical framework. Australian men living with HIV who were aged 18 years and older, believed they had acquired their infection while working or travelling overseas during or after the year 2000, and were diagnosed from 2003 onwards were eligible to participate. A semistructured interview schedule was developed and tested for content validity with the study reference group. Analysis was conducted using an adapted form of grounded theory to form the basis for the development of the experiences domains. ***Results*:** Analysis produced four domains of experience: (1) a fantasy realised, (2) escaping and finding a new self or life, (3) living a life less ordinary and (4) living local but still an outsider. The description of the four experience domains highlights how risk generally, particularly sexual risk, did or did not feature in these men's understanding of their experiences. ***Conclusion*:** Perceptions and experiences of long-term travel played a decisive role for men who acquired HIV when travelling overseas. Appealing to desired experiences such as connection to local culture or sustaining a new or adventurous life may provide important implications for guiding health promotion programs and policy.

Additional keywords: behavioural factors, condom use, cultural factors, mobility, risk, social factors.

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Introduction

International mobility presents risks for HIV transmission, driven by globalisation, tourism, migration, conflict and labour markets.[1–3] Epidemic patterns have changed as HIV acquisition via cross-border travel has become an increasing proportion of diagnoses for high-income countries.[4] Although Australia has typically experienced a concentrated epidemic, with male-to-male sexual contact being the primary route of transmission, some jurisdictions have experienced increases related to migration to Australia from high HIV prevalence countries, and to people travelling from Australia for work or leisure to countries with higher HIV prevalence.[5]

In Western Australia (WA), newly diagnosed HIV cases are notifiable to the Department of Health. Information regarding type of exposure and demographic details are collected for each diagnosis as well as the most likely place of acquisition. Since 2005, there have been almost 400 diagnoses of HIV acquired overseas ; more than 65% of these occurred among males.[6] This represented almost half of all diagnosed cases among men in WA (48%) during this period.[6] The majority of these diagnoses (64%) were reported as male-to-female or female-to-male sexual contact, and 31% of acquisitions were reported through male-to-male sexual contact.[6] Although these acquisitions have occurred both among Australian citizens and temporary residents who

acquired HIV in their country of origin, Australian-born individuals have primarily acquired HIV in South-east Asia. The Northern Territory (NT) population is smaller and the number of overseas transmissions is fewer; however, similar patterns have been observed.[7]

Increasing diagnoses have been accompanied by growing numbers of Western Australians travelling overseas. South-east Asia was the most commonly reported location of acquisition among Western Australian men during this time.[5] WA and the NT experienced some of the highest rates of population movement for short-term resident departures;[8] Indonesia and Thailand were particularly popular, with Western Australians increasingly travelling to these locations and travelling there more frequently than residents from other states.[8,9]

The Australian government's Seventh National HIV Strategy (2014–2017) continues, as in previous strategies, to include those travelling to and from countries of high HIV prevalence as a key target group.[10] However, although the strategy calls for better understanding of and responses to this broad group, no previous Australian study has investigated the social, cultural and behavioural factors influencing HIV sexual risk among Australian men who travel overseas.

There are some studies in the international literature that have explored the relationship between sexual risk behaviour and travel,[3,11–15] and a few studies that explore why tourists engage in transactional or unprotected sex.[16,17] However, to create effective HIV health promotion programs and interventions, we need not only an accurate understanding of risk behaviours but also the significance of culture and how its meaning is constructed, interpreted and presented. This is what we currently lack: a better understanding of how the interactions and relationships of male travellers shape meanings about culture, context and self.[18] There is also a need to acknowledge and explore the potential positioning of the destination countries, in this case primarily South-east Asia, as 'other' both within the research and by travellers more broadly.[19,20] The application of 'Western' or neocolonial perspectives predicated on the 'exotic East' as more inherently dangerous, more permissive, romantic or erotic may be stigmatising for host countries and has implications for the way in which individuals view themselves and their sexual health decision-making.[19,20] We need to better understand the importance of place, and the liminality of travel and the destination as a context for risk to our understanding of risk for HIV transmission acquired overseas among male travellers from a low prevalence country like Australia.[21,22]

This paper presents additional results from a small qualitative study that aimed to investigate the social, cultural, behavioural and cognitive factors contributing to the overseas acquisition of HIV by male Australian residents of WA and the NT who travelled overseas for work or leisure during or after the year 2000, and were diagnosed from 2003 onwards. It builds on earlier findings from our interviews with men from WA and the NT that presented perceived social norms and assumptions among participants, and discussed the role of social networks in the context of their travel in host countries. In particular, this paper explores four specific domains of experience common to the participants. The research contributes to the small body of existing literature on this emerging epidemic, with the intention of informing future policy and health promotion practice in the area of HIV and mobility.

Methods

Symbolic interactionism[23] provided the study's theoretical perspective and analytical framework. Symbolic interactionism as a framework has been employed for some time to explore sexuality, health and cultural contexts.[18,24] Symbolic interactionism explores how individuals interact meaningfully with their social and natural environments, and how humans socially construct their concept of self.[23,25,26] Various cultural practices, group norms and roles become symbols that impose meaning on events and objects, such as what behaviour is expected and appropriate in different settings and in different roles.[23,25,26] Such a framework was valuable, as it facilitated an investigation of the way in which participants interpreted and made meaning of their interaction with their overseas and home environments and settings, the cultural contexts of living and travelling in other countries, and their interactions with other travellers and locals.[23,27]

A reference group of clinical, community organisation and people living with HIV (PLHIV) representatives was established, providing guidance for study implementation. Ethical approval was granted from Curtin University, and participating community agencies and hospitals who promoted the study.

Participants

Eligible participants were men living with HIV who were aged 18 years and older, believed they had acquired their infection while working or travelling overseas during or after the year 2000, were diagnosed from 2003 onwards and were resident in Australia before acquiring HIV. This study did not target those who acquired HIV before living in Australia, nor did it target women. The inclusion criteria for research participants was based on the epidemiology of diagnoses at the time, which indicated that women who had acquired HIV overseas were more likely to have done so in their country of origin.

Data collection

Participants were recruited via staff from programs and services for PLHIV, including AIDS Councils, hospitals and general practices, which distributed promotional material to clients about the study. Interested eligible men were briefed about the study, provided informed consent and were enrolled in the study. The place and time for interviews was chosen by participants. Participants were offered a gift voucher to acknowledge their contribution to the study at the commencement of the interview. Due to changes in key liaison staff in the major hospital clinic and the change in the depth of corporate knowledge about patient social history, the recruitment period was longer than planned. The majority of interviews were conducted face-to-face in WA and the NT ($n = 12$). Due to the international travel of some participants, one participant was interviewed by successive emails and another by telephone. There were no discernible differences in the quality or depth of content of responses received through the different modalities. Although some participants had returned to Australia permanently at the time of the interview, some were

interviewed while they were in Australia temporarily before returning overseas.

A semistructured interview schedule was developed and discussed with the study reference group to ensure that the questions were credible and authentic for the area under investigation as assessed by experts. The schedule domains can be seen in Box 1.

A full description of the broader question areas is described elsewhere.[27] The schedule was adapted to respond to emerging themes during data collection and analysis. Recorded interviews ranged in duration across 1–2 h, and were transcribed verbatim and deidentified.

Data analysis

The analysis was conducted using an adapted form of grounded theory,[28,29] where interviews were conducted in batches before transcription and analysis (due to logistic and participant schedule reasons), rather than full analysis of each interview and comparison conducted before the next interview. Interview transcripts were entered into NVivo ver. 8 qualitative data analysis software (QSR International Pty Ltd, Melbourne, Vic, Australia), allowing for interview coding and cross-referencing, and the generation of categories and concepts for analysis and comparison.[28] Multiple members of the research team reviewed transcripts, compared analyses and collectively agreed on key concepts and themes. This formed the basis for the development and refinement of the description of experience types. The analyses presented here go beyond the results published earlier,[27] which focussed only on the context and networks of the sample as a whole. This analysis presents nuances in the men's experiences and perspectives.

Results

To maintain confidentiality, participant names have been altered and age categories used. Participant age, the region where they believed HIV transmission occurred and sexual identity are indicated in brackets.

Demographics

Fourteen men participated in the study, nine of whom identified as heterosexual and five as gay. Participant ages ranged between 20 and 69 years. Most participants identified as single during their time of travel and believed they had acquired HIV during sexual intercourse that occurred with a partner they had met while travelling overseas. All participants had travelled overseas multiple times; more than half the men had travelled overseas at least 11 times in past 5 years. Most men believed that HIV transmission had occurred when travelling in Asia. See Table 1 for a detailed overview of the characteristics of participants.

Box 1. Interview schedule domains of enquiry

Demographic information

Health and travel characteristics

Reasons for being overseas

Knowledge, attitudes, beliefs, values, context and setting-based constructs related to their experiences overseas

The risk of HIV acquisition given their personal circumstances and behaviours while they were overseas

Initial analysis found the role of social norms and networks to be significant[27] across the sample. Entry into local culture was facilitated by highly influential social networks comprising other foreign travellers and expatriates, guiding new travellers on how to manage the local scene, including where to meet sex partners and find good bars and clubs. Most participants' understanding of context and culture developed through interactions with other foreigners rather than with locals.[27]

Further analysis identified four dominant experiences: (1) a fantasy realised, (2) escaping and finding a new self or life, (3) living a life less ordinary, and (4) living local but still an outsider. Categories were based on descriptions of experiences and the participants' own perceptions and intentions before and during their time in their host country. Participant descriptions of their experiences could largely be grouped within one of these domains, though some men's experiences spanned two domains, as illustrated in Fig. 1. The following description of the four experience domains highlights how risk generally, and sexual risk in particular, did or did not feature in these men's understanding of their experiences.

A fantasy realised

For some men, the host country was seen as a short-term fantasyland, an outlet from their life in Australia. These men were not looking for a life change but opportunities to try and do new or different things as an occasional outlet. They could engage in activities they would not normally do or have the opportunity to do in Australia or, from their point of view, anywhere else.

Ronald (30s, Asia, heterosexual), whose experiences fell into more than one category (also 'living local but still an outsider') described his initial year of travelling to Thailand as a world that he had not known existed, later progressing to a stronger connection to local culture and environment. There was a clear distinction between his regimented and safety-focussed existence working in the mining industry and spending care-free time in Thailand.

> '*It's a mindset – working 5 weeks away and 1 week off, you do get that sense that you are being a robot... You're sacrificing your life... The minute you get a chance to live your life...you become hedonistic.*'

This was reinforced with each successive trip. Time in Thailand was expressly viewed as the opportunity to experience what he could not or would not experience in Australia. Although the experiences changed over time, moving from alcohol, partying and multiple partners to pursuing what he saw as more cultural pursuits and seeing one woman over a sustained period of time, the overall experience still represented a fantasy.

> '*You were there to experience what you wouldn't be able to do back here. It surprises*

Table 1. Background characteristics of study participants

	Heterosexual-identifying participants ($n=9$)	Gay-identifying participants ($n=5$)	All participants ($n=14$)
Age group			
20–29 years	0	1	1
30–39 years	2	1	3
40–49 years	2	2	4
50–59 years	2	1	3
60+ years	3	0	3
Country of birth			
Australia	6	4	10
Europe	3	0	3
Asia	0	1	1
Primary reason overseas			
Work-related	4	3	7
Holiday or leisure	5	2	7
HIV test before HIV diagnosis test			
Tested within previous 12 months	1	4	5
Tested 1–3 years previously	3	1	4
Tested more than 3 years previously	2	0	2
Not previously tested	3	0	3
Year believed HIV transmission occurred			
2000–2004	6	1	7
2005–2009	3	4	7
Year diagnosed with HIV			
2003–2006	5	2	7
2007–2009	4	3	7
Duration between believed HIV acquisition and initial diagnosis of HIV/AIDS			
Less than 1 year	0	2	2
1–2 years	5	3	8
3–5 years	4	0	4
Region HIV transmission was believed to have occurred			
Asia	7	4	11
Africa	1	1	2
North America	1	0	1
Identified modes of HIV transmission[A]			
Male–female penile–vaginal	9		9
Male–male penile–anal	–	5	5
HIV status of partner from whom HIV was probably acquired			
Unknown HIV-positive	9	5	14
Known or reason to suspect HIV-positive	0	0	0
Times travelled overseas			
2–5 times	1	2	3
6–10 times	1	1	2
11 or more times	6	3	9
Times travelled to country where HIV infection was believed to have occurred			
1	2	1	3
2–5	2	1	3
6–10	3	2	5
11 or more	3	0	3

[A]These are all the potential transmission modes identified by the men. None of the men reported injecting drug use or the sharing of needles, nor felt that oral sex had been a potential mode of transmission.

me that I was ever into something like that, you know?' (Ronald, 30s, Asia, heterosexual)

Christian (40s, Asia, gay) described another example of feeling immersed in an uplifting and positive fantasy environment compared with the description of his life in Australia:

'*You know, I'm not A list, but I'd scrape by as a B list. It was a real indulgence being around happy, confident, sexy people who were enjoying their lives and were quite happy to have you enjoying your life in the same spot*'.

For Christian, the experiences were about parties and friendships within those party networks of locals and expatriates and a sustained feeling of being 'in demand, knowing that you never have to go home alone. It's a big attraction.'

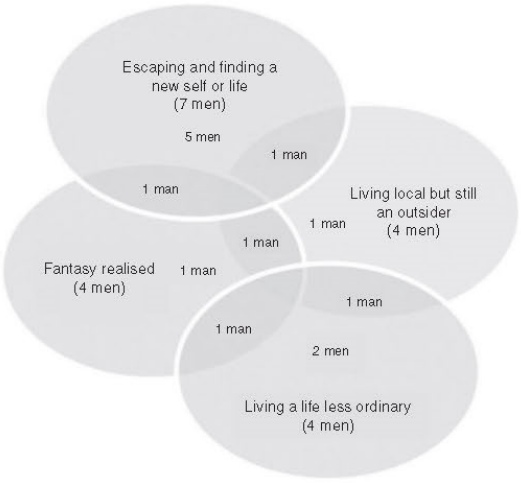

Fig. 1. Categorising participants across the four identified experience domains.

> '*It's one big aura of ecstasy that permeates the culture.*'

A similar fantasy was described by Benjamin (30s, Asia, heterosexual) when meeting women at local bars who were sex workers:

> '*When you have the girlfriend experience… you don't feel like you are soliciting a prostitute…You are being a sex tourist in doing what you are doing and she is a prostitute in doing what she is doing. But you feel like you are walking into a bar, chatting up a chick, you are buying her drinks and your mates are around. Everyone is dancing and having a good time.*'

For men in this category, the fantasy was not exclusively the sexual context but was also about the adventure of the country, the lack of regulatory or environmental safety limitations compared with those they experienced in Australia, beach culture, the time and inclination to try new things, and the opportunities 'to let your defences down with alcohol and the mix'. It was characterised as being in environments where 'the fact that you are on holiday' and the usual home environment responsibilities receded. Experiencing this fantasy became regular and although the risk in many scenarios was acknowledged, it was assessed in the same frame of reference to that which they used when at home, rather than assessed in the context of a setting that lacked the regulatory controls that exist in Australia.

> '*It is like going to a nightclub* [in Australia] *and picking up a girl, and you get along with her fairly well and condoms will go out the window…Over there it is like that too. It's like a falling in love mindset. It's something that might go somewhere*'. (Benjamin, 30s, Asia, heterosexual)

The same risks taken in the Australian context were also taken overseas; however, the setting became more inherently risky. Additionally, compared with their Australian life, the men found themselves in an environment where taking risks was normalised by both peers and locals, and being risk-averse was the antithesis of this.

> '*You don't want to know that everything is too tough… no matter how sensible or smart you are.*' (Benjamin, 30s, Asia, heterosexual)

The experience was more about managing or pursuing a fantasy than reducing risk.

Escape and finding a new self or life

The men whose experiences fitted in this category were mostly those who expressed a strong desire to be far from home and from their previous life, but did not see this as a long-term lifestyle change. For some men, travel had a clear end point.

> '*I just wanted to go and travel… just to travel; I wanted to be by myself.*' (Kim, 30+, Asia, gay)

Experiences were linked to a process of 'reassessing and re-evaluating,' described by Kim travelling soon after the end of a 13-year relationship.

> '*I really need to go out there and do something for myself.*'

The purpose of Kim's trip was to take a 'break from life as I knew it' and create distance from relationship, work and family obligations, and be free of restrictions:

> '*I just wanted to enjoy my freedom. I just wanted to enjoy not having any commitment, just not having to worry … cause I've always had responsible jobs and responsible hours.*'

For other men in this category, it was linked to a process of 'starting over', Benjamin (30s, Asia, heterosexual) was actively changing directions, stepping aside from what he felt had been a long period of frustrated romantic aspirations:

> '*Life's going by and you are missing out and you might be hit by a bus tomorrow… I was a virgin until I was 30 and was intensely romantic… Then because the romance wasn't happening, it was like I veered more and more towards base pleasures that compensate*[d] *for that, I guess. I felt I deserve*[d] *a bit of fun.*'

For Benjamin, the very nature of condom use was symbolic of being safe, expressed as beliefs such as 'you should wear condoms' and 'you should be sensible', which is what he felt he had been for many years without a positive romantic outcome, a situation from which he sought to escape.

> '*I didn't care because I had lost a fair bit of self-esteem…I had wasted myself*'.

For him, travel was about exploring his 'human nature' and 'forbidden' side'; sex without condoms was part of that process.

> '*It was the aura of doing something that was forbidden and wrong, and it was different.*'

Other participants described similar patterns of travel after a relationship to start afresh, with the intention of managing a new or changed life. This is something Tom (50s, Asia, heterosexual) describes seeing on a regular basis:

> '*Guys that are single or divorced come to start a new life and build up a new thing. They'll gamble to create something. . .I'd say 7 out of 10 guys will eventually bring* [a partner] *back to Australia.*'

In this experience, Tom describes that the focus of the travel was to seek a separation from their past life.

> '*A lot of guys around the 40- to 50-year-olds, they're up for a new life. . . and just blossom, mate.*'

Participants in this category did not avoid risk. In some respects, risk was a 'gamble to create something' or about engaging in activities that had previously been off-limits.

Living a life less ordinary

Generally, for the men who had this experience, it was about choosing to live life as an adventure, and actively pursue new and interesting experiences. The difference from the other types of experiences was that these men were not invested in one particular country and its culture or pursuing an escape or a short-term fantasy but were seeking an ongoing lifestyle of travel and adventure. These men considered themselves to be confident and resilient, and had experienced many countries and occupations. Travel was frequently work-related and they had little connection with their host country.

Gerald (50s, heterosexual) had worked in Indonesia for more than 15 years before taking up an employment opportunity in Thailand. He made a conscious decision about the life he had planned to live, valuing freedom, travel and opportunity.

'I went, "Gee, this isn't a bad place for a single male, an Australian," and had a really good 6 months.'

He often lived 'on the edge', undertaking dangerous or opportunistic assignments within his work:

> '*I went over and saw* [a doctor] *and told him my story, and he said "You still have a good time, mate, you're a lucky man, you know." But he said "It's getting dangerous to be playing games in those countries, you know.*"'

Gerald saw himself as someone pushing the boundaries but not irrationally or irresponsibly, indicating pride in an adventurous life and an aversion to suburban Australian life.

For Anthony (40s, gay), working in a post-conflict environment in Africa was more opportunistic than what other men in this group encountered. However, he had previously worked in similar environments and was not unfamiliar with challenging circumstances and characters:

> '*I had to go over there, sort out all their problems and stuff. . .I saw people robbing four guys who tried to rob a house down the road. They were executed just down by my house; just interrogated and shot on the spot. You think you can't be shocked and then something like that happens. You think "Whoa!*"'

For these men, risk was relative. They saw themselves living and working within risky contexts and situations, and so risk was to be managed, accepted and, for some, pursued, but certainly not avoided.

Living local but still an outsider

This domain was described by men as finding a location they felt more connection with at a social, cultural and experiential level than they did with Australia. Men in this category preferred to, planned to or had already decided to live permanently in their new country, considering themselves actively engaged in local language and customs. These men described themselves as becoming local but not being a local, with an underlying sense of difference.

> '*You go native a bit, I think, is the expression. . . Although you're definitely separate, you know?*' (Ronald, 30s, Asia, heterosexual)

Visits to Thailand by Ronald, a fly in–fly out[A] worker, became so regular that he purchased a house and based himself there when not working rather than returning to Australia. He suggests a growing sense of connection with Thailand but also acknowledged an ongoing sense of himself as an outsider, no longer a visitor but not a local either.

> '*So it's more like home. . . I was happier being up there, than down here. . .You sort of feel like you're at home or it's getting that way, but you're also an outsider to them, mostly.*'

Participants in this category revealed aspirations to become more connected to the host country, demonstrating the strongest views about respecting local culture, as they understood it.

> '*Bali's home now. I had a feeling of belonging there . . . I'm buying a house over there.*' (Don, 40s, Asia, heterosexual)

Discussing the role of spirituality and religion, Don reflected on his close affinity with the host country.

[A]'Fly in–fly out' refers to a work schedule, often used in mining and resource industries, where employees are flown in to the rural, remote or offshore work location for a certain period work (e.g. 2–4 weeks) and then flown out of the location for a similar period off work. Employees do not necessarily fly to their home location but often have the option of flying somewhere else at a similar distance for their relaxation. For WA, this may mean Thailand or Indonesia instead of returning to Perth.

> '*I've always had this attraction to Bali and now I can understand why, and it's because of the Hinduism.*'

For some, the experience of 'going native' or the sense of becoming or living like locals was linked to the formation of a sexual relationship with a local partner. Sexual risk was not a primary consideration; rather, sex assisted to develop a feeling of connectedness in the relationship. Some, but not the majority, of these ongoing relationships were with sex workers. Most participants described experiences where a level of familiarity and trust had developed with their sexual partner, resulting in a willingness to stop using condoms.

> '*I think I felt I knew her long enough... It's just one of those things that happened, really.*' (Ted, 60s, Asia, heterosexual)

The length of time or factors that created trust and connection varied. Some men stopped using condoms a few days or weeks into seeing the same partner, including relationships formed with sex workers.

> '*I went to Thailand because I had a girlfriend in Thailand, who I used to go across and see. And most of the time, we used protection. But there were a couple of times when we didn't.*' (Ted, 60s, Asia, heterosexual)

Ted's experience reflected that living locally but not being a local simultaneously developed a level of connection to country and partner. Experiences were not characterised by desire for adventure or excitement, but for belonging and stability. Few men described any clear negotiation or HIV testing in relation to decisions to stop condom use; instead, there was an unspoken assumption that they were, in Ted's words, 'in a relationship, so to speak' and managing sexual risk was less necessary. Although this is consistent, to a large extent, with research conducted with people in their home country, the added impact of a relationship also meaning increased connection with the country (and not just the person) was evident with these men.

Discussion

HIV transmission and international mobility is complex. Understanding the meanings, experiences and processes attributed to specific contexts can inform appropriate targeted health promotion. The domains of experience that have been developed in this research provide an understanding of the diversity of the perspectives, meaning and assessment of risk in the lives of men who had acquired HIV in a context different to that of Australia, and will assist to make recommendations for policy, practice and further research in to this facet of HIV and mobility. This paper has presented further findings from our study. The first explored the factors and contexts contributing to acquisition of HIV by Australian men in high HIV prevalence countries. We suggest that there are certainly several studies relating to HIV and migration of those from low- and middle-income countries to high-income countries[30,31] and some studies that have explored issues relating to risk behaviours, sex and travel.[3,11–15] However, few studies have explored the contextual factors that influence these behaviours. Those that do exist[16] support the findings of the current research, such as Yokota's[17] study of Japanese male tourists purchasing commercial sexual services in Thailand. Seeking a sense of freedom, having less responsibility and being free of usual social restrictions acted as enabling factors to purchase sex from locals. Similar to the descriptions of some of the men in our study, the study found that Japanese male tourists compared their host country to a fantasyland and a place of sexual freedom.

Other research suggests that travelling itself can lead to increased sexual behaviour and less protected behaviour due to similar reasons.[32,33] Consistent in both studies was the motivation among some men to engage in sex with locals because of the different attitudes experienced in the host country and their positive impressions of the people they were meeting. Whereas considerable cultural differences exist between Japanese and Australian populations, the findings nevertheless suggest that environmental, social and cross-cultural factors of the host countries play an important role in how risk is perceived and managed by travellers. Other research by Bianchi and colleagues explored the sexual experiences of Latino men who have sex with men who migrated to the US, and also highlighted the importance of the cultural factors that influence sexual behaviour and risk.[22]

Men in this study did not present themselves as risk-averse. Most suggested that some situations demanded a level of risk and trust. For some of the men, seeking and embracing risk was a response to a significant period of time being risk-averse, such as within employment. For these men, risk was part of both personal and professional domains, which is supported by a range of research that demonstrates strong links between employment and risky sexual behaviour. In some instances, this may be because of a highly disposable income or because employment may involve periods of monotony combined with stressful elements or situations of peer influence that normalise a culture of risk-taking or risk behaviour.[34–36] For others, there was little indication the men were ever particularly risk-averse. The types of experiences described in this article provide an insight as to how the men positioned and engaged risk within their life while travelling, living or working overseas. The themes also show that the relative meaning of risk and pleasure or adventure was pursued, constructed and reinforced by the men and their networks. Separate research has also observed that many gay men make similar assessments about risk and pleasure within this understanding of relative risk, often reflecting their own pre-existing perspectives about desire and risk.[37] This resonates with sentiments from Adam and colleagues of a 'risk society',[38] referring to a set of social, political and cultural conditions within which the men constructed and experienced risk in their daily lives. This includes normalising risk, reviewing what is worthy of being considered a risk or subsuming thoughts of risk.[39] Theorists of risk argue that 'what we see as a risk is not absolute reality, but instead depends on the kind of lens and the way in which we look through it'.[40] Risk perceptions cannot be objectively observed but, like community and identity, are socially and interactively constructed.[38]

Participant narratives invoked a concept of growing physical and emotional distance from Australia, from past relationships and, for some, from the transactional nature of sex work, which

was strengthened by a sense of increasing connection to their new environment. There was a powerful sense of place as being central to a sense of both losing and finding oneself. This is supported by studies such as those by Howard, who examined the experiences of Western retirees in Thailand, and Lewis, who explored migration in gay men in North America.[41,42] There was a sense of transition or 'in-betweeness' in the accounts shared by our participants, for example, of being neither tourist nor local. For some, HIV infection may have resulted because of a change in their usual sexual practices as a result of travelling and being in a different cultural context, and may reflect a greater sense of freedom or a change in the way that they thought about themselves or their partners (as raised in the account by Ted). For others, HIV transmission reflects consistency of condom non-use (or occasional condom non-use) established in Australia but taking place in an environment of greater HIV prevalence (such as in the account by Benjamin). However, the meaning and value of condom non-use may be given additional emphasis by being more than associations with forming a relationship,[18,24,39] but in forming a relationship there was an increased sense of connection with the country. These factors pose significant challenges to engage and reach such men about behaviour that may place themselves and their sexual partners at risk.

This exploratory qualitative study examined the experiences of Australian men who acquired HIV during overseas travel for work or leisure, a very specific context. The study included men who were comfortable describing their experiences and so may be subject to recall bias. The research heard and presented the male voice through the lens of the experiences of participating men. Perspectives and experiences provided were as the men interpreted them, and may or may not be consistent with experiences of nonparticipating men. Verifying interviews were not conducted with partners or networks of participants, which may have created some stereotypes that have remained unchallenged, particularly about female partners and sex workers, which may require further exploration. Some examination of potential or perceived stigmatisation or 'othering' of those in the host countries, particularly within South-east Asia, may be also valuable. Further interviews with men who have acquired HIV overseas or with those who are frequent travellers may generate additional or adapted experience domains in the future.

The Australian response to HIV has been characterised by the active participation of communities most affected by HIV. However, it is unclear what 'active participation' means for (often disparate) communities of expatriates and travellers. This research recognises that regular or long-term male travellers have a unique culture within which risk generally and sexual risk and safety specifically is enacted and given meaning. Active risk-seeking, adventure, escape or connection might be a key element to their desire for travel, and may impact on the way they understand risk, give meaning to relationships and respond to sexual health promotion strategies and messages. Generalised travel health promotion messaging is likely to be ineffective with this target group. If travel campaigns are to be used, they should be targeted to experiences and the most at-risk travellers, rather than travellers more broadly, and could target travel medicine and other testing sites. Members of the target group could be recruited to discuss possible interventions and approaches with their peers.

Focussing on the role of peer and social influence, which have been successful in other areas of HIV, may yield better results. There are several assets within the social network of those interviewed for this study that should be further explored to better understand how these networks function and flourish, and the potential role of key opinion leaders in the networks. Resulting interventions may explore the potential of bars and other local settings, or online networks.[43] There is also a role for greater advocacy from Australia regarding access to and quality of HIV testing within neighbouring countries in the region.

Any different or complementary engagement strategies must avoid undermining country or regional programs by reinforcing stigma or notions of stereotyped risk groups or cultures such as misconceptions about the role or use of sex workers both within Australia and overseas. Finally, this research indicates that targeting interventions to men experiencing the domains described in this study as though their aim is to minimise all risk is likely to be ineffective. Appealing to desired experiences such as connection to local culture, maintaining a fantasy or sustaining a new or adventurous life may have more resonance.

Conflicts of interest

None declared.

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2.3 Knowledge, attitudes and risk behaviour amongst expatriates and travellers from high-income countries: who is at risk, what are the risks?

Publication Three: HIV and STIs amongst expatriates and travellers to low and middle income countries: A systematic review

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Review

HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review

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Abstract: In some high-income countries, a proportion of human immunodeficiency virus (HIV), other blood-borne virus (BBV) or sexually transmitted infection (STI) diagnoses have been reported as acquired overseas in low- and middle-income countries. A review was conducted to explore HIV, other BBV or STI related knowledge, risk behavior and acquisition amongst expatriates and travelers, particularly males, travelling from high to low- and middle-income countries. Seven academic databases were searched for 26 peer reviewed articles that met inclusion criteria. Significant variability in the studies was noted, in age, travel duration and frequency and outcomes/risk factors measured and reported on. Risk factors described included longer duration of stay; being single; travel for romance or sex; alcohol and other drug use; lack of travel advice; being male; higher number of sexual partners; and inconsistent condom use. Vaccination, pre-travel health advice, and having fewer sexual partners were described as protective. Studies are needed focusing on the social context in which risk-taking occurs. Better collaboration is essential to deliver comprehensive health promotion interventions alongside more consistent pre- and post- travel testing and advice. Policy measures are crucial, including consistent evaluation indicators to assess impacts of HIV, other BBVs or STIs in the context of mobility. Risks and responses for these epidemics are shared globally.

Keywords: expatriates; travelers; HIV; HIV acquisition overseas; sexual health; high- to low- and middle-income countries; population mobility

1. Introduction

Population mobility is significant in scope, complexity and impact. It is an intrinsic feature of an increasingly globalized and borderless world [1,2]. Every year, more than three billion passengers travel by air [3] and over 50 million people travel from high to low- and middle-income countries [4,5]. Public health is confronted by issues inexorably linked to population mobility [6,7]. For example, evidence closely links population mobility with deleterious impacts on sexual health, including the transmission or acquisition of human immunodeficiency virus (HIV), other blood-borne viruses (BBVs) or sexually transmitted infections (STIs) [8]. Mobility has not only been identified as a driver of epidemics, it may also exacerbate existing risk factors, or increase individual vulnerability for

acquisition of HIV, other BBVs or STIs [9]. This is influenced by push and pull factors, including motivation (employment, leisure) for, direction and destination (e.g., from the global south to the global north) of, and level of control (e.g., asylum, displacement) over travel [5].

HIV, other BBVs or STIs are some of the most commonly notifiable infections globally and are endemic in many low- and middle-income countries, particularly among priority populations (such as sex workers, men who have sex with men (via unprotected anal intercourse) or people who inject drugs) [10]. In 2012, the World Health Organization (WHO) estimated around 357 million new STI infections amongst those aged 15–49 years: trichomoniasis (n = 143 million), chlamydia (n = 131 million), gonorrhea (n = 78 million) and syphilis (n = 5.6 million) [10,11]. Additionally, as of 2015, there were an estimated 34.3 million people over the age of 15 years living with HIV [12]. The presence of an STI left untreated significantly increases the risk of acquisition and transmission of HIV [13]. The economic cost of STIs in the United States (U.S.) alone is around $16 billion (USD) in direct medical costs [14], notwithstanding the psychological and social consequences of STIs that have a major impact on quality of life [13].

During the last 25 years, population mobility has experienced significant growth both within and between countries and regions [1]. The United Nations World Tourism Organization suggested that for the first time, more than 1 billion people crossed international borders in 2012. Of those, one in two travelled for recreation or leisure and around a third for a range of reasons, such as visiting friends and family, or for religion or health care [15]. Amongst United Kingdom (UK) residents, international travel was common with an estimated 55 million visits overseas in 2010 [16]. In Australia, there were 16.9 million departures in 2014–2015, comprising 9.2 million Australian residents departing short-term, 7.3 million visitors and 391,200 permanent and long-term departures [17].

Increasingly permeable geopolitical borders quickly and easily link countries with high and low prevalence of HIV, other BBVs or STIs [18]. People migrate to high-income countries from low- and middle-income countries, and a growing number of people travel, constantly, semi-permanently or permanently from low prevalence, high-income countries, such as Australia and the UK, to regions where HIV, other BBVs and STIs are prevalent, particularly Sub-Saharan Africa and South East Asia. People may travel from high to low- and middle-income regions for purposes including working and volunteering, family reunion, leisure and tourism (including to seek sex), military and peacekeeping exercises, and retirement [19–22].

Travelling to and from countries of high HIV, other BBV or STI prevalence, places migrant and mobile populations at risk for communicable diseases [8] and enhances the likehood of onward transmission (particularly for those that do not know their infection status) in both the destination country as well as the country of origin (on redomestication). The context of risk is complex. The literature highlights a range of factors that may influence vulnerability for transmission and acquisition of HIV, other BBVs or STIs [23–25]. This includes frequency of travel to countries of high prevalence; participation in high risk sexual practices; use of protective behaviors (such as condoms); or, the presence of an untreated STI [26,27]. Further, risk may be mediated by knowledge of modes of transmission; access to health services (for testing, diagnosis and treatment); availability of travel advice; or the existence of supporting laws which do not criminalize practices of priority populations (such as men who have sex with men and sex workers) [28–30].

Increasing notifications have been observed, particularly of HIV, amongst migrants from low and middle-income countries travelling to high-income countries (acquired both prior to and after arrival in their destination country) [9]. Additionally, a number of high-income countries have reported increasing notifications of overseas acquired HIV, other BBVs or STIs, including those acquired in low- and middle-income countries [9]. Notwithstanding the inherent challenges in achieving the appropriate level of granularity in the way in which data is reported within and between countries, there is some merit in mentioning the broad trends that have been seen. For example, of UK-born adults diagnosed between 2002 and 2010, 15% (n = 2066) acquired HIV overseas, most commonly in Thailand, the U.S. and South Africa [31]. In Canada, from 2009 to 2011, 348 cases of blood-borne

viruses or sexually transmitted infections related to travel were diagnosed via a CanTravNet site (of 3943 ill returned travelers) [32].

In Australia, HIV data are reported inconsistently across states and it has taken some time to harmonize surveillance data. Generally, surveillance data now shows where the individual was born and where HIV was likely acquired. Data from Western Australia show that between 2005 to 2009 and 2010 to 2014, the number of overseas acquired HIV cases increased by 56%. Of 731 new infections which were diagnosed in the period 2010–2015, 52% (n = 382) of cases reported overseas acquisition. Of these, a quarter (n = 93) were diagnosed amongst Australian born men, who had acquired HIV overseas most commonly in South East Asia or Sub-Saharan Africa [33]. In South Australia, 2014 data reported that 50% of cases had been acquired overseas (n = 28) [34]. In New South Wales (NSW), (the state with the highest HIV prevalence, historically acquired amongst men who have sex with men), 350 new diagnoses were made in 2015. Of these, 9% (n = 30) were born in Australia but likely acquired HIV overseas (compared with 6% of new diagnoses in 2009–2014). A further 19% (n = 65) were born overseas and likely acquired HIV overseas, compared with 15% of new diagnoses 2009–2014 [35].

Increasing travel to and from countries with high prevalence of HIV, other BBVs or STIs, coupled with contexts which may amplify risks, creates an emerging and important priority for public health [36]. Countries such as Australia have prioritized mobile and migrant populations in their national strategies for HIV, other BBVs or STIs [37]. Operationalizing this has proved more challenging, and addressing this issue presents challenges for clinicians, public health practitioners, policymakers and researchers to influence behavior and practices which occur beyond country borders [21]. Action is required to better understand the needs of both migrants and other mobile populations. Approaches and responses must be sensitive to culture and context and must not reify stigma towards specific countries or populations.

Few studies have been identified which examine the behaviors and contexts of HIV, other BBVs or STIs acquisitions amongst expatriates and travellers to low- and middle-income countries. However, the literature points to a number of opportunities for intervention and engagement such as pre-and post- travel advice, use of HIV treatments as prevention to reduce community viral load, in-country outreach and online and other health promotion interventions [9].

To explore this issue further, and as part of a larger study examining male expatriate and traveler social networks and risks for HIV and other STIs, we sought to build on previous reviews exploring traveller sexual health [20,22,28,30,38–43]. This work was undertaken concurrently with work examining the experiences, barriers and enablers related to HIV acquisition risk amongst migrants from low- and middle-income countries travelling to high-income countries. We reviewed existing evidence regarding the sexual health behaviors, experiences and outcomes (including HIV, other BBVs or STIs) amongst expatriates and travellers from high-income countries aged 18 years or older travelling to low- and middle-income countries.

2. Materials and Methods

The review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [44]. Procedures used in this review followed those from other systematic reviews conducted by the Collaboration for Evidence, Research and Impact in Public Health [45–47]. The review was registered in the PROSPERO International Prospective Register of Systematic Reviews (Registration number: CRD42016033106).

Only quantitative and qualitative primary studies, published in English, in peer reviewed journals, between the years 2000–2015 were included in the review. Studies included those conducted with: (1) adults (over the age of 18 years); (2) males; (3) expatriates and travelers; (4) from high-income countries travelling to low- and middle-income countries; and (5) exploring sexual health behaviors and harms. For the purpose of this review, high-income countries were those nominated as Organization for Economic Co-operation and Development (OECD) countries with a Gross National Income per capita above $12,746 (USD) [48].

The review excluded studies published prior to 2000 or after 2015; non-peer reviewed articles and grey literature; studies about participants under 18 years of age; studies specifically with women; studies on expatriates and travelers who move between high-income countries; studies on expatriates and travelers from low- and middle-income countries; and studies that did not focus on sexual health. Outcomes included demographics of travelers and individual characteristics; knowledge of sexual health behaviors; experiences; risk factors; testing and diagnosis of HIV, other BBVs or STIs.

Seven databases were searched. Databases and search terms are listed in Table 1 below. All applicable variations, including Medical Subject Headings (MeSH) terms were used according to database specifications. PubMed, the Cochrane Library and Google Scholar were used to substantiate results of database searches. Reference lists from pertinent papers were examined to determine whether database results were exhaustive. Initial searched fields included keyword, title and abstract.

Table 1. Search terms and databases used in the systematic review.

Databases	PsycINFO, MEDLINE, ProQuest, Scopus, Global Health, Web of Science, Embase
Search Terms	Sexual health related terms ("sexually transmitted infection" OR "sexually transmissible infection" OR "sexually transmitted disease" OR "sexually transmissible disease" OR "human immunodeficiency virus" OR "blood borne virus" OR STI OR HIV OR BBV OR STD OR sex OR "condom use" OR "sexual health" OR "sexual behavior" OR "sexual behavior" OR "sexual health risk" OR "sexual risk" OR "unsafe sex" OR "unprotected sex" OR "casual sex" OR "sexual intercourse" OR "sexual health behavior" OR "sexual health behavior" OR "venereal disease")
	Expatriate and traveler related terms (expatriate OR traveler OR traveler OR "overseas volunteering" OR "military personnel" OR "aid work" OR "humanitarian aid" OR "lifestyle migration" OR "residential tourism" OR "international retirement migration" OR retirement OR retirees OR relocate OR relocation OR "transnational travel" OR "corporate travel" OR "business travel" OR "occupational travel" OR mining)
	Target group related terms (male OR men)

STI: sexually transmitted infection; HIV: human immunodeficiency virus; BBV: blood-borne virus; STD: sexually transmitted disease.

Endnote X7 (Clarivate Analytics, Philadelphia, PA, USA) citation management software was used to manage all articles. Two researchers conducted individual searches for each database, to ensure a full and comprehensive search was conducted with limited bias [49]. Articles from each database were imported into each researcher's Endnote file. A search of the secondary databases was also conducted, using either the same search terms as the primary database searches, or key concepts, depending on the specificity of the database. Once all articles were imported, duplicates were removed. Endnote libraries were then combined and further duplicates were removed. Titles and available abstracts were screened for applicability based on inclusion criteria. Those not obviously relevant were removed. Citations were categorized into three groups for all databases: (1) possibly relevant studies; (2) background literature (including reviews); and (3) clearly irrelevant studies.

Only primary studies were included within the review. Reference lists of relevant literature and other reviews were manually searched to identify any other relevant primary articles as part of the inclusion assessment described above. Selected articles were reviewed in full where there was any uncertainty as to whether studies met inclusion criteria based on title and abstract alone. A quality appraisal was conducted to assess methodological quality of included studies. Two researchers conducted the assessment, using an adapted checklist [50–52]. The appraisal was then cross-checked by a further two members from the research team.

A standard recording form was used to extract data of every study included in the review. This process was carried out by two researchers and then cross-checked by a second researcher to ensure consistency, facilitate accurate data presentation and confirm that there were no mistakes [49,53].

The data extracted included citation; participant characteristics; methods; results; and key conclusions of study authors. Figure 1 shows the process undertaken for the review.

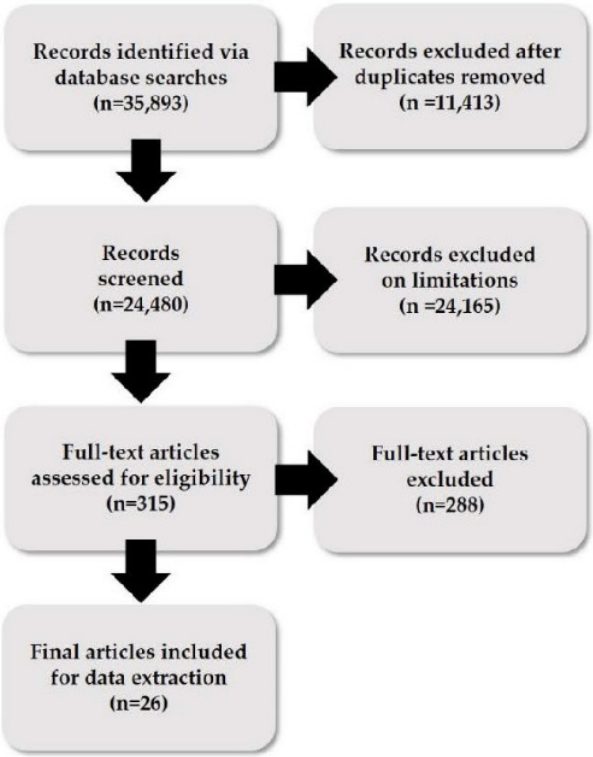

Figure 1. Flow diagram of review process.

3. Results

Twenty-six studies met the criteria for inclusion. The results have been categorized through the inclusion criteria, into multiple domains:

- Study Overview—design, setting, participant type and number
- Traveller and Travel Characteristics—gender, sexuality and age; participant country of origin and destination; purpose of travel, length of stay and frequency of travel
- Knowledge, Attitudes and Beliefs—perceptions of travel and destination countries; sexual expectations; knowledge of HIV, other BBVs or STIs
- Sexual Partner Acquisition—influencing factors; sexual mixing; commercial sex; number of sexual partners
- Alcohol and Other Drug Use—frequency of use, type, role as risk factor
- Condom Use—consistency of condom use; influencing factors
- Pre-Travel Health Consultation-use and experience; advice given
- Vaccination—knowledge and vaccination coverage
- Acquisition of HIV, other BBV or STI—risk behavior; diagnosis and related symptoms; place of acquisition; influencing factors
- Study Recommendations—policy, practice (clinical and health promotion) and research

A sample of the data extraction for the review and summary of key information extracted from the selected studies can be found in the Supplementary Materials (Table S1) attached to this review online and are reported for each included study under the following headings: author and purpose; origin and destination of travel; study details; sample and response; and reported outcomes.

3.1. Study Design and Setting

The final included articles comprised 21 quantitative studies [27,31,32,54–71] and five qualitative studies [29,72–75]. The size of the studies ranged from between eight and 34 participants in the qualitative studies and quantitative studies with up to 112,180 participants. The majority of the data collection for the studies occurred between 2000 and 2013. Four of the studies conducted consultations with patients during the 1990s, however all studies were published within the 2000 and 2015 date limits assigned for this review.

Of the 26 included studies, nine were conducted in Europe [55,59,60,63,64,67,68,71], five in the UK [27,31,56,65,69], four in each Australia [66,70,73,74] and South America [54,57,58,72], three in South-East Asia [29,62,75] and one in each Canada [32] and West Africa [61] respectively. Four studies [55,64,67,71] were conducted in travel medicine clinics and two South American studies were conducted in Peruvian airports [57,58].

3.2. Traveller and Travel Characteristics

Traveler and travel characteristics described are gender, sexuality and age; participant country of origin and destination; purpose of travel, length of stay and frequency of travel.

3.2.1. Gender, Sexuality and Age

Twenty-two of the studies included both male and female participants; only four of the studies specifically targeted males. Sexuality was recorded in eleven studies [29,31,54,57,58,65,67,70,73–75]. Of these, six studies reported both heterosexual and homosexual participants [31,65,67,70,73,74], three studies reported heterosexual, homosexual and bisexual participants [54,57,58], while there was one study each that focused on homosexual participants only [75] and heterosexual participants only [29]. The studies varied in participant age with the majority including participants between 18 and 70 years.

3.2.2. Origin

Specific country of origin was reported in 23 studies [27,29,31,32,54,56–63,65–70,72–75], with the majority of studies including participants from a range of countries. Amongst the 23 studies that reported participant origin, eight specifically originated in the U.S., seven were from Australia and six originated from England. Both the United Kingdom as a whole and The Netherlands had five studies each. Four of the studies originated from Germany, Sweden and general Europe respectively, while France and Belgium had three studies each and Italy had two. Austria, Switzerland, Spain, Finland, Canada, Scotland, Ireland and Japan were all represented once in the studies.

3.2.3. Destination

Destination of travel was reported in 23 studies [27,29,31,54–58,60–74]. Most of the studies included multiple destinations. The most frequently cited destinations were Asia broadly ($n = 12$), Central and South America ($n = 10$), Africa broadly ($n = 9$), Sub-Saharan Africa ($n = 8$), Thailand ($n = 5$), the Caribbean ($n = 4$), South-East Asia ($n = 3$), Peru specifically ($n = 3$) and North Africa ($n = 2$).

3.2.4. Purpose of Travel

Purpose of travel was captured in 22 studies [27,29,32,54–62,64,66–69,71–75], with the majority of the studies reporting more than one purpose for travel. Tourism and vacation were most commonly reported ($n = 17$) followed by work and business ($n = 12$) and visiting relatives and friends ($n = 7$). Other less frequently reported reasons for travel included studying ($n = 5$), volunteering ($n = 4$), expatriation ($n = 4$), other ($n = 4$) and immigration ($n = 1$). Although most of the studies reported various reasons for travel, four of the studies specifically focused on longer term travel due to work [56,60,61,67] and three

focused on lifestyle migration [73–75]. Nine of the studies recorded whether the travelers travelled with any partners or companions [54,57–60,62,63,71,72].

3.2.5. Length of Stay and Frequency of Travel

Fifteen studies recorded length of stay of expatriates and travelers [27,29,32,54–62,64,66,67,71]. Stays ranged between six days and 11 months. The median length of stay reported for these studies was less than one month. For studies reporting on voluntary service overseas [56], aid work [60] and corporate expatriation [61], longer than six months of stay was most commonly reported. Five studies stated the frequency of travel of participants to particular destinations, ranging from a one-time occurrence, to more than eleven times in the past five years. [27,29,62,73,74].

3.3. Knowledge, Attitudes and Beliefs

Fourteen studies [29,57–59,62,63,65,66,68,69,72–75] reported on knowledge, attitudes and beliefs of travelers regarding sexual behavior and risk while overseas.

3.3.1. Perceptions of Travel and Destination Countries

Five qualitative studies described perceptions of travel [29,72–75]. Studies by Brown and colleagues [73,74], Yokota [29] and Collins [75], reported specifically on perspectives and experiences among male travelers particularly travelling to Africa and Asia. The men within these studies often characterized their home countries as repressive, controlling and normative towards gender and sexuality. Factors identified that encouraged sexual activity and risk behaviors amongst men while overseas included perceptions that host countries are non-normative and that promote sexual freedom and participation in activities that are deemed "off-limits" at home [29,73–75]. Participants often sought out adventurous and different experiences, without an intention to assess the risks of doing so, or applied pre-existing understanding of risks in the home country to the destination country. Risk-taking behaviors such as the use of alcohol and other drugs, and multiple sexual partners were not uncommon [58,72,74]. These perceptions and attitudes toward mobility and sexual risk-taking behavior were shared among male Japanese travelers, particularly those seeking commercial sex in Thailand [29]. Knowledge of commercial sex services, specifically the known low-cost and wide availability of such services, were cited as contributing factors for increased likelihood of participating in commercial sex in Thailand [29]. Other attitudes identified towards mobility included a longing for a short-term escape or the sustaining of a new, long-term lifestyle within destination countries [73,74]. Several of the studies, including the study by Bauer [72] in Peru, suggested that engaging in sex overseas may offer a bridge for connection with the destination country's culture, in order to successfully establish this long-term lifestyle, while mobility enables the opportunity for self-actualization and re-invention [72–74].

3.3.2. Sexual Expectations

Nine studies [29,57–59,63,72–75] reported on attitudes concerning travelers' expectations or intentions to have casual sex while overseas. Cabada et al. [57] identified travelers from the U.S. to have a greater expectation of casual sex in Peru and in turn, a greater number of sexual partners ($p = 0.002$), in comparison to those from Europe. Additionally, Croughs et al. [59] reported that the expectation to have sex overseas was more common among males in comparison to female travelers, with one-half and one-quarter expecting casual sex, respectively. The study by Manieri et al. [63] of Swedish male sex tourists in Thailand found that around half (48%; $n = 76$) of participants had expectations of casual sex with sex workers while overseas. Finally, Yokota [29] found perceived permissive norms toward commercial sex in Thailand which influenced expectations of casual or commercial sex.

3.3.3. Knowledge of HIV, Other BBVs or STIs

Three studies reported on travelers' knowledge of hepatitis B (HBV) and related risks [66,68,69]. Approximately half (45% [66] and 54% [69]) of travelers within two of these studies could define HBV or the related modes of transmission. The studies by Zuckerman and Hoet [68] and Zuckerman and Steffen [69] found however, a range of misconceptions including that hepatitis B was a result of excessive alcohol consumption, was rare as a sexually transmitted disease primarily affecting homosexuals and transmitted through contaminated food and water. Streeton and Zwar [66] determined that only one in five travelers identified HBV as a travel-related infection and only one in four knew of HBV vaccination availability. While one-third of travelers perceived themselves to be at risk for HBV exposure while in their home country (Australia), less than half (12%) of these travelers believed they were at risk of HBV exposure while travelling [66].

In relation to the risk of HIV exposure, Mercer et al. [65] reported greater perceived risk of HIV exposure among both women and men who had acquired a sexual partner overseas, compared to those who had not ($p = 0.001$). Manieri et al. [63] also reported a low (15%) mean risk estimate in relation to the perceived risk of HIV exposure through unprotected sex with a sex worker. Mercer et al. [65] also found that around 80% of respondents considered risks for HIV "somewhat more likely" or "much more likely" for individuals living in Thailand or Kenya. Brown et al. [73,74] found that men who identified as gay were more aware than those who identified as heterosexual, of preventative campaigns and testing to prevent HIV infection. Bauer [72] found generally poor levels of knowledge of STIs and safer sex within both locals and visitors to Cuzco associated with a lack of prevention campaigns and other education. Further, the study found that locals believed HIV infection was only associated with "homosexual behavior".

3.4. Sexual Partner Acquisition

Nineteen studies reported on the acquisition of sexual partners while overseas [27,29,54,55,57–62,64–67,69,71–74]. Four studies purposefully sampled those either with an STI or those who had a sexual relationship overseas [29,64,71,74]. Of the remaining studies, the proportion of participants that had sex overseas ranged from 5% ($n = 23$ of 503) [66] to 52% ($n = 245$ of 468) [54], with between 5% and 30% most commonly reported.

Sex overseas was more frequently reported by male participants [27,57–60,62,67,69]. Other factors associated with greater likelihood of sexual partner acquisition and type included being single or travelling alone [29,57–60,65,67]; length of stay longer than one month [55,57,58,60,62]; premeditated expectation of sex overseas [58,59]; visiting multiple countries [67–69]; alcohol or other drug consumption [29,54,57–61,72,74]; identifying as homosexual or bisexual [57,58,65,67]; previous experience in the destination country [29,62], and a previous STI diagnosis [27,65].

3.4.1. Sexual Mixing

Partner type was reported in 17 studies [29,31,54–59,61,62,65,67,71–75]. Locals in destination countries were the most commonly reported type of sexual partner ($n = 15$). Six of the studies reported between 42% and 67.3% of study participants engaged in sexual encounters with a local partner [55,57,59,62,67,71]. Of these, males were more likely than females to report a sexual encounter with a local companion ($p < 0.05$) [59,61,67]. Sexual encounters with other travelers were also documented, with Mercer et al. [65] reporting 50% of Britons having other UK nationals as their sexual partners, and 30% with partners travelling from European countries.

3.4.2. Commercial Sex

Frequency of use, experience with or intention to purchase services of sex workers in the destination country was reported in 10 studies [29,31,54,57,58,62,63,73–75]. All Japanese male participants ($n = 30$) in the study by Yokota (2006) had engaged in commercial sex with a Thai sex

worker in Bangkok, Thailand. Six studies [31,54,57,58,62,75] found only a relatively small proportion of participants had engaged sex workers. The proportion of participants that engaged sex workers in these studies ranged from 2%–25%. Participants in studies by Alcedo et al. [54], Cabada et al. [57,58] and Kaehler et al. [62] were more likely to report sex with other travelers or locals than sex workers. Rice et al. [31] reported that individuals acquiring HIV overseas were more likely to report purchasing sex (5%; $n = 70$ of 1516) than those who acquired HIV in the UK (0.7%; $n = 51$ of 7766) ($p < 0.01$). Further, engaging a sex worker was reported most frequently among men acquiring HIV in Thailand (11%; $n = 39$ of 347). Manieri et al. [63] reported on participant intention to pay for sex with Thai sex workers amongst men travelling for sex tourism ($n = 158$). Two-thirds of participants (63%) reported previous experience with sex workers, and around half (48%) had an intention to have sex with a sex worker during the current trip. While age was not associated with intent to engage a sex worker, relationship status (OR = 3.9) and prior experience with sex workers (OR = 17.7) were highly significant. No association was found between travel companionship and intent to purchase sexual services, though travelling alone (OR = 2.8) was somewhat significant. Both being single (OR = 5.0) and previous experience purchasing sex (OR = 43.3) were associated with an intent to purchase sex during the current travel.

3.4.3. Number of Sexual Partners

Of the seven studies reporting the median number of sexual partners among travelers [54,57,58,60,67,71,72], one partner was most commonly reported [54,57,60,71], with the median number of sexual partners being three [54]. Male travelers were more likely than female travelers to report multiple sexual partner overseas [27,59,60,62,65,67]. The study by Whelan et al. [67] is one example of this; reporting that the median number of sexual partners among males was three, in comparison to female travelers who reported a median of two. Men who have sex with men and bisexual travelers were also more likely to acquire a sexual partner overseas, and at a more frequent rate in comparison to their heterosexual counterparts (OR = 6.17 (1.16 < OR < 33.5)) [57,58,65].

3.5. Alcohol and Other Drug Use

Nine studies reported on alcohol and other drug use while overseas [29,54,57–61,72,74]. Three studies specifically reported on alcohol use prior to sexual activity [54,57,58]. The proportion of participants that reported alcohol consumption prior to sexual activity ranged from 40% to 61.7%. Three studies specifically reported on other drug use prior to sexual activity with the proportion of participants ranging from 8% to 18% [54,57,58]. Croughs et al. [59] reported on the combined use of alcohol and other drug use, finding that around 80% of participants had used alcohol or other drugs prior to sexual activity. Women reported casual sex after using alcohol or other drugs more often than men (95% vs. 73%; $p < 0.05$) [59]. A further two studies reported generally on the use of alcohol or other drugs [60,61]. Dahlgren et al. [60] found that of 1029 participants, around 90% reported using alcohol overseas with 14% ($n = 139$) reporting an increase in use. The study found no association between time in destination country and increased alcohol use. Just under half ($n = 14$ of 32) of participants in the study by Hamer et al. [61] reported no change in alcohol consumption while in Western Ghana, however around a third ($n = 11$ of 32) reported increased consumption. Dahlgren et al. [60] found a small proportion of participants (2.9%; $n = 34$) reported using other drugs during their time in the destination country. Most reported cannabis use and were returning from Africa and Asia [60]. This was consistent with the study by Alcedo et al. [54] which found that of the 14.6% of participants using other drugs, cannabis was reported by around two-thirds.

Qualitative findings regarding the use of alcohol and other drugs while overseas ranged. Brown et al. [74] reported that alcohol was often perceived as part of a holiday or beach culture with prospects to "let your defences down with alcohol . . . ". The study by Bauer [72] suggested that alcohol may facilitate new contacts, while Yokota [29] also reported on the positive role that alcohol

played in reducing social inhibitions. However, Bauer [72] also found that alcohol consumption could reduce inhibitions and impair judgement, facilitating unsafe sex.

3.6. Condom Use

Seventeen studies reported on condom use [29,54–63,66,67,71–74].

3.6.1. Consistency of Condom Use

Studies reporting unprotected sex varied. More than half of participants within the studies reported on condom use, with consistent use ranging from 0%–87% [29,55,57,58,60–62,71]. In the study by Yokota [29], in Thailand, more than 85% (n = 26 of 30) of participants consistently used condoms with Thai partners, including sex workers. The lowest level of consistent use was reported by Ansart et al. [71] (n = 47).

Inconsistent condom use was reported in seven studies [54,56,57,59,67,71,72]. Alcedo et al. [54], for example reported three out of five participants using condoms inconsistently. Ansart et al. [71] and Whelan et al. [67] reported inconsistent use by two out of five participants, followed by Cabada et al. [57] and Croughs et al. [59] with approximately one in five and one in three (20% and 30.9%, respectively) of participants practicing inconsistent use. A number of studies also reported participants never using condoms [54,57,60,62,67,71,74]. For example, Ansart et al. [71] reported 60% of participants never using condoms, followed by 56% and 46% by Cabada et al. [57] and Whelan et al. [67], respectively.

3.6.2. Factors Influencing Condom Use

Unprotected sex was reported as more likely to occur among travelers who were not in a relationship (p = 0.01) [67], and among those not receiving pre-travel health advice [59,61]. Inconsistent use did not differ between relationships with locals or other travelers [67]. However, Whelan et al. [67] also reported that for each additional partner acquired, the likelihood of sex being unsafe rose by 20%. Of those studies that reported participants who purchased sexual services from sex workers, Kaehler et al. [62] identified that two-thirds of these had consistently used condoms. In the survey by Manieri et al. [63] of Swedish men travelling to Thailand specifically for commercial sex, 20% had intended to practise inconsistent condom use, while 4% had intended to never use condoms. In a study of sex behavior of Japanese male tourists in Thailand, Yokota [29] found around 15% of participants practised inconsistent condom use with sex workers. While only one participant in the study by Cabada et al. [57] had engaged a sex worker, condoms had not been used.

Further reasons reported for not using condoms consistently reported in the qualitative studies by Bauer [72] and Brown et al. [73,74] included, that it was the "right feeling"; assumption that the "relationship was different", consequently the "real thing"; trust and familiarity with partners; a sense of holiday romance; assessing a partner as a minor risk; being better not using them ("mas rico"); not deeming the sexual encounter to be "risky", not wanting to interrupt "great sex"; throwing off the mantle of perceived previously "safe and cautious" behavior; sense of forming a new committed relationship; being portrayed negatively if carrying condoms and different perceptions of risk and patterns of risk behavior in home and destination countries [72–74]. A number of practical reasons were also cited for discontinuing use, such as cost, lack of knowledge and understanding, running out of condoms and embarrassment to purchase condoms [72].

A premeditated expectation to use condoms inconsistently also increased the likelihood of unsafe sex [59,62]. For example, although more than half of the participants in the study by Kaehler et al. [62], had condoms, only half of these (51.3%) intended to use them. Nevertheless, Croughs et al. [59] identified that individuals who carried condoms while travelling had a greater likelihood of safe sexual encounters than those who did not (OR = 5.4, 95% CI 1.7–17.0).

3.7. Pre-Travel Health Consultation

Use and experience of pre-travel health advice varied among ten studies measuring this [55,57–59,61,62,64,66,68,72]. Between 4% and 90% of participants within these studies had sought health advice prior to travel. For example, in the study by Zuckerman and Hoet [68] ($n = 4151$), around 90% of participants sought advice prior to travel. They found that more than half of participants sought this advice from a general practitioner and nearly 70% sought this advice five weeks or more prior to travel [68].

However, several studies found that up to half of participants had not received specific sexual health or hepatitis B information regarding risk factors and vaccination during their consultation [66,68]. Further, the Swedish travel clinic study by Angelin et al. [55] found that 113 participants reported advice received as irrelevant or inaccurate, with 14 participants reporting this specifically in relation to vaccination and vaccine preventable diseases.

In regards to gender and age, Angelin et al. [55] reported that males were less likely than females to seek pre-travel health advice (70% compared to 81%, respectively). Younger travelers benefitted less from pre-travel consultation in comparison to older travelers, and in turn showed a greater level of illness during travel and upon return ($p < 0.001$) [55]. In their study of U.S. and European travelers in Cuzco, Peru ($n = 2540$), Cabada et al. [58] found an association between pre-travel advice and casual sex whilst travelling ($n = 77$ of 997, $n = 64$ of 1539, OR = 1.92 ($1.37 < OR < 2.71$)). Further, they found that non-U.S. travelers received more pre-travel advice than those from the U.S. ($n = 698$ of 1587, $n = 210$ of 718, OR = 1.86 ($1.54 < OR < 2.24$)) [58]. This was consistent with findings from an earlier study by Cabada et al. [57] which also supported this statement (relative risk, 1.14; 95% CI 1.00–1.31). Additionally, Cabada et al. [57] showed that around 40% of participants received pre-travel advice with Canadian travelers having the highest frequency of pre-travel education ($n = 23$ of 33; 70%). Finally, Boggild et al. [32] found that among all ill returned non-immigrant travelers, the lowest levels of pre-travel advice were recorded amongst those travelling to visit relatives and friends ($p < 0.001$).

3.8. Vaccination

Five studies reported on vaccination prior to overseas travel [59,66–69]. Reported coverage ranged from 17% to 74%. Croughs et al. [59] reported on vaccination amongst travelers from The Netherlands and Belgium who consulted a travel clinic prior to travelling ($n = 1907$). Forty-one percent of participants had not been vaccinated against hepatitis B, while 45% of participants had received at least one injection in relation to hepatitis B vaccination. Streeton and Zwar [66] also explored vaccination coverage with Australians travelling overseas ($n = 503$). While more than half of participants had travelled to a hepatitis B endemic region, less than half (43%) had been vaccinated either prior to their most recent trip or in a separate instance. Just under half (46%) of those exposed to at least one risk factor for hepatitis B during recent travel were not vaccinated. Those travelling to regions of medium to high hepatitis B endemicity had a greater likelihood of being vaccinated (52%; $n = 146$) compared to those travelling to low hepatitis B endemic regions (32%; $n = 71$) ($p < 0.001$). Travelers who were younger were more likely than older travelers to be vaccinated (58% of 18–29 year olds compared with 24% of those aged 50 years and older) ($p < 0.001$) [66].

Whelan et al. [67] conducted a study with long-term Dutch travelers ($n = 552$) to "sub- tropical" countries via pre- and post-travel surveys and pre- and post-travel blood sampling. Hepatitis B vaccination was offered to all participants prior to departure, of whom, 74% were fully vaccinated. Zuckerman and Hoet [68] and Zuckerman and Steffen [69] explored vaccination for hepatitis B via two separate telephone based cross-sectional surveys with participants from a range of European countries. In the first study, Zuckerman and Hoet [68] found that of 5948 participants, one in five had travelled to destinations of "moderate to high" hepatitis B endemicity in the past 5 years. Only 15% of 4151 travelers received vaccination against hepatitis B. A further one in five recalled being vaccinated for hepatitis but were unclear regarding the type they were vaccinated against. In the second study by Zuckerman and Steffen [69], with a cross sectional sample of 9008 participants, results showed that

17% (n = 1535) of travelers had been vaccinated for hepatitis B. One-quarter (n = 109) at high risk for hepatitis B had been vaccinated.

3.9. Acquisition of HIV, Other BBVs or STIs

3.9.1. Risk Behavior

Twenty-one studies reported on risk for HIV, other BBVs or STIs among participants travelling overseas [27,29,31,32,56–69,72–74]. The studies ranged from exploring participant awareness of the risks associated with HIV, other BBVs or STIs, as well as outcomes amongst participants who engaged in behaviors deemed to put them at risk for acquisition.

Eleven percent of volunteers (n = 24 of 215) in the study by Bhatta et al. [56] expressed concern that they had placed themselves at risk for HIV, other BBV or STI related symptoms, most commonly due to unprotected sexual intercourse. An association was also found between HIV, other BBV or STI risk behavior and age, where participants aged between 26 and 45 years had the greatest risk (p = 0.016). Kaehler et al. [62] identified that more than one-third (n = 10) of participants (n = 27) having sexual encounters with Thai sex workers were at risk of acquiring HIV or other STIs. In a study by Dahlgren et al. [60], approximately 12% (n = 41) of participants believed they undertook risky sexual behaviors they otherwise would not have taken at home. Furthermore, one in five participants (n = 68) reported taking a HIV test, while another 20% (n = 67) admitted to having a reason to take a HIV test due to risky behavior.

3.9.2. Diagnosis and Related Symptoms

Ten studies reported on HIV, other BBV or STI diagnoses and related symptoms acquired during travel overseas [31,32,58,60,64,67,70,71,73,74]. The studies by Combs and Giele [70] and Rice et al. [31], examined retrospective epidemiological data of HIV cases within Western Australia and the UK, respectively finding 44% (n = 114 of 258) and 14% (n = 2066 of 13,891) of cases were diagnoses acquired overseas. Ansart et al. [71] and Matteelli et al. [64] reported specifically on STIs diagnosed at a travel clinic in Paris (n = 49 cases) and GeoSentinel clinics worldwide (n = 974 of 112,180). Genital gonorrhea, gonococcal urethritis, herpes simplex virus 2 (HSV2), syphilis (among those already diagnosed with HIV infection), chlamydia trachomatis, and HIV infection were identified as the most common STIs and BBV diagnosed among travelers presenting to those clinics. Similarly, in a study at the Canadian GeoSentinel sites of returned ill travelers (n = 3943), Boggild et al. [32] found 348 cases of BBVs and STIs including 15 cases of HIV infection. In the studies by Brown et al. [73,74], all participants (n = 14) had been diagnosed with HIV. In the study by Cabada et al. [58], 2.2% (n = 3 of 138) participants reported symptoms consistent with sexually transmitted infections during their time in Peru.

In the remaining studies, between zero and four diagnoses were reported. In a study of 219 returned overseas volunteers from the UK, Bhatta et al. [56] found that around 7.5% (n = 4) of participants had been diagnosed with an STI or BBV. In a similar study of returned Red Cross expatriates, Dahlgren et al. [60] found less than 1% had been diagnosed with HIV or other STIs or BBVs. This was despite being stationed in a country of high HIV prevalence and one in five returned expatriates (n = 67) reporting that they had reason to test for HIV. Finally, the study by Whelan et al. [67] with Dutch travelers (n = 552) found despite reported risk taking behavior, no participants had been diagnosed on their return home with HIV or other STI or BBV.

3.9.3. Place of Acquisition

Place of acquisition was reported in seven studies [31,32,64,70,71,73,74]. Generally, Asia and Africa were the most commonly cited places of acquisition. For example, in the study by Combs and Giele [70], the majority of HIV acquired overseas amongst men was acquired in countries other than in their region of birth. South-east Asia was reported most frequently as the region of acquisition. This was consistent with the findings from studies by Brown et al. [73,74] and Rice et al. [31], which

reported that amongst men who had sex with men, common locations of acquisition were U.S., Thailand and Spain.

3.9.4. Influencing Factors

Contributing factors reported in the studies associated with HIV, other BBV or STI diagnoses included being male [64,70,71]; men who have sex with men [70,71]; travelling for non-tourist purposes [31,32,64]; or travel to a country of high HIV, other BBV or STI prevalence [31,64,70,71]. For example, Combs and Giele [70] reported males as being more than twice as likely (81%) as female travelers (29%) to acquire HIV overseas. This is consistent to studies reporting STI acquisition, with Matteelli et al. [64] reporting the likelihood of males and females acquiring an STI overseas as 67% and 33%, respectively. Pre-travel advice was found to be a protective factor in at least one study. Matteelli et al. [64] suggest that those who received health advice prior to travel were less likely to be diagnosed with an STI (0.5%) than those who had not (0.8%); this was statistically significant ($p < 0.0001$).

3.10. Study Recommendations

All studies provided a range of recommendations for future policy, practice or research. Recommendations were generally related to public health or clinical practice, with all except four [21,24,57,69] of the studies making recommendations relating to travel health advice, education or health promotion. Around a third of the studies ($n = 8$) [21,51,55,57,58,64,67,68] provided recommendations for research including for behavioral or intervention design. Less than one in five of the studies ($n = 5$) [23,24,48,62,68] provided recommendations related to policy.

4. Discussion

4.1. Overview of Findings

This review aimed to (1) build on previous reviews exploring traveller sexual health; and (2) examine existing evidence regarding sexual health behaviors, experiences and outcomes (including HIV, other BBVs or STIs) for male expatriates and travellers aged 18 years or older from high-income countries travelling to low- and middle-income countries. In summary, we found 26 peer reviewed articles published between 2000 and 2015 that met the inclusion criteria. Table 2 summarizes the key results.

Table 2. Results Summary.

Overview	Twenty-six peer reviewed articles. Published between 2000 and 2015. High degree of variability in the study design and demographics.
Risk factors for acquisition of HIV or other STIs	Travel to a low-income region or region perceived to be less repressive, longer duration of stay.
	Single relationship status, travel specifically for romance or sex, (commercial or non-commercial).
	Alcohol and other drug use and not receiving pre-travel advice.
	Being male having a higher number of sexual partners and a lack of, or inconsistent condom use.
Other key findings in relation to HIV or other STIs	Levels of knowledge were poor.
	Few studies comprehensively discussed pre-travel advice.
Protective factors	Vaccinations and pre-travel health advice (particularly for older travelers).
	Being female and fewer sexual partners.
Recommendations	Lack of policy ready recommendations and only a third provided recommendations for research.
	Focus on education and travel health advice, for example prevention opportunities to increase vaccination rates.

Few protective factors were highlighted in this review. Those included were vaccinations and pre-travel health advice (particularly for older travelers), being female and fewer sexual partners [59,65,68], and perhaps participation in aid work. Risk factors highlighted in the review included destination, duration of stay and frequency of travel. A link was identified between travel to low-income destinations and an increase in risk taking behavior [63,70]. Travelers may seek sexual experiences and travel to destinations that are perceived to be less repressive, consequentially becoming less risk averse, especially males [29,63]. This was found to be more frequent in travel destinations such as South East Asia and South America [57,58,74]. Other findings report on the "situational disinhibition" that travelling itself presents, which can lead to increased risky behavior [28], suggesting there may be a relationship between length of stay or frequency of travel and disinhibition as people become more familiar and confidant with a location and its culture and environment. The relationship between travel destination and increase in risk taking behavior was also related to the duration and frequency of travel. A number of studies suggested that the longer participants were in the destination country, the greater the risk of having unprotected sex with a new partner [59,73], with a duration of stay over 30 days a key risk factor for unsafe sex while travelling [57,67].

Other risk factors included the number and type of sexual partners, condom use, alcohol and other drug use, gender and sexuality. Males were found to be generally at higher risk for acquisition of HIV, other BBVs or STIs [31,67,70] and had a great number of sexual partners overseas [67]. Men who have sex with men were also found to have an increased number of sexual partners [57,58], however only few included studies focused explicitly on this population. A number of the studies highlighted expectations of sex. Participants were often single and formed casual sexual partnerships while overseas [57,58,67]. This was found to be both unplanned and premeditative, with some travelers travelling specifically to destinations to seek sexual or romantic partners and/or sexual experiences [29,57,63]. Inconsistent condom use was found across studies with a range of barriers reported to their use including not deeming the encounter risky and not wanting to interrupt or take away from the encounter [72–74]. Unprotected sex was reported more frequently by travelers not in a relationship and those who did not receive pre-travel health advice [58,67]. Frequency, experience or intention to purchase or engage sex worker services in the destination country was reported in just under half of studies [29,31,54,57,58,62,63,73–75]. Arriving in the travel destination without a partner, participating in unprotected sex and having multiple sexual partners were all factors documented in other studies [22,38,76,77], as was the frequent purchasing of sex worker services and "sex tourism" industry overseas [30,78].

The review suggests that levels of knowledge and risks for transmission relating to HIV, other BBVs or STIs were poor [56,60,63,70]. Four studies suggested that alcohol and other drugs played a role in increased risk taking behavior, decreasing inhibitions and commonly used prior to sexual activity [54,57–59]. These results are consistent with findings from other studies, which highlight the relationship between alcohol and other drug use and sexual risk taking [20,76]. Finally, the reported pre-travel health advice among these studies was inconsistent and largely focused on health issues not specifically associated with sexual behaviors, such as malaria and parasitic infections [32,55]. Only four studies thoroughly discussed pre-travel advice for HIV, other BBVs or STIs [59,66,68,69]. The findings from this review are consistent with another systematic review regarding pre-travel advice [79]. The lack of advice specifically for HIV or other STIs and sexual health for travelers is apparent, with the review highlighting key recommendations for STI specific pre-travel advice [79].

Finally, while most studies included some recommendations, these mainly related to public health or clinical practice. Education and travel health advice were the key foci, for example prevention opportunities to increase vaccination rates [55,65,68,74]. Most failed to provide policy ready recommendations and only a third provided recommendations for research [29,57,58,61,64]. This is despite a number of previously completed reviews and policy documents [9], which provide explicit recommendations such as developing and increasing links and partnerships with affected

communities, and creating closer cooperation with policy and support sectors in both origin and destination regions [9].

4.2. Study Design and Reporting Limitations

Papers included in this review cited a range of methodological limitations, with all studies bar two reporting limitations in research design, data collection or interpretation of results. More than half of included studies lacked reporting on ethics approval. Most included studies ($n = 21$) were quantitative. Of these, the majority were cross-sectional surveys which collected self-report data. Such methods may be disposed to measurement error which may weaken validity of findings [54,56,63,73]. The most frequent limitations outlined in the studies included over reliance on self-report measures; recall bias; variability in sample size and response rate, social desirability bias and self-selection bias. In addition, language barriers in data collection including lack of translated instruments, were highlighted in several studies [27,69].

Other limitations included the lack of standardized data collection instruments and lack of detail regarding validity and reliability of data collection instruments. Furthermore, few commonalities were found regarding the items within the instruments used to assess knowledge, attitudes, self-reported behaviors and outcomes. The studies included a range of ages and mixed gender samples which may have been limitations. Use of non-random, or non-representative samples were highlighted as limitations. There were few qualitative studies ($n = 5$) available to provide context to behavioral outcomes. For a number of the qualitative studies, there was a lack of in-depth analysis and reporting of findings against best practice reporting criteria [72,75]. Some studies also indicated a lack of in-depth interpretation using theoretical concepts or frameworks [72,75]. Overall studies used inconsistent definitions and categories (e.g., in relation to what constituted a sexual partner, relating to frequency of travel, traveler and expatriate).

4.3. Strengths and Limitations of the Review

This review has a number of strengths. It provided a 15-year snapshot of the peer reviewed literature and built on previous reviews relating to HIV, other BBVs or STIs and travel from high to low- and middle-income countries. To our knowledge, it is the only study that sought to have an explicit focus on male expatriates and travelers, travelling from high to low- and middle-income countries. This has allowed an in-depth analysis of a particular priority population identified as requiring action and can assist the sector to support or refute a range of assumptions about the behavioral contexts in which acquisition of HIV, other BBVs or STIs occurs amongst expatriates and travelers to low- and middle-income countries. This may better guide policy and practice decision making and intervention design.

The use of an established protocol used in other reviews provided a series of checks and balances. The use of seven databases provided expanded scope as it included a wide range of databases with multiple search terms and variations. To reduce any margin for error, multiple researchers conducted the database searching and a team approach was used to assess quality of the included studies. Including both qualitative and quantitative studies using a variety of methods expanded the scope of the review. The review was registered with the PROSPERO International Prospective Register of Systematic Reviews.

We recognize that there is a wealth of information available in the grey literature and within literature in languages other than English. Only including peer reviewed papers means that there have been an inherent level of publication bias. Most studies included both male and female participants, making it difficult to draw conclusions specific to the male expatriate and traveler population.

The inclusion of papers in languages other than English may have identified other relevant studies which may have enhanced the findings. We note that there are a number of countries that may have valuable experiences to contribute that may support or refute or provide additional context to our findings that do not have the resources to publish their findings in the peer reviewed literature.

Further, no meta-analysis or synthesis was conducted due to the heterogeneity and the high level of variability in the included studies. Thus consistent measures of quality were difficult to assess and we were limited in the conclusions that we are able to draw. Nevertheless, the study has updated the literature and addresses a gap in the literature regarding HIV, other BBVs or STIs and mobile populations.

4.4. Implications for Research, Policy and Practice

There are a range of policy, practice and research implications from this review. Consistent with the principles outlined in the "HIV and Mobility in Australia: RoadMap for Action" [9], these incorporate international, national and local leadership and governance; community mobilization, enhanced service design and delivery; and ongoing surveillance, research and evaluation. These actions should be underpinned by a human rights approach that reduces barriers to testing and treatment, that commits ongoing resources, continues to resource effective strategies, and which acknowledges that addressing issues relating to mobile populations and the transmission and acquisition of HIV, other BBVs or STIs need more than information and education. Comprehensive, resourced and well evaluated strategies are required that do not demonize or penalize those most vulnerable [9]. The following sections outline opportunities to respond to and build on gaps identified in the included studies with reference to the broader literature.

4.4.1. Research Opportunities

We found few studies that explicitly examined perspectives of migrants or expatriates and few which focused on men who have sex with men. Further, a number of the studies failed to segment target groups and included studies showed a lack of studies specifically focusing on men travelling to destinations of high prevalence. Consequentially, the studies provided broad findings that may not be relevant to the needs of those most at risk. For example, those who travel for extended periods of time or those who travel frequently may be at heightened risk, however may not perceive their risk to be high due to familiarity with the destination or because they believe that they are not part of a target group that is most at risk, such as holidaymakers or backpackers [29,73,74]. Accordingly, studies which better understand acquisition risks for different sub populations are required along with consistent data on destination, duration and frequency of travel. Most studies in this review were quantitative and cross-sectional and focused heavily on self-reported behavior and knowledge. It is important that valid standardized measures are incorporated and used to supplement self-report data provided by participants. This enables comparisons to be made across studies and results in the development of firm conclusions about current trends.

Few studies explored the settings in which risk taking behaviors occurred or the role of social or peer group influences. Historically, many high-income countries have viewed low- and middle-income countries through a colonial lens, created a perspective of them as permissive places, sources of infection or as playgrounds for those from more wealthy regions to engage in a range of behaviors that are viewed as less sanctioned in their country of origin [29,73–75]. There is a need for a greater level of contextual, qualitative social research which examines the diversity of perspectives of the target populations, particularly in relation to the perspectives of risk-taking and constructions of risk both in origin and destination countries [28,58,72,73]. Research that explores domestic attitudes, policies and practices which lead to risky behaviors among travelers is imperative [9,72–75]. Further, determining to what extent such laws and policies fuel negative attitudes in the general population towards low- and middle-income countries is vital. Further research may be valuable on social networks among long-term travelers to understand their function and role in sexual partnering and behaviors [9,36,73,74]. Studies which explore pathways and experiences of mobile populations, as individuals and as peer groups, may also better identify opportunities for policy and program intervention and for clinical practice [27,29,60,61,73,75]. Participation in aid work may provide a level of protection, however the studies describing this were inconsistent and further examination of this

potential may be warranted, particularly to determine why risk behavior generally results in low levels of acquisition of HIV, other BBVs or STIs [56,60].

Based on the wide range of limitations in study design and type highlighted within the review, there is a need for methodological improvements for studies which are able to better inform the design and delivery of interventions as well as a greater level of applied intervention research. This may include identifying more specifically where HIV and other STI infections are occurring which will help target and tailor interventions, both in countries of origin and destination [9,32,58,71]. The review highlighted research opportunities which explore barriers and enablers to pre and post travel consultation and testing for both travelers and clinicians [32,55,57,66,68]. This could include intervention research to explore the efficacy and acceptability of treatment as prevention (such as pre-exposure prophylaxis for HIV) [64,69], for long-term travelers engaging in high risk behavior in destinations of high HIV, other BBV or STI prevalence [9,56,60,61,64,70].

4.4.2. Clinical Practice Opportunities

This review highlighted implications that are important for clinical practice. A number of studies indicated poor knowledge and awareness regarding risks and protective behaviors related to HIV and other STI during travel [65,66,68,69,72,73]. This requires a reassessment of the role and scope of pre-travel counselling and advice, regarding sexual risk behaviors. Potential barriers should be addressed which prevent health professionals raising concerns with patients and instigating standard practice around recommending testing and treatment [31,56,58,68,69]. Guidelines for practitioners around pre-post travel consultation are needed as well as information and advice that is tailored to the context of travel [56,60,61,68,69]. Travel medicine providers should continue to provide information to travelers regarding HIV, other BBVs or STIs, but also undertake sexual health testing more regularly with travelers on return to countries of origin. Additionally, clinicians should consider the role of treatment in prevention for travelers at greater risk and provide consistent and systematic advice about carrying and using condoms [27,31,32,54,57,59,66,68,69]. Given the benefits of vaccination for hepatitis and the reported inconsistencies in knowledge, opportunities should be explored to increase vaccine coverage with follow up mechanisms, especially for older travelers [31,55,63,66,80].

4.4.3. Health Promotion Opportunities

Recommendations for health promotion highlighted in the review mainly focused on the role of education [27,31,54,55,59–61,64–70]. Accordingly, there may be some scope to better deliver information or training to travelers as suggested in the review and as supported by the broader literature. This may be via traditional or new media (including smart-phone or other internet based tools) [55] or other suitable strategies to target specific mobile populations and travelers at greater risk [27,54–56,61], for example, those working in countries of high prevalence for protracted periods of time and males (and their partners), travelling to or through high prevalence countries [9]. This may include delivering in situ information in partnership with, or supportive of, local organizations [9,27,57,58,72,73]. Non-government organizations and employers could better engage with sex worker organizations at the local and regional level to better address risks for those seeking or engaging in commercial sex and reciprocal risk for sex workers [31,62,72,73]. Further consideration should be given to the development of partnerships with non-government and aid organizations working across borders and with transnational companies who employ people in countries of high prevalence and which experience significant cross border travel amongst their workforce as an opportunity for health promotion within the organization but also within the community more broadly [60,61].

A number of recommendations were made regarding working with airports, airlines and travel agencies as key points for information exchange or awareness raising [31,54,57,58]. However, to be most effective, multifaceted interventions including policy and environmental strategies as well as those tailored for individuals are likely to be most effective [9,31,64]. Segmentation of interventions

which recognize heterogeneity of populations (e.g., recognizing key differences between older and younger travelers, men who buy sex and those that do not, men who have sex with men versus heterosexual men or those that are in situ for longer or shorter durations) may also be more effective, though cost benefits would need to be examined [9,55,65,67,69,71–73,80]. Finally, few studies discussed access to other preventive health measures such as safer sex or clean injecting equipment. Accordingly, there is a need to review the potential role for non-government organizations to trial strategies to increase access to and availability of equipment to reduce transmission risks [9,59,72].

4.4.4. Policy and Advocacy Opportunities

Consideration should be given to the development of key indicators to evaluate programs for migrant and mobile populations which may assist to better identify what works and why [9,27,56,58,60,61,72,73]. Greater attention must be paid to both cross border and in-country responses. Ongoing monitoring and evaluation and harmonized surveillance is needed alongside more standardized jurisdictional surveillance for sub populations such as men who have sex with men [9,58,73–75]. Working with low- and middle-income countries to enhance their surveillance and publish their findings would increase our ability to effectively respond and reduce the impact of stigma and discrimination on specific populations and countries.

Despite being located in high prevalence regions for significant durations, the review found limited diagnoses amongst travelers, including volunteers and aid workers, despite a range of identified risk behavior. Protective and risk factors related to work roles should be further explored to determine the impact of workplace policies, education and access to equipment to reduce transmission risks, information and testing [56,60,61]. More advocacy and mobilization is needed from high-income countries to better support HIV, other BBV or STI testing (access and quality) within countries of high prevalence [9,31,60,73,74].

Countries such as Australia continue to enforce laws and policies that may have the consequence of making those most at risk more vulnerable for acquisition, including those relating to migration, sex work and drug use. Such laws and polices need to be re-examined in the context of cooperative cross border responses that recognize that HIV, other BBVs or STIs are co-transmitted. Where narrow protectionist policies (such as migrant screening on entry) exist, measures should be enacted to remove them [9].

5. Conclusions

Mobile and migrant populations are vulnerable for HIV, other BBV or STI acquisition, leading to significant health and other social impacts at the individual and community level. High-income countries have seen increasing acquisitions of overseas acquired HIV, other BBVs or STIs. Whist those travelling to and from countries with significant prevalence particularly of HIV have been identified as priority populations in a number of strategic frameworks, this review is one of few that has had an explicit focus on longer term travelers such as expatriates. The review revealed a high degree of heterogeneity among travelers and their behaviors, even when from similar sociodemographic backgrounds. This is a complex issue and one which requires greater inspection and a variety of tailored responses.

The domains identified in the 26 included studies included traveler and travel characteristics; knowledge, attitudes and beliefs; sexual partner acquisition; alcohol and other drug use; condom use; pre-travel health consultation; vaccination; acquisition of HIV, other BBVs or STIs; and study recommendations. This review found that the available evidence was limited in scope and inconsistent in study design and reporting. Accordingly, there is a need for future well-designed studies, particularly focusing on the social context in which risk-taking occurs. The review suggests that there are opportunities for public health to collaborate more closely with travel medicine and primary health care to deliver comprehensive multi-strategy health promotion interventions alongside more consistent pre- and post- travel testing and advice. Finally, well-funded and evaluated policy measures

are needed as a matter of urgency, including advocacy for consistent evaluation indicators at a local, national and global level to assess the impact of HIV, other BBVs or STIs in the context of mobility.

HIV, other BBVs or STIs acquisition among mobile and migrant populations highlight that the risks and responses for these epidemics are shared globally. A "contain and control" approach or blunt migration strategy (that stops people at the borders) which has historically been used by high-income countries, abrogates their responsibility in relation to these epidemics. Policy and program responses in high-income countries which focus only on domestically acquired infections or conversely, only looking outward to destination nations to assume responsibility, will miss an important part of their epidemic as well as fail to meet reciprocal responsibilities to reduce cross border infections.

Supplementary Materials: The following is available online at www.mdpi.com/1660-4601/13/12/1249/s1, Table S1: Data Extraction Summary.

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Supplementary Materials: HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review

Gemma Crawford, Roanna Lobo, Graham Brown, Chloe Macri, Hannah Smith and Bruce Maycock

Table S1. Data Extraction Summary.

Author/Purpose	Origin/Destination of Travel	Study Details	Sample/Response	Reported Outcomes
Alcedo et al. (2014) [1] To analyse factors associated with risky sexual behaviour among travellers	**Origin:** North America, Europe **Destination:** Varied across North America, Africa, Latin America and/or the Caribbean, Europe, Asia, Oceania	**Design/Method:** Cross-sectional; online questionnaire. **Participants/Recruitment:** Males and female; aged 18–35 years; recruited via Couchsurfing website.	**Sample:** *n* = 468 **Response rate:** 78%	• Sex during last travel • Characteristics of sexual behavior • Condom use
Angelin et al. (2014) [2] To determine relevance of and adherence to health advice given to travellers to lower levels of travel-related illness	**Origin:** Sweden **Destination:** Varied across Asia, Africa, South America	**Design/Method:** Prospective, cross-sectional; pre- and post-travel questionnaire. **Participants/Recruitment:** Male and female; 18 years or older; Swedish speaking travelers attending a travel clinic.	**Sample:** *n* = 1277 (pre) *n* = 1059 (post) **Response rate:** 83%	• Perceptions of health advice • Compliance with health advice • Travel-related illness • Risk behaviors while overseas
Ansart et al. (2009) [3] To identify and evaluate STIs diagnosed among travellers consulting the health unit after returning from the tropics	**Origin:** France **Destination:** Varied across America, Caribbean, Asia, Africa, Oceania	**Design/Method:** Cross-sectional; prospective; analysis of patient data. **Participants/Recruitment:** Male and female; 18–49 years; returning travelers attending a travel clinic with signs of STIs.	**Sample:** *n* = 49 **Response rate:** 83%	• Signs indicative of STIs • HIV status • Sexual behavior • Condom use
Bauer (2007) [4] To explore tourists' and locals' knowledge, attitudes, and reasoning for engaging in casual sexual relationships	**Origin:** Varied across U.S., UK, Germany, Netherlands, Australia **Destination:** Peru	**Design/Method:** Qualitative; in-depth, unstructured interviews; informal conversations; participant and non-participant observation. **Participants/Recruitment:** Male and female; 19 years and older; locals linked to tourism or travelers for tourism, language courses or volunteer work recruited via convenience and snowball sampling.	**Sample:** *n* = 23 **Response rate:** Not Recorded	• Relationship type • Sexual behavior • Condom use • Safe sex knowledge/education
Bhatta et al. (2009) [5] To identify common health problems encountered by VSO volunteers during placement and after returning home	**Origin:** UK **Destination:** Varied across North Africa, sub-Saharan Africa, Asia, Oceania, South America	**Design/Method:** Cross-sectional; self-complete post travel questionnaire. **Participants/Recruitment:** Male and female; all ages; returned voluntary service overseas workers sent questionnaire and information pack on resettlement; completed anonymously, returned by mail.	**Sample:** *n* = 219 **Response rate:** 36%	• Demographics • Pre-existing health conditions • Illness suffered while on placement • Illness upon return from volunteering

Table S1. *Cont.*

Author/Purpose	Origin/Destination of Travel	Study Details	Sample/Response	Reported Outcomes
Boggild et al. (2014) [6] To identify the spectrum of illnesses experienced by Canadians travelling abroad	**Origin:** Canada **Destination:** Varied across India, Mexico, Cuba, Dominican Republic, Costa Rica, U.S., Ghana, Thailand, Peru, China	**Design/Method:** Analysis of retrospective surveillance data of ill returned travelers from GeoSentinel database. **Participants/Recruitment:** Male and female; all ages; returned travelers with probable/confirmed diagnoses, diagnosed at Canadian GeoSentinel clinics.	**Sample:** n = 4365 n = 3943 ill returned travelers **Response rate:** Not Applicable	• Demographics • Destinations of travel • Travel purpose • STI diagnosis • Pre-travel health advice
Brown et al. (2012) [7] **Brown et al. (2014) [8]** To explore risk perspectives and experiences of Australian men who acquired HIV while travelling overseas	**Origin:** Australia **Destination:** Varied across Asia, Africa, North America	**Design/Method:** Grounded Theory; semi structured interviews; symbolic interaction as theoretical perspective and analytical framework. **Participants/Recruitment:** Males; 20 years and older; travelers who believed they had acquired HIV overseas between the years 2000–2009; recruited via through services accessed by people living with HIV, particularly AIDS Councils and hospitals. Majority of interviews face-to-face, but also online and telephone.	**Sample:** n = 14 **Response rate:** Not Recorded	• Destination, reason for travel • Meaning ascribed to home and destination • Knowledge of HIV • Reported mode of HIV transmission • Participant experience overseas-knowledge/attitudes/values
Cabada et al. (2002) [9] To identify sexual behaviour and risk factors of travellers from the US and Europe to Peru	**Origin:** U.S., England, France **Destination:** Peru	**Design/Method:** Cross-sectional; self-complete questionnaire. **Recruitment:** Male and female travelers aged 15–51 years; departing from Peru on flights to the U.S. or Europe; convenience sampling in international departures lounge at airport.	**Sample:** n = 442 **Response rate:** 87%	• Sexual behavior • Sexual expectations while travelling • Condom use • Sex partners while travelling
Cabada et al. (2003) [10] To identify sexual behaviour and risk factors for STIs among travellers and locals interacting with travellers in Peru	**Origin:** U.S., England, France **Destination:** Peru	**Design/Method:** Cross-sectional; self-complete questionnaire. **Participants/Recruitment:** Male and female; 15–50 years; travellers; convenience sampling at airport and main bus stations prior to departure.	**Sample:** n = 2540 **Response rate:** 79.2%	• Demographics • Sexual behavior • Condom use • Pre-travel health advice
Collins et al. (2009) [11] To explore lived experiences of transnational mobility for gay-identified expatriates who reside in Manila	**Origin:** Varied across U.S., Great Britain, Germany, Scotland, Ireland, Sweden **Destination:** Philippines	**Design/Method:** Ethnography; in-depth, informal field interviews. **Participants/Recruitment:** male; gay; 29–70 years; expatriates; recruited at gay bars in Malate.	**Sample:** n = 8 **Response rate:** Not Recorded	• Experiences of gender, sexuality, nationality, race and mobility
Combs and Giele (2009) [12] To analyse heterosexually acquired HIV cases observed among non-Aboriginal WA residents	**Origin:** Australia **Destination:** Varied across Europe, Southeast Asia, sub-Saharan Africa	**Design/Method:** Descriptive, retrospective, cross sectional; analysis of Department of Health data of those newly diagnosed from 2002–2006. **Participants/Recruitment:** Male and female; all ages; non-Aboriginal residents who had lived or intended to live in Western Australia.	**Sample:** n = 258 **Response rate:** Not Applicable	• Demographics • Country of origin • Reported place of HIV acquisition • HIV exposure categories

Table S1. *Cont.*

Author/Purpose	Origin/Destination of Travel	Study Details	Sample/Response	Reported Outcomes
Croughs et al. (2008) [13] To determine degree to which Dutch travellers receiving travel clinic pre-travel advice have protected or unprotected sexual contact with new partners and factors influencing this behaviour	**Origin:** Netherlands and Belgium **Destination:** Varied across sub-Saharan Africa, Asia, Turkey, South America, Central America, North Africa	**Design/Method:** Cross-sectional; self-complete questionnaire. **Participants/Recruitment:** Male and female; 18–50 years; travelers; Dutch speaking; questionnaire sent to travelers within 6 weeks of visiting a pre-travel clinic, followed by reminder.	**Sample:** n = 1907 **Response rate:** 55%	• Demographics • Sexual behavior of travelers • Condom use
Dahlgren et al. (2009) [14] To assess self-reported health risk and risk-taking behaviours of humanitarian expatriates	**Origin:** Primarily Europe, America **Destination:** Primarily Africa, Asia	**Design/Method:** Cross-sectional; self-administered questionnaire. **Participants/Recruitment:** Male and female; all ages; humanitarian aid workers who had been on an ICRC mission for at least 1 month; contacted and asked to complete a questionnaire.	**Sample:** n = 1190 **Response rate:** 95.2%	• Demographics • Health status • Health related problems of workers • Risk-taking behaviors
Fenton et al. (2001) [15] To determine extent to which black African communities residing in London visit countries of birth, and the associated factors of acquiring new sexual partners while overseas	**Origin:** UK **Destination:** Democratic Republic of Congo, Kenya, Uganda, Zambia, Zimbabwe	**Design/Method:** Cross-sectional self-complete questionnaire. **Participants/Recruitment:** Male and females; all ages; from Sub-Saharan Africa residing in London; recruited at social and commercial venues, such as churches, universities, embassies, and bars in London using ethnically matched interviewers.	**Sample:** n = 756 **Response rate:** 75.6%	• Demographics • Condom use • previous diagnosis with ST • Number of sex partners • HIV testing • Perceived peer group norms
Hamer et al. (2008) [16] To evaluate use of pre-travel medical services, current knowledge, and behaviour among expatriate corporate workers stationed in Ghana	**Origin:** North America, UK, Europe, other high income countries **Destination:** Western Ghana	**Design/Method:** Cross-sectional self-complete questionnaire. **Participants/Recruitment:** Male and female; 21 years or older; corporate expatriate employees; field medical officer distributed questionnaire to all relevant expatriate employees.	**Sample:** n = 42 **Response rate:** 70%	• Demographics • Pre-travel medical services • Knowledge, behavior regarding a range of diseases and infections, alcohol use, high-risk sexual activity
Kaehler et al. (2013) [17] To determine sexual behaviour and attitudes among foreign backpackers in Thailand	**Origin:** Europe, North America, Australia **Destination:** Thailand	**Design/Method:** Cross-sectional self-complete questionnaire. **Participants/Recruitment:** Male and female; 18 years and older; English-speaking backpackers without a spouse; using convenience sampling, participants approached in backpacker center in Bangkok.	**Sample:** n = 415 **Response rate:** Not Recorded	• Demographics • Pre-travel preparations • Sexual risk behaviors • Condom use • Selection of sex partners

Table S1. *Cont.*

Author/Purpose	Origin/Destination of Travel	Study Details	Sample/Response	Reported Outcomes
Manieri et al. (2013) [18] To investigate sexual risk-behaviour of Swedish men who have sex with sex workers in Thailand	**Origin:** Sweden **Destination:** Thailand	**Design/Method:** Cross-sectional self-administered questionnaire. **Participants/Recruitment:** Male; all ages; Swedish citizens; recruited by male interviewers in the streets or inside bars and restaurants of the red-light districts of Pattaya and Bangkok.	**Sample:** n = 158 **Response rate:** 65%	• Demographics • Experience with sex workers • Intention to user Thai sex workers • Condom use and perceived risk
Matteelli et al. (2013) [19] To describe the range of diseases and factors associated with acquisition of travel-related STIs via the GeoSentinel database	**Origin:** Varied **Destination:** Varied across Asia, Africa, America, America, Caribbean, Europe, Middle East, Oceania	**Design/Method:** Observational, cross-sectional; using standardized questionnaire to analyze diagnosed cases from GeoSentinel database. **Participants/Recruitment:** Male and female; 13–90 years; crossed international borders within 10 years; confirmed/probable diagnoses	**Sample:** n = 112,180 **Response rate:** Not Applicable	• Demographics • Travel history and reason for travel • Pre-travel consultation • STI diagnoses
Mercer et al. (2007) [20] To determine the proportion of British residents who reported new sexual partners overseas in the past 5 years and the associated demographic, behavioural and attitudinal outcomes	**Origin:** UK **Destination:** Varied across Europe, UK, Oceania, America, Caribbean, Asia, Middle-East, sub-Saharan Africa	**Design/Method:** Stratified national survey using multistage probability cluster design; face-to-face interviews using computer-assisted personal interviewing in respondents' homes, followed by computer-assisted self-interview. **Participants/Recruitment:** Male and female; 16–44 years; travelers; British residents. A sample of addresses selected. For every selected household, one resident randomly selected to participate. Ethnic boost sample obtained with stratified postcode sampling.	**Sample:** n = 11,161 **Response rate:** main survey = 65.4%; ethnic boost sample = 63%	• Socio-demographics • Health status, general risk factors • Attitudes and knowledge of HIV • Sexual attraction and experience • Overseas travel • Number of sex partners overseas • Overseas sex partner demographics
Rice et al. (2012) [21] To determine the characteristics of travellers born in the UK who acquire HIV infection overseas	**Origin:** UK **Destination:** Spain, Nigeria, South Africa, Zimbabwe, USA, Jamaica, Thailand, other	**Design/Method:** Retrospective descriptive analysis; using case reports and follow-up data from national HIV database. **Participants/Recruitment:** Male and female; 15 years and older; diagnosed with HIV infection in the UK; likely acquired HIV overseas.	**Sample:** n = 15,997 **Response rate:** Not Applicable	• Demographics • Reported route of HIV transmission and country of infection
Streeton and Zwar (2006) [22] To determine risk for hepatitis B exposure while travelling overseas for Australian travellers	**Origin:** Australia **Destination:** Varied across Africa, Asia, Middle East, South and Central America, Europe, Oceania	**Design/Method:** Cross-sectional telephone survey. **Participants/Recruitment:** Male and female; 18 years and older; had travelled overseas in the past two years, either for pleasure or business; recruited randomly via telephone calls to potential participants from each Australian mainland capital city using screening questions.	**Sample:** n = 503 **Response rate:** 74%	• Demographics • Travel history • Pre-travel health advice • Uptake, adherence to pre-travel immunization • Risks exposed to while travelling • Perceptions, knowledge of hepatitis B

Table S1. *Cont.*

Author/Purpose	Origin/Destination of Travel	Study Details	Sample/Response	Reported Outcomes
Whelan et al. (2013) [23] To determine the casual sexual relationships and condom use consistency among Dutch, long-term travellers to (sub) tropical regions	**Origin:** Primarily the Netherlands **Destination:** sub-Saharan Africa, Central America, Caribbean, South America, Asia	**Design/Method:** Cross-sectional pre- and post-travel survey, pre- and post-travel blood sampling. **Participants/Recruitment:** Male and female; 18 years and older; immunocompetent; travelers to (sub) tropical regions for at least 3–12 months; recruited via Public Health Service travel clinic.	**Sample:** n = 552 **Response rate:** Not Recorded	• Demographics • Travel duration, destination, purpose • Number, type, sex, ethnicity of sex partners • Condom use • HIV status
Yokota (2006) [24] To explore reasons heterosexual male Japanese tourists engage in commercial sex in Thailand, and how motivations differ to those of Caucasian male tourists	**Origin:** Japan **Destination:** Thailand	**Design/Method:** Qualitative semi-structured, in-depth interviews. **Participants/Recruitment:** Male; 19–36 years; heterosexual; tourists; had sex with Thai sex worker(s) and who were travelling without partners; purposive sampling used to recruit participants in guesthouse lobbies.	**Sample:** n = 34 **Response rate:** 88%	• Demographics • Sex with and history of commercial sex with Thai sex workers • Condom use with Thai sex workers • Reasons to buy sex from Thai sex workers
Zuckerman and Steffen (2000) [25] To determine risks of hepatitis B infection among European travellers compared with immunisation status in other risk groups	**Origin:** Austria, Belgium, France, Germany, Italy, Netherlands, Sweden, Switzerland, UK **Destination:** Varied-Primarily Africa, Asia, Central or South America	**Design/Method:** Cross sectional survey using telephone interviews with mostly closed questions (translated for all participants). **Participants/Recruitment:** Male and female; 18 years and older; travelers; randomly sampled from telephone directories, using quotas.	**Sample:** n = 9008 **Response rate:** Not Recorded	• Demographics • Travel destination (by endemicity) • Risk behaviors • Hepatitis vaccination status • Knowledge
Zuckerman and Hoet (2008) [26] To determine European travellers' risk for exposure and immunisation status of hepatitis B while travelling	**Origin:** Belgium, Italy, Finland, Germany, Netherlands, Spain, Sweden, UK **Destination**: Varied across Africa, Asia, South America, Eastern Europe	**Design/Method:** Cross-sectional two-stage survey: (1) telephone Omnibus survey and (2) online survey. **Participants/Recruitment:** Male and female; 18 years and older; travelers; to hepatitis B endemic countries; Omnibus survey participants chosen through random digit dialing used as quotas for participation in the online survey; Online survey participants recruited through online panel.	**Sample:** n = 5948 (Omnibus survey) n = 4151 travelers (online survey) **Response rate:** Not Recorded	• Demographics • Travel frequency, purpose, destination • Self-reported hepatitis B immunization status before travel • Risk exposure to hepatitis B • Pre-travel health advice

2.4 Summary

Literature presented in this chapter has presented the rationale for the research contained in this thesis. Findings from the three published papers which comprise Chapter Two suggest that Australian-born men, as in other high income countries are vulnerable for HIV and other STI acquisition. This is not a situation unique to Western Australia, though its proximity to Asia, frequent travel and high levels of disposable income in the previous decade were likely contributing factors to increased vulnerability.

Publication One provides context and a rationale for this study. The paper presented an overview of the historical and contemporary nature of the HIV epidemic in Australia with reference to the global context. The changing epidemiology of HIV in Australia and Western Australia was examined and the influence of population mobility on these changes is highlighted as a rationale for the present study. Issues were identified in the international and Australian public health and HIV response.

The article argued that population mobility affects transmission dynamics of HIV and other STIs globally. High-income countries (HICs), such as Australia have experienced a change in their HIV epidemiology with increasing notifications amongst mobile and migrant populations including ELoFTs. Despite this, little is known about ELoFT behaviours, attitudes and knowledge. The paper suggested trialling a range of strategies to better understand this target group and their needs is warranted. An effective response will require capitalising on Australia's effective HIV legacy. It will require a coordinated approach and collaboration between Australia and countries of destination for mobile populations. Failing to apply what has been learned from previous approaches to HIV prevention, treatment and care in the context of mobility may risk further infections.

Later HIV epidemiological data from after the date of this publication were obtained to present as part of the thesis which were presented in Chapter One.

Publication Two presented the results of a qualitative study that provided context and motivation for the present study. The author became familiar with the topic for investigation and context of overseas acquired HIV through this paper. The paper explored perspectives of WA men who had acquired their HIV infection overseas, predominantly in SEA. The recommendations and findings of this study influenced the implementation of the current study.

Research with Australian (mainly heterosexual) men who had acquired HIV overseas suggested the existence of social networks which may influence risk. In this paper, the experiences of men who acquired HIV when travelling overseas, perceptions and understandings of mobility in the country of origin and destination played a critical role. Findings indicated that ELoFTs created a specific and unique culture which gave meaning to risk knowledge and practices. Consequently, broad travel health promotion messages that are not tailored are likely to be ineffective. Peer interventions or those that target assets within social networks may have applicability; this requires better understanding of how such networks function and flourish. Interventions for ELoFTs that appeal to desired experiences such as risk taking, cultural connection, maintaining a fantasy or sustaining a new life are important considerations for practice and policy.

Publication Three presented a systematic review of 15 years of peer-reviewed literature (2000-2015) that describes HIV, other BBV or STI related knowledge, risk behaviour and acquisition amongst ELoFTs, particularly males, travelling from high to low- and middle-income countries. It provides context and a rationale for the study target group and topic for investigation.

Findings from the review suggested significant variability among ELoFTs with regard to knowledge, attitudes and practices related to sexual health, HIV and other STIs and BBVs in low- and middle- income countries. A range of risk and protective factors were identified relating to mobility. These included: duration of stay, number of sexual partners, condom use, pre-travel advice, vaccination, gender, relationship status, travel intention, and alcohol and other drug use. Collaboration between health promotion organisations and travel medicine and primary health care was highlighted as a key opportunity to deliver comprehensive public health interventions in conjunction with more consistent pre- and post- travel testing and advice. Better understanding is required of the dynamics of cross-border infection in relation to the implementation of policies and programs in countries such as Australia.

To ensure that the findings of the review remained relevant, a subsequent rapid scan of the literature was undertaken for the years 2016 - 2019 to provide any updates to the review findings. Using the previous search terms and inclusion/exclusion criteria, a PubMed search was performed to find articles published since the review was undertaken. This was supported by a Google Scholar search (first 20 pages, n=200 entries). The reference lists of included studies were also searched for additional articles. In total, six studies were found

that met the inclusion criteria and were published between 2016 and 2019. Findings and recommendations were consistent with those published in the systematic review (Publication Three). It is worthwhile noting that since 2016 there has been an increasing focus in the literature on the role of pre-exposure prophylaxis (PrEP) in prevention of HIV amongst ELoFTs, particularly males, travelling from high to low- and middle-income countries. The data extraction table for the additional studies is included as Appendix C.

The literature included in this chapter has provided the framing for the research and positioned it within its public health and sociocultural context. The review includes both local and international data to support the research thesis. The inclusion of a range of literature sources provides a concrete overview of the public health topic and issue under investigation, with each approaching it from a different perspective.

Critically this chapter has highlighted the lack of research to support our understanding of this important area of public health and the critical need to gain deeper insights into the culture and practices of ELoFT men before, during and after mobility and migration.

Included literature is drawn on in subsequent chapters and provided framing for the research direction and analysis of data.

The following chapter outlines the research methods for the study (Chapter Three).

3. Research Methods

When it's summer in Siam
And the moon is full of rainbows
When it's summer in Siam
When we go through many changes
When it's summer in Siam
Then all I really know is that I truly am

- Summer in Siam, The Pogues, 1990 -

PRELUDE

The research methods are presented in two parts.

Section 3.1 is a published study protocol which provides an overview of the methodological approach, conceptual framework and study process.

> **Crawford G,** Bowser N, Brown G and Maycock B. 2013. Exploring the potential of expatriate social networks to reduce HIV and STI transmission: a protocol for a qualitative study. *BMJ Open.* 2013; 3 (2):e002581. doi:10.1136/bmjopen-2013-002581 (Impact Factor: 2.376)

Section 3.2 describes how the study adhered to the protocol and presents greater detail that was unable to be provided within the brevity of the published paper. In-depth information is provided on sources of data, sampling, data collection, analysis, researcher sensitivity and reflexivity, rigour and ethical considerations of the research. The research methods proceeded in accordance with the protocol.

Section 3.3. provides a summary of the research methods.

3.1 Research Protocol

Publication Four: Exploring the potential of expatriate social networks to reduce HIV and STI transmission: a protocol for a qualitative study

Citation: Crawford G, Bowser N, Brown G and Maycock B. 2013. Exploring the potential of expatriate social networks to reduce HIV and STI transmission: a protocol for a qualitative study. *BMJ Open.* 2013; 3 (2):e002581. doi:10.1136/bmjopen-2013-002581 (Impact Factor: 2.376)

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Exploring the potential of expatriate social networks to reduce HIV and STI transmission: a protocol for a qualitative study

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ABSTRACT

Introduction: HIV diagnoses acquired among Australian men working or travelling overseas including Southeast Asia are increasing. This change within transmission dynamics means traditional approaches to prevention need to be considered in new contexts. The significance and role of social networks in mediating sexual risk behaviours may be influential. Greater understanding of expatriate and traveller behaviour is required to understand how local relationships are formed, how individuals enter and are socialised into networks, and how these networks may affect sexual intentions and behaviours. This paper describes the development of a qualitative protocol to investigate how social networks of Australian expatriates and long-term travellers might support interventions to reduce transmission of HIV and sexually transmitted infections.

Methods and analysis: To explore the interactions of male expatriates and long-term travellers within and between their environments, symbolic interactionism will be the theoretical framework used. Grounded theory methods provide the ability to explain social processes through the development of explanatory theory. The primary data source will be interviews conducted in several rounds in both Australia and Southeast Asia. Purposive and theoretical sampling will be used to access participants whose data can provide depth and individual meaning.

Ethics and dissemination: The role of expatriate and long-term traveller networks and their potential to impact health are uncertain. This study seeks to gain a deeper understanding of the Australian expatriate culture, behavioural contexts and experiences within social networks in Southeast Asia. This research will provide tangible recommendations for policy and practice as the findings will be disseminated to health professionals and other stakeholders, academics and the community via local research and evaluation networks, conference presentations and online forums. The Curtin University Human Research Ethics Committee has granted approval for this research.

ARTICLE SUMMARY

Article focus

- Qualitative exploration.
- Role of expatriates and longer term travellers as mentors and change agents.
- Deeper contextual understanding of culture, personal behaviours, socialisation process and pathways.

Key messages

- Untested area which will provide context and tangible outcomes for research, policy and practice.
- Determine the potential of social networks to support peer and social influence interventions to reduce HIV and STI transmission.
- Gain insight into expatriate and long-term traveller behaviour.

Strengths and limitations of this study

- Opportunity to develop novel ways of thinking and sense making about changes to the HIV epidemic.
- Challenges in recruiting participants owing to cross-country (distance, resources) and cross-cultural (language, culture, beliefs and stigma) considerations.

INTRODUCTION

Internationally recognised for its response to the HIV epidemic, Australia has demonstrated strong partnerships, high levels of investment, action by affected communities and utilisation of peer and social influence in prevention.[1 2] However, changing transmission dynamics [1 3 4] mean these approaches need to be considered in new contexts. Australian data point to an increasing number of diagnoses of HIV among men, acquired while working or travelling overseas, including among heterosexual men.[5 6] People who travel to and from countries with high HIV prevalence have been

identified as a priority population in the National HIV Strategy 2010–2013.[1]

Over the past decade, there has been an upward trend of overseas-acquired HIV notifications in Western Australia. The number of Western Australians acquiring HIV overseas increased from 97 people during the 5-year period from 2001 to 2005 to 227 people from 2006 to 2010.[4 6] Surveillance demonstrates that a proportion of these new HIV infections have occurred in Southeast Asia, particularly Thailand and Indonesia.[4 6] This has occurred concurrently with an increase in travel to this region.[7] Thailand and Indonesia are the countries most frequented by Australian travellers, with a 3.3% increase in travel to Indonesia and 2.6% increase in travel to Thailand since 2001.[7] Over the same time period, travel to destinations such as New Zealand and the USA decreased.[7]

Recent research by Brown *et al*[8] indicates that increases in HIV prevalence may be linked to factors including a strong mining industry with associated travel and high incomes, and strong expatriate cultures and networks which exist outside Australia. This is supported by findings from a national seroconversion study reporting that one in six men interviewed had experienced a high-risk event overseas, with a third of these events occurring in Asia.[9] Of those men, two-thirds were living or working in Asia at the time of the high-risk event and almost 40% had been there for more than a year. However, for around a third of those interviewed, the occasion of the high-risk event was their first visit to the country.[9]

The impact of transport infrastructure, frequent and cheap plane travel and tourism have been drivers of the rapid global growth of HIV and sexually transmitted infection (STI) rates.[10] In many regions, the interplay between sex and alcohol and other drug use in risk-taking behaviour amplifies the effects of the epidemics.[11] A region to experience these effects is one of Australia's nearest neighbours, Southeast Asia, particularly Thailand which continues to experience high rates of HIV among people who inject drugs (PWIDs), informal sex workers and men who have sex with men (MSM).[4 12]

While there is a body of literature on the relationship between sex and travel, much is historical. Research with expatriates posted to HIV-prevalent areas has shown inconsistent condom use and poor estimated prevalence of HIV in the destination country.[13] Additionally, studies found that casual and unprotected sex were reasonably common among expatriates as was the use of commercial sex services.[13 14]

A contemporary meta-analysis also demonstrated that those staying abroad for longer periods may be more likely to engage in new sexual relationships and casual sex, including seeking commercial sex.[15] A recent study of Japanese tourists found that some of the main reasons for seeking commercial sex included the anonymity and sense of freedom, being lonely and the influence of peers, along with the availability of sexual services that were relatively inexpensive.[16] Additionally, research in Thailand found that longer term intimacy formed between travellers and expatriates and local 'bar girls' who may have one or more concurrent partner, blurring the line between 'relationship' and commercial transaction.[17]

The significance and role of social networks may mediate sexual risk behaviours. Brown *et al*[8] found that networks among expatriates and frequent travellers potentially created strong social norms regarding a range of attitudes and behaviour related to HIV and STIs. Engaging with and utilising the social networks of expatriate and long-term travellers may provide assets for interventions, but a comprehensive and clear understanding of how these networks operate is required to be effective.[8]

Tucker *et al*[18] suggest that analysis of networks can identify social factors relevant to risk behaviours and reveal characteristics of networks that can be used to develop innovative and effective interventions. Peer and social influence have been dominant approaches in HIV prevention, particularly within Australia, in often marginalised groups such as sex workers, PWIDs and gay, bisexual and other MSM.[8 19 20] Programmes employing these methods access key individuals who are members of groups or networks engaging in risk behaviours and use them to disseminate prevention messages and promote behaviour change.[12 18 19 21]

Greater understanding is required of the context of expatriate and traveller behaviour. There is a lack of knowledge of how local relationships are formed, how individuals enter and are socialised into networks, and the effects that these social networks have on the sexual intentions and behaviours of expatriates and long-term travellers. This paper describes the development of a protocol to investigate how social networks formed among the Australian expatriates can be used to develop effective interventions. This study builds on recent research, seeking to gain a deeper understanding of the Australian expatriate culture, behavioural contexts and experiences within social networks in Southeast Asia to guide further research, policy and practice.

METHODS AND ANALYSIS

Conceptual framework

This research is interested in the development of self and self-identity, which occur within and between the interactions of male expatriates and long-term travellers and their environment. This domain of enquiry is consistent with the theoretical perspectives of symbolic interactionism,[22] which is based on the subjective meaning that individuals attribute to their own actions and to how they interpret and interact with the world around them.[23] The benefit of utilising this perspective as part of the research framework is to provide an opportunity to look for culturally derived and historically situated interpretations of the world from the expatriate point of view, and to record how individuals end up assuming an expatriate identity.[24]

The research seeks to examine the transition process from *Australian* to *Expatriate Australian* and *Insider* in the expatriate and local community. The development of self, social processes and pathways and the impact of culture will be investigated along with the relationship between expatriates, the environment and the different communities they engage with.[25 26] The concept of culture used in this study is taken from the symbolic interaction perspective as used by Charon[23] and includes the use of significant symbols and ritual.[27]

Methodology

The methodological approach chosen for this research is grounded theory[28–30] because the 'emphasis is on process, theoretical sensitivity and the centrality of a storyline around which analysis can coalesce'.[31] The use of grounded theory provides the researcher with a level of reflexivity[25] that is particularly valuable in the current context of cross-cultural research. The use of constant comparison of data as they are collected and analysed enables themes to emerge that become more focused and theoretical as the research progresses.[25]

The grounded theory methods provide the ability to explain social processes through the development of explanatory theory.[32] It is a useful complement to the use of symbolic interactionism as both derive from similar epistemological and ontological perspectives.[29] The combination of symbolic interactionism and grounded theory as theoretical framework and methodology has been successfully used in previous HIV social research.[8 26]

Assessing methodological quality

The consolidated criteria for reporting qualitative research (COREQ)[33] will be used to ensure that this study meets appropriate standards for qualitative research.[34] While well-known tools exist to assess the quality of quantitative research,[35] similar tools for use in qualitative studies are less common.[36] Criteria were developed to address the lack of comprehensive frameworks to assess the quality of qualitative research for publication.[33] The tool is a 32-item checklist grouped into several key areas: research team and reflexivity, the study design and data analysis and reporting.[33] The criteria have been used with a range of studies to enhance their rigour.[37–39] Use of the COREQ tool will be explored in detail when field-testing the protocol.

Aim and objectives

The primary aim of this study is to determine whether the social networks of Australian male expatriates in Southeast Asia have the potential to support peer and social influence interventions to reduce the transmission of HIV and STI. Specifically, the research seeks to build a deeper contextual understanding of culture and personal behaviours, describe the socialisation process and pathways and investigate the roles of Australian expatriates and long-term travellers as mentors and change agents within their social networks.

Recommendations will be made for further research, policy and interventions targeting expatriates and frequent or longer term travellers.

For the purposes of this research, an expatriate is defined as: *someone who has taken up a paid work position within an organisation in Southeast Asia for a period of more than 6 months.* A long-term traveller is defined as: *someone who has spent more than 6 months within a 12-month period in Southeast Asia.*

Setting

This research will take place primarily within Western Australia with additional data collected in the Northern Territory and Thailand. These locations were chosen owing to previously established networks and because of the patterns of overseas acquired diagnoses of HIV. Online settings such as expatriate forums will also be utilised. Anecdotally, these sites experience significant use by current and potential expatriates and may provide opportunities to recruit participants. The experiences of participants recruited via online networks will be compared to those of participants recruited through other avenues to explore similarities and differences. Thailand-based research will include interviews within bars and other entertainment venues as well as an audit of key night locations as recommended by Brown *et al*[8] Stakeholder interviews will be conducted in places of business including departments of health, universities, HIV organisations and other non-government organisations.

Research team

A steering group will be convened for this research project. This will comprise both researchers and practitioners who will provide expertise on social groups and networks, risk-taking behaviour, HIV and other STIs and include those who have experience in conducting research in Southeast Asia. The reference group will also include expatriates who have participated in earlier research, including those who have acquired HIV, now living in Australia. It is envisioned that a small proportion of the key informants who will be interviewed may be drawn from this group. The group will provide an opportunity to reflect on and refine themes throughout the research process, provide research direction, ensure rigour, triangulate data and manage ethical considerations.[32 36 40]

The team undertaking the research in Thailand will comprise female and male researchers and practitioners drawn from the research steering group including university-based research staff and staff from state and national HIV organisations with experience in working with the community and engaging organisations in Thailand. This small 'away' team will enable consideration of issues including the most appropriate gender to conduct the interview, most appropriate role or organisational seniority level to lead interviews, as well as safety considerations. The team will also provide support for in-country reflection and direction for data collection. The need to have multiple data collectors in the 'away'

team will require a high level of management and a coordinated approach to the data collection process. To strengthen this process, dedicated time will be spent with the research team before trips to Thailand and in a scheduled debriefing throughout the time away.

Sample selection, recruitment and size

Purposive and theoretical sampling will be used to access participants whose information can provide depth, detail and individual meaning.[41 42] The expertise of those participants familiar with expatriate culture will guide the research. Several types of participants will be recruited including those who can provide personal accounts of living as an expatriate or long-term traveller as well as participants whose role will assist to identify expatriate networks.

Selection

To participate in this study, participants must be either:

A. Men over the age of 18 and either a current or past expatriate or a long-term traveller to Southeast Asia. Interviews will be conducted with a range of men including expatriates from Australia working in the entertainment industry (bars/clubs), those working in other contexts including professionals, men working in mining/resources or aid workers or expatriates and longer term travellers from Australia travelling to and from Southeast Asia for pleasure, work or both.
B. Key informants from agencies and organisations who can provide context for this research and provide contacts for expatriate networks. Western Australian and Southeast Asian-based community, government and business organisations will be used to source these key contacts for interviews. Participants may be of any gender but will all be over 18 years of age.

Recruitment

Participants will be recruited via phone, email and online expatriate forums. Initial recruitment will focus on research participants in Western Australia and Thailand drawn from existing networks developed through previous research[8] and contacts from departments of health, universities, HIV organisations and other non-government organisations in Australia and Southeast Asia.

Sample size

As the themes develop, theoretically driven sampling using a snowballing technique[42] will be employed to ensure access to the social networks of the target groups. This will allow the researchers to examine and explore directions within the data that will bring about maximum returns, and to further develop and saturate the sampling categories originally identified.[43] This sampling will become more theoretically driven and directed as the research progresses.[43] Interviews and analysis will continue until saturation is reached on key areas under investigation and theory emerges and is developed from the data.[43–45] Saturation is estimated to occur after the analyses of approximately 12 interviews if the participants are relatively homogeneous.[45] While sample sizes in grounded theory studies are difficult to determine for the reasons described above,[32] for this research, approximately 20 to 30 participants will be required.

Data collection

The primary data source will be interviews with key informants, though this will be supplemented through observation of some venues to increase researcher sensitivity and to validate interview data. It is anticipated that this will be conducted in several rounds in both Australia and Southeast Asia. Follow-up interviews may be required and undertaken once the initial data have been examined and themes developed.[44] The follow-up may take place face to face or via telephone or email. Participation dropout rates will be recorded and reasons for non-participation will be explored.

There will be several phases of the research where multiple interviews and other data will be collected using a modified constant comparative approach. This will include data gathered in Thailand and the Northern Territory. During this time, interview data will be collected with reflection and comparison occurring after each day of data collection. This modified approach to grounded theory[44] will enable reflection by an expert panel, immediate insights and provide multiple reflection points. It will also enable modification of the interview schedule in a formal debriefing setting for questions to be asked after each interview. This will maximise the potential of the data collection which may occur over a short period of time in the field.

Interviews

Guided interviews of approximately 1–2 h will be used owing to the flexibility of this technique.[42] This technique provides a systematic and comprehensive approach to interviewing participants where clarification can be sought and gaps in the data can be addressed and closed.[41 42] Interview themes will be guided by the literature on symbolic interactionism, expatriate culture and social influence and consultation with informants and the steering group. Consistent with the grounded theory method, the content of the interviews may be modified over time to respond to emerging themes within the data.[44] However, the initial enquiry domains for the interview guide, as outlined in box 1 below, will include data about the formation of networks and the roles that individuals play within networks.

Interviews will be digitally recorded for verbatim transcription.[46] The interviewer will also complete relevant field notes and journals which are important processes in qualitative research.[41 42]

Observation

Where appropriate, the interview data will be supplemented with an audit of settings such as bars and online

Box 1 Initial interview domains of inquiry

- The reasons for spending time away from Australia
- Whether they consider themselves to be an expatriate, and if so what this means
- When the participant considers themself to be an expatriate
- When others consider the participant to be an expatriate. This will explore issues of naming
- The influence of culture and socialisation among expatriates of their identity
- The meaning of country. What Australia means versus Southeast Asia to participants
- How the participant learnt the cultural and social norms within the country
- How expatriates and long-term travellers interact and create meaning from these interactions
- Who expatriates socialise with, and what social networks expatriates are part of
- Who the participant gained support from, and learnt from
- Who the participant feels they support or educate
- Personal behaviour among expatriates including participation in online networks and the way this behaviour differs 'at home' and 'away'
- Where participants feel risk is located. This will explore proximity
- To what extent a 'natural community' exists in the way it does in many groups that peer and social influence is used in Australia.

forums. Bars and entertainment precincts have been highlighted in previous research and interviews with key informants as locations regularly frequented by expatriates.[8] Other social locations such as cafes or sporting clubs may be audited, based on the recommendations provided by research participants during the course of the interviews. It is difficult to determine the breadth of these potential locations and the viability to audit them until the research starts.

The purpose will be to compare audit findings to interview data and identify which spaces and settings contain qualities suitable for intervention. This process will enhance researcher sensitivity and allow the researcher to develop social and cultural meaning to support interview findings.[47] Observation will provide an opportunity to examine processes of socialisation, including ritual and routine (such as attendance at particular social spaces and involvement in particular social activities) within the network.[27] This may help to identify normalised behaviour within expatriate social networks, as well as behaviours which deviate from that deemed acceptable. The audit will use focused observations as a method of triangulating particular aspects of interview data and analysis.[36 47] Field notes, researcher journals and photographs will be compiled for use during this process.[46]

Analysis

Data for this research will be analysed using the constant comparative approach.[44] Constant comparison requires a comparison of interviews, and later the data to theory that is generated until a strong understanding of the phenomena of interest has emerged. This means data will be collected and analysed simultaneously.[41 44] The data analysis will comprise: data collection, ordering, organisation and explanation.[44]

As described above, symbolic interactionism will provide the overall analytical framework. Psychosocial theories which assist in understanding the qualities of communities or settings that support the use of peer education, peer support and social influence will also be assessed for their relevance. These theories could include Diffusion of Innovations Theory,[48] Social Cognitive Theory[49] and Social Identity Theory,[50] which are broadly consistent with the symbolic interactionism framework.

Once data have been collected, they will be transcribed into a document compatible for use with computer-based word processing. Interviews will be transcribed in a manner that will maintain the confidentiality of the participants.[40] The data that are collected will be systematically managed.[51] Computer-assisted data analysis will be used to enhance the management, storage, coding, retrieval comparison and linkage of data.[32] For the purposes of this research, the NVivo V.10 qualitative software will be used.

ETHICS AND DISSEMINATION

This research has received approval from the Curtin University Human Research Ethics Committee, conforming to the National Statement on Ethical Conduct in Human Research.[40] Participants will be informed that they are free to withdraw from the interview at any time and that in reporting, participant responses will be de-identified.

Safety is a consideration for this study. Data collection in Thailand and the Northern Territory will be conducted by a team of both male and female researchers who will provide support and debriefing to the primary researcher and assist in developing protocols to address issues of concern.

Research that examines challenging or sensitive issues may involve risk. Clear protocols are required to deal with a participant's distress.[40] In collaboration with the research steering group, the researcher will develop guidelines to identify distress and develop appropriate referral pathways. The researcher will liaise with relevant organisations in Australia and Southeast Asia to provide assistance to any participant on issues arising during the course of the interview including sexual health, sexuality, alcohol and other drug use or other emotional or physical health issues.

The role of expatriate and long-term traveller networks and their potential to impact health are untested. This is a new area of research which provides the opportunity to develop novel ways of thinking about the application of grounded theory and sense-making about

changes to the HIV epidemic and those at risk. The chosen methodology can develop typologies to gain insight into expatriate and traveller behaviour. Further, it can illustrate how to locate and identify champions as change agents to address key health and social issues experienced by expatriates and longer term travellers.

This study will develop recommendations for government, non-government and research organisations regarding intervention methods. The research provides an opportunity for publications arising over the course of the study. This includes a literature review, findings regarding expatriate culture and personal behaviour and an exploration of expatriates as mentors and potential change agents. Findings from the research will be disseminated to health professionals and other stakeholders, academics and community via local research, and evaluation networks, conference presentations and online forums.

It is anticipated that a more cohesive and national response to the issue of HIV and mobility will be forthcoming including funding for research at a national and state level. Travellers will continue to be a key priority population for the next Australian national HIV strategy and the current study can provide context and tangible outcomes for research, policy and practice.

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Contributors All authors listed above fulfil all three of the International Committee of Medical Journal Editors (ICMJE) guidelines for authorship which are: (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content and (3) final approval of the version to be published. GC was responsible for coordinating the contribution of all authors to this paper. All authors made significant contributions to the development and conceptualisation of the protocol. GC and NB were responsible for drafting this paper. GB and BM were responsible for editing and guidance on the paper. All authors were responsible for critically revising the paper. All authors approved the final version of this paper for submission.

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3.2 Research process

This section describes sources of data for the study, data collection, study setting, research process, ethical considerations and researcher sensitivity and reflexivity. It builds on and supplements the information presented in the published study protocol (Publication 3).

3.2.1 Research Paradigm

This study's research paradigm was interpretivist, comprising a relativist ontology, constructionist epistemology, Symbolic Interaction (SI) as the theoretical perspective, Grounded Theory (GT) as the methodology and in-depth interviews and observations as the methods. This paradigm was consistent with my worldview which is that reality is socially constructed. Accordingly it is critical to understand the world from the subjective experiences of individuals and to examine meaning that lies behind social action. I believe the paradigm privileges participation which is consistent with my values as a researcher.

SI provided the **theoretical framework** for this study. SI is considered a micro-level theoretical framework (Turner 2011) emerging in the 20th century via the work of Mead (1934b), Cooley (1902a) and other pragmatists. It was subsequently developed by Blumer (1969), and positivists Kuhn (1964) and Stryker (1980). Blumer's broad perspective, that human life is lived in the symbolic domain, is utilised in this research (Blumer 1969). Key ideas of SI can be articulated as follows:

> (1) human beings act towards things based on the meanings objects have for them;
> (2) meaning is derived from social interactions with others and with society; and
> (3) meaning is created and modified through an interpretive process during interaction with one another (Blumer 1969).

In this research, use of SI facilitated consideration of reality from an ELoFT point of view. The research explored the development of ELoFT self and self-identity and social network processes and pathways and how participants created meaning through their interactions with other ELoFTs and with their environment. The research sought to examine the transition process from *Australian* to *ELoFT* and *insider* in SEA.

GT, conceived by Glaser and Strauss in the mid-1960s was utilised as the study's **methodology** (Glaser and Strauss 1967). The process of generating theory from data, GT was considered appropriate for this study as it provided a level of reflexivity valuable in the context of cross-cultural research. Sheridan and Storch (2009) cite the work of Blackman

(1983) who suggested that the contribution GT could make to cross-cultural research is *"theory, conducting research in a systematic manner and the charting of researcher experiences and perspectives resulting from intercultural contact"*. In this way it is able to provide reflexivity as it provides a vehicle through which to consider the complex web of factors influencing migration and do so from multiple theoretical perspectives. GT has been suggested as helpful in public health when investigating social problems or situations to which individuals and groups must adapt (Wilson, Hutchinson et al. 2002), as in the case of the Australian ELoFTs to SEA and subsequent risks of HIV transmission. GT has been suggested by many including Strauss (1990) and Crotty (1998) as complementary to the use of SI as they both derive from similar epistemological and ontological perspectives (Charmaz 2006; Chamberlain-Salaun, Mills et al. 2013). Their combination, as theoretical perspective and methodology has been used in previous HIV and other related social research, including research focused on peer interactions and influence (Wilson, Hutchinson et al. 2002; Brown and Maycock 2005; Klunklin and Greenwood 2006; Brown, Ellard et al. 2012; Brown, Ellard et al. 2014).

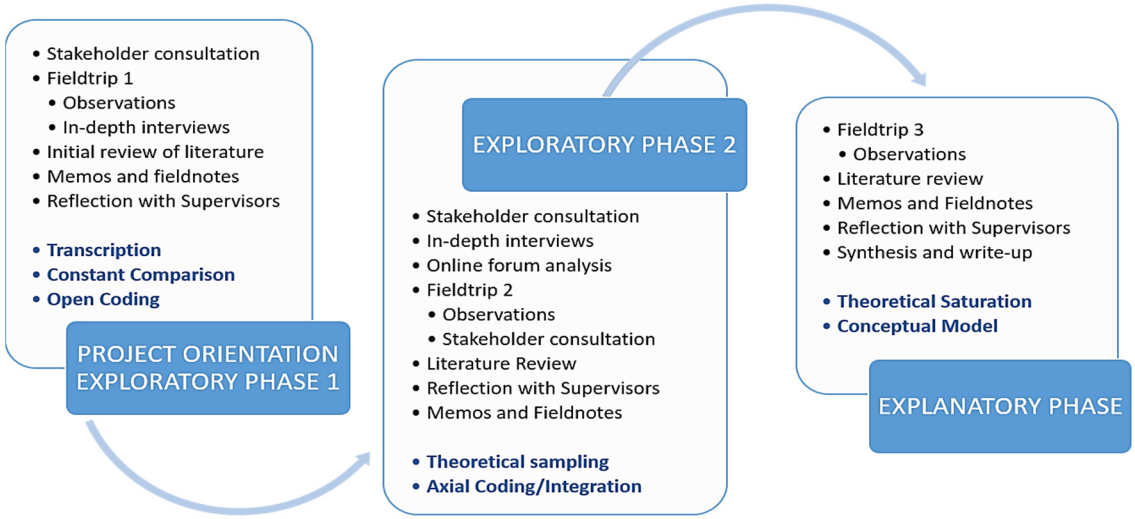
A schism between the approaches of Glaser (1967, 1992, 1998) and of Strauss and Corbin (1990, 2008) led to diverging methods, the main difference being dissimilar beliefs about and approaches to analysis and verification (Charmaz 2006). Later iterations were developed by Charmaz (2008) and others who suggest a more constructivist perspective. In The current research adopted an adapted form of GT, most consistent with the approach championed by Corbin and Strauss (2008). The approach was adapted in that constant comparison of the data did not commence immediately due to pragmatic fieldwork considerations. Further, a more flexible approach to the research was taken than espoused by Corbin and Strauss (2008), particularly in relation to coding at the axial stage in line with Glaser's (1967) original and more traditional method, with a focus on emerging theory (Glaser 1992). Consideration of other formal theory in analysis, integration of SI as the theoretical perspective and the use of the literature to guide analysis were more consistent with Corbin and Strauss (2008).

3.2.2 Methods and Data Collection

This study made use of multiple data sources, which strengthened the credibility and trustworthiness of its design and findings (Corbin and Strauss 2008). Behavioural theory, particularly Social Cognitive Theory (Bandura 1986) and Diffusion of Innovations (Rogers 1983) guided initial formation of research questions, development of methods and data

collection and supported analysis and research implications. Sources included: 1. A review of the literature; 2. In-depth interviews; 3. Online forum data; 4. Observational field trips; and 5. Stakeholder consultation. These data sources are described in more detail in subsequent sections. The data collection and analysis process is summarised in Figure 2 below.

Figure 2. Data collection and analysis process



Sampling

This study utilised purposive sampling to access the target group and their environments. Purposive sampling intentionally selects specific individuals or settings of interest that can provide information rich cases (Patton 2002) pertinent to the research aim and objectives (Liamputtong 2009). To be eligible to participate in interviews and for inclusion in analysis of the online forum data, participants needed to meet the following inclusion criteria:

- an Australian male;
- aged 18 years or older;
- an ELoFT; and
- an ELOFT whose destination was SEA, particularly Thailand.

Efforts were made to achieve a diverse sample of ELoFTs on the basis of age and experience (time in Thailand, relationships, employment status etc.), recognising that ELoFTs came from a wide range backgrounds and were not necessarily born in Australia, but may have been long term residents. Settings for observation were purposively selected using

criterion-based sampling, as was the online forum. Selection of settings for observation was based on discussions with stakeholders and via interview with an initial informant.

Review of the literature

Engagement with the literature was a critical component of the research process. Consistent with the Corbin and Strauss (2008) perspective on GT, use of the literature was pivotal in guiding the study protocol, aim and objectives of the research, the development of the interview guide, during analysis and in developing the conceptual model. Literature assisted me to determine the scope of the problem under investigation and was a required component of the doctoral proposal, candidacy and thesis. Literature review provided an opportunity to formulate concepts for sampling and enhance researcher sensitivity to the data. Supporting literature is used in Chapters 1 – 8. Chapter Two presents a review of the literature in detail in the form of an issues commentary (Publication 1), a previous study (Publication 2) and a systematic review (Publication 3).

In-depth interviews

Narratives from Australian male ELoFTs to SEA were elicited via semi-structured, in-depth interviews (n=25). Two interviews were held in Australia with an initial key informant who provided further contacts for interviews and perspectives on ELoFT life in Thailand and SEA. A further twenty-three interviews were conducted with Australian men both in Australia and in Thailand (primarily Phuket). Each interview, one to four hours in duration (average one and half hours), was conducted either face to face or via Skype. Two interviews were conducted with pairs of participants and one participant was interviewed twice. Email follow-up was conducted with three participants to clarify or extend concepts in their original interview.

Recruitment and sampling

The initial key informant, who participated in a previous study, provided early contacts in Thailand to facilitate recruitment of study participants for in-depth interviews. Snowball sampling was used whereby participants were asked to provide the details of other individuals deemed suitable participants for the study (Magnani, Sabin et al. 2005). Such sampling has been used extensively with hard to reach groups including those unlikely to participate without referral from another member of their network (Magnani, Sabin et al. 2005; Liamputtong 2009) such as steroid users (Maycock and Howat 2007), gay men (Brown and Maycock 2005), and migrants from SEA and sub-Saharan Africa (Gray, Crawford

et al. 2018). The snowball approach was used particularly in early interviews with the key informant, stakeholder discussions and in-situ in Thailand during early data collection.

Recruitment also occurred via fliers and advertising material (see Appendix D) distributed at a number of WA sexual health organisations and online via expatriate and travel forums, the Stickman Bangkok blog website, several mining and resources companies and via snowball contacts. These avenues were chosen in consultation with the research team and advice from previous research. Recruitment for in-depth interviews via the online forums was conducted after data collection for the observational component and analysis of forum data was complete. This was to ensure that my presence did not affect interaction on the online forum.

Interview guide

Interviews were conducted using a semi-structured interview guide which focused broadly on themes and domains of inquiry to allow a flexible approach (as outlined in Publication 4, page 5) and one which could develop as theoretical sampling occurred (Corbin and Strauss 2008). Domains of inquiry were guided by the relevant literature and behavioural theory, discussions with stakeholders and were viewed through the lens of the SI perspective which allowed for a deep exploration of the way in which meaning was constructed through interactions (Blumer 1969).

A semi-structured approach allowed participant narratives to surface and enabled exploration of emerging themes whilst also providing some structure to the interview (Bernard 2006). Open-ended questions were generally used and I encouraged participants to tell stories about their experiences with minimal prompting. Over the study, small iterations were made to the guide to enable the exploration of emerging themes. The guide was piloted with the key informant which allowed me to assess the flow and sequencing of questions and receive feedback about the interview and the questions therein. This provided me with a level of confidence about the interview process prior to embarking on fieldwork in Thailand.

Interviewing

Approximately one-third of the interviews were conducted in Thailand. The remainder were conducted in and from Perth. Perth-based interviews took place at Curtin University in an office or café on campus or at the place of work of the participant. Interviews in Thailand took place in guesthouses, cafes and bars. Negotiation with the participant regarding interview scheduling occurred primarily via email or face to face during the fieldtrips to

Thailand. This process allowed participants to ask additional questions prior to the interview or to opt out.

I conducted all interviews. A research assistant or member of the supervision team was present in a number of cases. A research assistant was present for interviews conducted via Skype to assist with note-taking. Male PhD supervisors provided support during early interviews in Thailand, particularly for interviews for which I deemed that the presence of a male could:

- Increase feelings of safety for the female interviewer;
- support rapport to develop more quickly between the researcher and participant;
- provide an 'in' with potential participants; and
- enhance the interviewer's sensitivity to the topic and interview style.

Prior to fieldtrip one, the research team spent time together discussing issues of confidentiality, ethics, privacy, boundaries and developing a plan for interviewing informants and stakeholders.

As an 'outsider', it was important for me to clarify participants' statements, particularly those that related to issues of gender, power or cultural context. Participants used slang, profanity, abbreviations and casual language, such as *"you know"*, which frequently punctuated narratives. Where possible and where deemed appropriate (i.e. maintaining confidentiality), places and people that the participant knew or might know were discussed to establish trust and rapport. I explained my professional background to help put the participants at ease when sharing personal information or information that the participant thought might shock or embarrass me (mentioned by several participants).

To remain empathetic and non-judgemental, I drew on previous work on helplines, conducting brief motivational interviewing and health assessments. This was bolstered by previous training undertaken in working with challenging topics and facilitating education with young people and adults as well as tertiary-level teaching of sensitive issues. The end of the interview provided participants with an opportunity to ask more about the research. In a number of interviews, participants shared pertinent information as the interview concluded, often after the digital recorder had been switched off. On these occasions, I made notes which could later be included and asked participants for their consent for this information to be used.

Online Forum data

Observation and analysis of interactions of five Australian male ELoFTs in one online forum (posts – n=500) provided additional data. Methods relating to sampling and data collection through the online forum are described in Publication 5 (summarised here). A two-month internet search identified forum users for inclusion. The first stage identified online forums frequented by the target group. Internet search terms were selected by reviewing commonly used terminology on forums, a thesaurus search and review of the literature. Search terms entered into Google [Google LLC, Mountain View, CA, USA] identified 13 forums. Potential forums were selected according to a list of predetermined criteria:

- Posts were accessible to the public.
- Users self-identified as Australian males who were currently or had previously resided in Thailand.
- Nationality and sex of users could be identified (through posts or avatar details).
- Users' post history could be tracked.
- Met the definition of an online community according to Herring (2004).

Only one forum met the selection criteria. Subsequently five users met the forum criteria: users who self-identified as Australian men, who had resided in or were residing in Thailand, and who had created over 100 posts (determined to be a sufficient number to enable the analysis of the socialisation processes (Salzmann-Erikson and Eriksson 2012). These users' posts and interactions with other members were examined (Arsal, Woosnam et al. 2010) by searching the forum member list for the profile of each user and then accessing posts and threads. For each of the five users, the first 100 and 10 most recent posts were collected, along with the thread in which they were posted.

Observational Fieldtrips

Based on initial research and advice from agencies and the initial informant, three observational fieldtrips were made to Thailand, specifically Phuket, Pattaya and Bangkok, which included informal conversations with eight other ELoFTs, tourists and business owners who did not participate in the formal interviews noted above.

Process

Approximately 120 hours were spent observing locations, people and interactions. Observations were conducted in pubs, adult entertainment venues, restaurants,

guesthouses, hotels, and via a modified form of transect walk[8] with community members or as a research team, systematically walking the streets of particular locations, taking photographs and making field notes. Debriefing sessions were also held as a research team to explore emerging ideas, disassemble observations, challenge assumptions and make sense of the data. Further detail is provided in Chapter Four.

Participant observation provides an opportunity to examine processes of socialisation, including ritual and routine (such as attendance at particular social spaces and involvement in particular social activities) within a network which may assist to identify normalised behaviour within ELoFT social networks, as well as behaviour which deviates from that deemed acceptable (Denzin 1974). Fieldtrips provided an opportunity to sensitise me to the context of the research, identify consistencies and inconsistencies from other data sources, undertake interviews and recruit for interviews and observe participants in their environments and cultural contexts. The purpose was to compare findings to interview data and identify which spaces and settings may contain qualities suitable for interventions.

Through the observation process I sought to better understand the settings in which ELoFTs lived, worked and played as well as witness interaction within and between groups of ELoFTs. From previous research (Brown, Ellard et al. 2010; Brown, Ellard et al. 2012; Brown, Ellard et al. 2014), bars and entertainment precincts were highlighted as locations ELoFTs regularly patronised, in which they socialised, and that may be owned by other ELoFTs. All members of the mixed-sex research team had spent time in Thailand prior to this study and accompanied me on at least one of the three observational fieldtrips to increase their sensitivity to the topic and environment. Team members spent time together prior to these fieldtrips to prepare and undertook debriefing throughout and following visits.

Field notes were made during the trips and photographs taken of locations and interactions. As data collection and observation occurred over a number of years, field notes and photographs captured during these trips were critical in assisting my recall during coding and in debriefing sessions with supervisors. Photographs and field notes also captured any changes in places and spaces over time and provided a device to document places and processes described in participant narratives, enabling me to view these first-hand. Field notes also served as the basis for subsequent memos during data analysis.

Table 1 provides an overview of the three fieldtrips.

[8] A transect walk is a tool for describing and showing the location and distribution of resources, features, landscape, main land uses along a given transect.

Table 1. Fieldtrip overview

	FIELDTRIP ONE
Duration	10 days (towards beginning of data collection).
Locations	Phuket (Patong Beach, Phuket Town, Karon and Kata), Bangkok and Pattaya
Team	Researcher, two male PhD supervisors, female from a WA HIV organisation
Fieldwork activities	Organisational meeting: ○ Education Means Protection Of Women Engaged in Recreation (EMPOWER) ○ Rainbow Sky Association of Thailand (RSAT) ○ Service Workers In Group (SWING) ○ Joint United Nations Programme on HIV and AIDS (UNAIDS) ○ United Nations Educational, Scientific and Cultural Organization (UNESCO) Observational activity occurred in bars and restaurants, nightclubs and adult entertainment venues and at the main beach and tourist locations. Field notes were made and photographs were taken of locations and interactions.
Days and times in field	Both weekend and weekdays. Range of times from 8am through to 1am. The majority of time was spent from midday to early evening.

	FIELDTRIP TWO
Duration	10 days (towards end of data collection).
Locations	Phuket (Patong Beach), Pattaya
Team	Researcher's colleagues and female research supervisor (providing a different perspective to that of the visit undertaken with male supervisors). Other research colleagues were not directly involved in the present study yet were experienced qualitative researchers and offered interesting insights throughout the fieldtrip.
Fieldwork activities	Agencies visited: ○ Phuket Hospital Observational activity occurred in bars and restaurants, nightclubs and adult entertainment venues and at the main beach and tourist locations. Photographs were taken of locations and interactions.
Days and times in field	Both weekend and weekdays. Range of times from 8am through to 12am. The majority of time was spent from midday to early evening.

	FIELDTRIP THREE
Duration	7 days (towards the end of the entire research process).
Locations	Bangkok (provided an opportunity to become reacquainted with the setting whilst coding data and developing theory).
Team	Female research colleague not directly involved in this study.
Fieldwork activities	Observational activity occurred whilst walking, in tuk-tuks and taxis and catching public transport, in hotels, bars and restaurants.
Days and times in field	Both weekend and weekdays. Range of times from 8am through to 10pm. The majority of time was spent from breakfast to mid-afternoon.

Fieldtrip settings

The following section provides brief context about Thailand and the main locations visited as part of the observational fieldtrips: Phuket, Bangkok and Pattaya (see Figure 3).

Figure 3. Map of Thailand

Source: https://www.goway.com/travel-information/asia/thailand/geography-and-maps/

Thailand

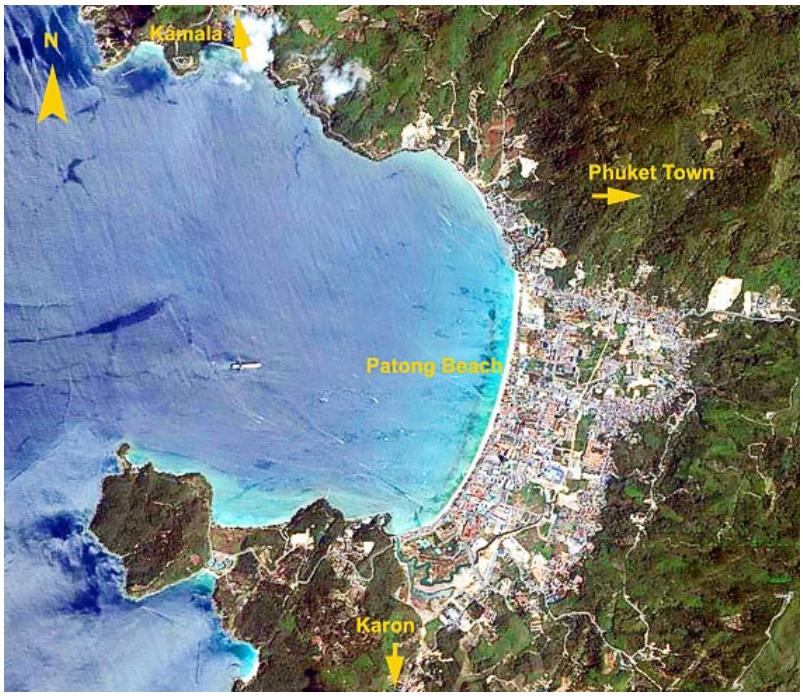
Thailand is a constitutional monarchy in the centre of SEA (see Figure 3) with the 2016 population estimated at 68.8 million (World Health Organization 2018b). The second largest economy in SEA after Indonesia, Thailand received approximately 35 million tourists in 2017 with an estimated 12% of the country's income derived from tourism (Thakral and Sriring 2018). Thailand's centrality within SEA facilitates the transmission of HIV and other STIs via frequent cross border travel and mobility of sex work and drug use-risk practices which drive the HIV epidemic among vulnerable groups (World Bank 2008). People living with HIV in SEA is estimated to be 3.5 million as at 2017 (World Health Organization 2018c). The interplay of social, economic, cultural and health factors continues to drive increased diagnoses in the region (Pendse, Gupta et al. 2016; Who Regional Office for South-East Asia 2016). There are approximately 440,000 people living with HIV in Thailand, with adult prevalence around 1.1% (UNAIDS 2017a).

Thailand has been active in prevention initiatives since the late 1980s (Siraprapasiri, Ongwangdee et al. 2016). By the early 1990s, Thailand was one of a small number of countries that had achieved success at reversing its epidemic, particularly amongst heterosexuals (Wilson and Halperin 2008; Punyacharoensin and Viwatwongkasem 2009; Colby, Srithanaviboonchai et al. 2015). This was achieved through high-level political leadership that built on and encouraged community responses, including the 100% Condom campaign with sex workers (UNAIDS 2000; Wilson and Halperin 2008; AVERT 2017). Following this, HIV prevalence began to decline amongst brothel-based sex workers as well as those working from entertainment establishments (Rojanapithayakorn 2006; Nhurod, Bollen et al. 2010). Thailand's contemporary HIV epidemic is concentrated, with GMSM the most affected (Colby, Srithanaviboonchai et al. 2015). In 2017, Thailand launched a new 13 year national AIDS strategy, providing a blueprint for ending its epidemic (UNAIDS 2017b).

Phuket

Phuket is located approximately 850 kilometres south of Bangkok and is Thailand's largest island (see Figure 4) with a population estimated at 520,000 (National Statistical Office of Thailand 2010). The island is a common destination for foreign tourists and expatriates with anecdotal estimates (quoting 2011 figures from the Statistical Techniques and Planning Branch at the Phuket Provincial Statistical Office) suggesting more than 100,000 foreigners were living in Phuket on a fulltime or part-time basis (International Living Magazine n.d.).

Figure 4. Map of Phuket



Source: https://www.flickr.com/photos/sharepics100/5680566462

Bangkok (including Patpong)

Bangkok is Thailand's capital city and serves as the political, commercial, industrial, educational, and entertainment hub of the country.

Figure 5. Map of Bangkok

Source: https://wiki--travel.com/map-of-bangkok-districts.html

Home to over nine million people, Bangkok has a monthly household income almost double that of anywhere else in the country (CEIC Data 2017). Bangkok has three main red light districts of which Patpong is the oldest (see Figure 5). Patpong is a designated entertainment district which comprises several private streets (or sois). It has been in operation since the Vietnam War and traditionally catered heavily to 'Western' expatriates and travellers.

Pattaya

Pattaya is located approximately 150km south of Bangkok off the Gulf of Thailand (see Figure 6). A small fishing town before the 1960s, it became a destination for tourists and travellers after soldiers from the U.S.A. visited during the Vietnam War for rest, relaxation and recuperation (Suntikul 2013). Most recent census data indicated a registered population of just over 100, 000 people, although this figure excludes people working in Pattaya but who are registered in their hometowns, as well as long-term expatriates (National Statistical Office of Thailand 2010).

Figure 6. Map of Pattaya Bay

http://www.orangesmile.com/travelguide/pattaya/high-resolution-maps.htm

Stakeholder consultation

Consultation with stakeholders was conducted in Australia and Thailand. This occurred predominantly at the beginning of the research process and guided the development of the interview schedule and provided a valuable source of information about the context of the study and its participants. Discussions ranged in length from thirty minutes to two hours. A number of stakeholders were contacted multiple times.

Discussions in Australia were held with representatives from:

- Australian Federation of AIDS Organisations (AFAO)
- Cairns Sexual Health Service
- Curtin University International Health Program
- Curtin University School of Information Systems
- Departments of Health (WA, NT, SA)
- Scarlet Alliance
- South Terrace (formerly B2) Clinic
- La Trobe University
- Monash Health Service
- National Association of People with HIV Australia (NAPWHA)
- Public Health Association of Australia (PHAA)
- Western Australian AIDS Council (WAAC)
- World Bank

Discussions in Thailand were held with representatives from:

- Education Means Protection Of Women Engaged in Recreation (EMPOWER)
- Rainbow Sky Association of Thailand (RSAT)
- Service Workers In Group (SWING)
- Joint United Nations Programme on HIV and AIDS (UNAIDS)
- United Nations Educational, Scientific and Cultural Organization (UNESCO)

3.2.3 Data Analysis

Though adapted to address fieldwork considerations, data analysis broadly followed methods espoused by Corbin and Strauss (2008): "*a process of generating, developing, and verifying concepts…that builds over time and with the acquisition of data"* (p. 57). A description of the data analysis of interviews and online forum data is provided here. Analysis was conducted within the four phases described by Miles and Huberman (1994):

- Data collection: interviews, field notes, memos, observational data, data from online forums, data from meetings with stakeholders and key informant.
- Reduction: coding data.
- Data display: memos and diagrams.
- Conclusions: synthesis, verifying and theory generation, development of conceptual model.

SI was used to provide conceptual framing to the analysis in considering the development of categories and their related properties and their relationship to other concepts. Broadly and without forcing the data or being too rigid, SI concepts (e.g. mind, self, society, action, interaction) were used in the development of the grounded theory and conceptual model and in refinement of themes as they became progressively more theoretical. As noted by Milliken and Schreiber (2012), SI provided the *"initial windows through which the researcher can view and think about the phenomena under study, thus expanding the breadth of theoretical codes available"* (p.685).

Theoretical sampling and saturation

Theoretical sampling, "*a method of data collection based on concepts derived from data"* (Corbin and Strauss 2008, p.144), was used during data analysis to guide sampling of additional participants who could provide relevant perspectives that could verify data or address gaps in knowledge. For example, as the interviews progressed, the use of online ELoFT spaces were described by participants as locations of support and information. This

led me to explore the use of online spaces more fully in later interviews and to the analysis of posts on one of these online forums. Data collection via interviews, observations and the forum continued until saturation was attained.

Data saturation as described by Corbin and Strauss (2008) is the point at which not only no new categories emerge, but also that "*development of categories in terms of their properties and dimensions, including variation, and possible relationships to other concepts"* (p.148) is achieved. The literature does not suggest any fixed number of interviews as providing sufficient data to achieve saturation. As described by Kelly, Bourgeault et al. (2010):

> …the researcher must justify her sample size on the basis of achieving informational redundancy or theoretical saturation, balanced against the amount of information generated and the analytic tasks it poses (p. 317).

Saturation was achieved in this study after 25 in-depth interviews, three observational fieldtrips (120 hours), analysis of 500 posts from five Australian males in one online ELoFT forum, stakeholder and informal discussions (n=8 – 10).

Transcriptions

Interviews were digitally recorded and transcribed verbatim. Transcripts were produced using Microsoft Word and exported to NVivo 10 software (QSR International Pty Ltd). I transcribed five of the interviews to become familiar with participant narratives, critically reflect on the interview process and prepare for the process of coding (Poland 2008; Liamputtong 2009). A professional service or research assistant transcribed the remaining interviews. I reviewed transcripts for accuracy and consistency. This verification was particularly important given that a number of the interviews were undertaken in venues with significant background noise and that participants also used a high degree of Australian slang, abbreviations and acronyms which could be misinterpreted (Oliver, Serovich et al. 2005; Poland 2008). Transcripts were also created of posts and threads from the online forum. Participants were provided with the opportunity to review transcripts and/or to clarify discussion points. Whilst no participants asked to review their transcripts, several participants followed up via email to provide further clarification on key points that they had made or where they had thought of something after the interview that they considered would be useful to share.

Forum data

The following is a summary from Publication 5. Discussion threads, rather than individual posts, were the initial units of analysis. Posts located within discussion threads were then individually analysed and coded. A sample of transcripts was validated by a second researcher. This process continued until each of the five users' posts (n=550) had been coded thematically. Subsequently, I led a review of transcripts in consultation with research team members comparing analyses and developing and refining themes. Themes were not totally emergent but were explored against SI concepts. Data from the online forums were coded concurrently with interview data.

Interviews

Constant comparison was used to analyse interviews which involved concurrently collecting and analysing data to generate explanatory concepts and theory (Glaser and Strauss 1967; Charmaz 2006; Corbin and Strauss 2008). In this research the approach was adapted, in that not all data were compared and analysed concurrently due to the pragmatic considerations of fieldwork in Thailand.

During the first fieldtrip a number of interviews were conducted alongside observational data collection and stakeholder meetings. The nature of the fieldtrip and the significant amount of activity performed therein, precluded transcription or analysis of interview data during the fieldtrip itself. Nonetheless, I was able to record field notes and memos and participate in daily debriefing sessions with other members of the research team. In doing so, key ideas and themes emerged and were documented as field notes and memos. These were explored as interviews were undertaken and questions were able to be modified or elaborated.

Early in the research, key locations (e.g. Pattaya, Phuket), activities (e.g. work, leisure, role of bars), ELoFT types (e.g. long-term, short-term) and relationships (e.g. with locals, with other ELoFTs) emerged which provided the basis for initial comparison. Conceptual and theoretical comparisons were then made, moving away from descriptive analysis to more abstract ideas (e.g. exploring concepts of belonging, support and place and their interrelationships). Concepts identified from the literature also informed the direction of constant comparison and coding alongside observations and fieldwork. Field notes and memos recorded during fieldtrips and observation became part of the analysis.

Coding

Coding as described by Corbin and Strauss (2008) is the process of data mining; taking raw data and examining it conceptually by interacting with the data, asking questions of it, making comparisons and then further developing emerging categories and concepts. Miles and Huberman (1994) refer to coding and its relationship to analysis:

> *To review a set of field notes, transcribed or synthesized and to dissect them meaningfully while keeping the relations between the parts intact, is the stuff of analysis. This part of analysis involves how you differentiate and combine the data you have retrieved and the reflections you make about this information.* (p. 56)

In this research and consistent with GT, coding involved several key components: open and axial coding and integration. I performed coding and discussed with supervisors who performed some early open coding of transcript components to confirm inter-coder consistency.

Open coding commenced after the first interview (Wilson, Hutchinson et al. 2002) to uncover meanings the text held (Corbin and Strauss 2008). This involved line-by-line analysis of transcripts to chunk and split data into meaningful segments. Transcripts were imported into NVivo. Nodes were created using descriptive labels (e.g. *cheap and warm*). Firstly, around 150 nodes were developed with some data coded multiple times. Codes were then grouped (e.g. *cost of living*) and a working definition was developed (e.g. *Living in Thailand provided affordable access to a more 'luxurious' life - housing, food, relationships*) which provided interpretation and identification. Open codes guided theoretical sampling where concepts were compared to explore similar and diverse properties (Emmel 2013). For example, comparing *cost of living* with *better life*. Coding became less descriptive as data were reduced and grouped together (e.g. *quality of life*) and as more abstract ideas and relationships became apparent.

Coding categories were discussed with supervisors as the data were reduced to receive feedback on concept development. The literature and observational visits also supported the development of insights. A broad approach to axial coding (Corbin and Strauss 2008) was used to reassemble data to look for relationships. In particular, context and interactions were explored (Creswell and Poth 2018) for one category of interest at a time (e.g. *place, home, risk*). This step was used broadly to avoid limiting the emergence of theory through an overly prescriptive approach to analysis (Benaquisto 2008) which has been a criticism of axial coding from some including Glaser (1992). Coding became more

theoretical as dimensions and relationships were captured. Theoretical coding continued until each category was fully described and saturation achieved. Integration was the final component of analysis in which categories were brought together in the development of the "story" (Creswell and Poth 2018), culminating in the grounded theory and explanatory conceptual model.

Memos, diagrams and field notes

I captured memos, diagrams and field notes throughout the research process. These were important as they: (1) enhanced the rigour of the research by contributing to an audit trail of activity, (2) provided a rationale underpinning concepts and decisions about data analysis, (3) sensitised me to the data by helping them understand the meaning behind the words, and (4) supported the development and elaboration of the conceptual model (Creswell and Poth 2018).

Memos, integral to GT, documented thinking processes (how did codes relate, what was the emerging story), developed ideas (expand on concepts, trial metaphors and parables) and progressed coding to writing (integrating memos and developing theory) (Liamputtong 2009). I initially wrote memos as a stream of consciousness, recording thoughts about open codes and their interrelationships. Memos developed concepts more fully through axial coding, subsequently becoming more elaborate (see Figure 7).

Figure 7. Example memos

Memo-Neverland 1
Some participants are describing their experiences as expatriates and travellers as "living in the in-between", "a nice place…fairly loose…not very restrictive" bringing to mind Peter Pan and Neverland. What is the participant saying in using the words loose and not restrictive? A modern grand tour or boys' own adventure? Permissive? A participant suggests they are "behaving a little bit like a Molly Meldrum on vacation". They have a desire to fit in and to live a "good life", to replicate/create a (positive) mythologised Aussie life, "free from limits" in an exotic/erotic new home. This suggests that place and home are important considerations in development of identity. Perhaps also important in the development of relationships with place and with others and in developing social networks?

Memo-Neverland 2
Participants represent Thailand as a permissive imaginary, liminal ground between the real and the imaginary. In Neverland, time moves strangely and fantastical things happen. Neverland (and Thailand) are 'sideways out of time'. Like the island of Neverland, Thailand is a place of potentialities, a place of wish-fulfilment, free from traditional rules. Participants are free to engage in a range of practices from home or learnt in the new environment. Neverland creates ideas of them and us (the pirates and the lost boys) and here and there (Neverland and England) where "anything goes". Participants describe a place where boys can be boys, perhaps where boys don't need to grow up and where they can "act like a king and be treated like a king". Participants such as Stewart describe Peter Pan like tendencies "he's a bit of a naughty boy". Naughty suggests nothing too sinister, something good natured.

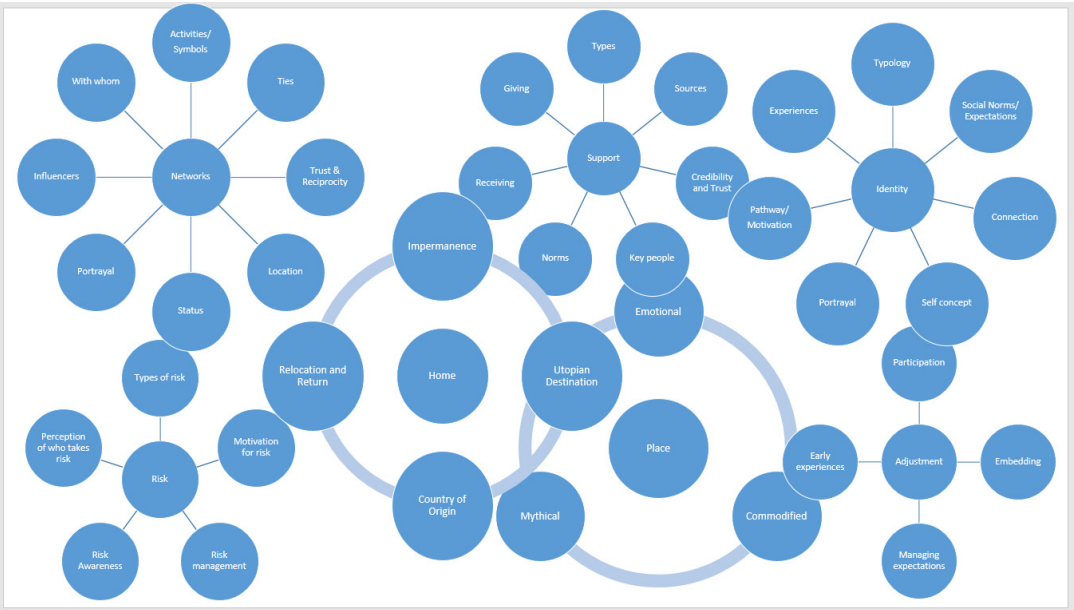
Participants suggest a sense of self that is free and libertine which is reinforced by place as both feminised to be dominated and masculine to be explored or conquered. Women are noticeably absent in Neverland or act as nurturers (Wendy) or sometimes as harpies (sirens, Tinkerbell) which is consistent with the way women are described in many of the participant narratives. 'Here' (Neverland/Thailand) and 'There' (England/Australia) are juxtaposed helping to create and reinforce an 'insider' status by embracing the magical here and rejecting the mundane reality of there.

Participants (a representation of Peter) take on the identity of Neverland and its make believe, and the identity and characteristics of the imagined expatriate community-making real the fantasy that they had imagined in their migration. In Neverland there is the ability to forget which means that the real can remain the Other, an opportunity to avoid the realities of Australia. The environment/place both moderates and reinforces participants' sense of self and behaviours. Participants seek to become part of the Lost Boys (an enclave, expatriate bubble), developing a communitas that emerges in the absence of more strict, traditional social structures or mores imagined from home.

Memos were integrated as the research progressed, moving analysis from descriptive to abstract and supporting theory building (Corbin and Strauss 2008). Guided by Glaser (1998), memos were flexible, top of mind accounts to prevent the loss of ideas and relationships between ideas.

I created **diagrams** which were used as "graphic memos" (Groenewald 2008) and played a role in conceptually understanding process and links between categories (Liamputtong 2009). Consistent with the work of Miles and Huberman (1994) diagrams and flowcharts helped examine relational connections between codes and constructs and make sense of the complexity emerging from the data. Diagrams moved from exploratory to explanatory as the research progressed (see Figure 8).

Figure 8. Concept map of all themes and codes using NVivo and PowerPoint



Diagrams were often drawn by hand, although tools in NVivo, Microsoft Word and PowerPoint were also used (see Appendix E for other examples).The figures demonstrate the development of codes and themes and the increasing complexity. Diagrams were also used in the form of sociograms to explore the formation of small networks within the sample and to develop common scenarios of ELoFT experience (see Figure 38).

I generally wrote **field notes** in first person narrative form which assisted to articulate and integrate research findings, provided a richer account of ELoFT experiences of migration and a subjective view of how ELOFTs developed their social networks (Brodsky 2008). Field notes captured information about the setting, participant, quotations and my reactions. Two types of field notes were made, those during and after observation sessions and personal reflections (Fetterman 2015). Observational field notes captured actions and activities, participant details and information about the context and environment. Personal reflections captured impressions on findings, feelings about the research process and participants and were used to document my perspectives, biases and reactions to fieldwork (see Figure 9 for example which explores early ideas of hegemonic masculinities).

Figure 9. Example fieldnote

Fieldnote from interview with T1 at XBar-11am with BM - BOYS CLUB/MASCULINITY

Get the sense that T1 was a little wary/cagy-I am definitely feeling a challenge here with me as a 'Western' female-I'm feeling that he really buys into that 1950s ideal of what the role of a woman should be – think that he originally comes from the country, so there is a bit of that as well.
Eased into the general conversation as we went along. Get the impression that BM may have been able to elicit more stories than me. I'm getting a sense of the boys club and what is appropriate to talk about in front of women-because he wouldn't want to offend? Thinks he might shock me?
Invited to a party hosted by D1 (blue shirted resort owner) –might have an opportunity to get the war stories. Not sure that it's appropriate for me to attend? For discussion….

3.2.7 Sensitivity, reflexivity and professional context

I am an Australian born and educated, cisgender woman. I identify as a feminist. I acknowledge my privilege with relation to my sociodemographic and cultural characteristics. Whilst I shared characteristics with participants as an Australian with English as my first language, my status as a women in this research rendered me as an outsider. This outsider status was initially challenging in developing rapport and developing understanding of participant perspective. I believe these positionalities challenged my beliefs in relation to practices and behaviours relating to gender and power and hegemonic masculinities.

Many of my formative years were spent in a regional, non-metropolitan location of Western Australia. Experiences shared by many of my participants were of small town experiences and life in regional and rural locations which I understood. However I was relatively inexperienced with cultural knowledge about Asia and I believe this coloured my perspective, at least in the formative stages of the research. I am the child and grandchild of migrants. I believe I have a strong sense of empathy and justice in relation to migration built on stories of persecution experienced by my family in the lead up to, during and after the Second World War. This has contributed to and shaped my practice ensuring that I champion my participants and critically examine areas in which I may contribute to marginalisation or oppression.

I have a tertiary education and postgraduate qualifications. I was only the second person in my family to receive a tertiary qualification. Education, participation and service are important to me and were. I came to this thesis with an academic background in Health Promotion, Public Health, English and Psychology (gained through a liberal arts degree). It was the power of words and language that drew me to research and to the areas in which I have chosen to work. A love and study of literature during childhood and adulthood including formal schooling and undergraduate university study guided the use of devices and metaphor in this thesis. My interdisciplinary background was a strength in the research process as it meant that I was able to draw on a variety of literature and consider the topic and data a range of other fields, lens, paradigms, disciplines and frameworks. That being said, I found this to be a tension throughout the study - links the porous borders of the work. At times it was challenging to focus the scope of the study within public health.

I have chosen to work in diverse and sensitive contexts in public health and health promotion including mental health, alcohol and other drugs and sexual health. I identify as a 'pracademic'[9]. I have experience as a public health practitioner, academic and advocate in tertiary, private, civil society and government organisations. Research, teaching, practice and advocacy have been guided by a human rights agenda and principles of equity, empowerment, evidence and ethics. These have been fundamental to the current study and have guided my thinking throughout the research journey.

For the past decade I have been based primarily in an academic environment focused on teaching and researching diversity and public health leadership though I continue to undertake practice work from time to time. I believe in the role of a university in

[9] Engaged in practice and academia

conducting both researcher led and industry driven research but also in a balance of teaching and engagement which focuses on building good world citizens and provides critical thinking and conceptual knowledge. As a qualitative researcher I consider methods, such as community-based participatory research and co-design that include the voices of participants as stakeholders as fundamental to research, practice, service and teaching. Community facing, applied research is my focus with strong engagement in the health promotion profession. My experience has involved using participatory approaches that confronted stigma and which focused on health equity.

Prior to academia I worked predominantly in non-government and not for profit agencies including in the community-based HIV sector. This focused on contexts such as prisons and with hard to reach or vulnerable groups including men who have sex with men, Aboriginal and Torres Strait Islander people, young people, people living with HIV and people who inject drugs.This provided a strong grounding in the topic and related issues and fuelled an interest in social justice. My ongoing role with the peak professional association for health promotion offers a national and international health promotion perspective.

Working from a rights-based agenda in the context of the current study often presented a challenge. Participants were not considered marginalised, in the way that much of the research on those most vulnerable to HIV acquisition has been framed. Indeed, the literature often refers to the types of ELoFTs described in this study as 'privileged'. Over the course of the study, I was challenged about attitudes and behaviours described by participants and by pre-conceptions regarding risk practices. These practices, and indeed the participants themselves, were often stereotyped or made into caricatures by the media and by people in my social circles. This required careful consideration and management. Regular debriefing, immersion through fieldwork and journaling assisted to unpack, challenge and work through issues as they arose.

To ensure diversity of experience and thinking I sought a research team for the current study who could provide a range of perspectives. My supervisors were experienced public health researchers. One supervisor had direct experience working in community BBV organisations, while others had experience working with such organisations and with marginalised groups through qualitative and participatory action research. Regular debriefing with academic supervisors provided the opportunity to position myself in the research and the research it its socio-cultural context. Strong, relevant academic supervision assisted to name and address biases and assumptions. Previous qualitative research provided guidance in my approach.

I recall one incident where I was struck, and in part shamed, by a comment made by a stakeholder of a global NGO in Bangkok who seemed puzzled by the reason for our meeting, "*What was our issue? A few, middle-class white men getting HIV?"* Implicit in the comment was the sense that they should know better or worse, that if they came to Thailand for sex, then perhaps they may 'get what they deserve'. I understood in part the motivation for the comment when considered alongside the scale of the HIV epidemic in Thailand. Nevertheless, it marked a slippery slope toward 'us and them', 'innocent and guilty', and 'deserving or less so'.

I had to learn and relearn how to be an advocate, in the context of the current study, for participants and for their vulnerabilities to HIV or other STI risk. At the heart of this was the social justice which underpins the public health response to HIV; the need to avoid victim blaming and to follow the epidemiological data. As Peter Piot and colleagues asked a decade ago, "*where are the next 1000 infections*?" (Piot, Bartos et al. 2008).

My desire to undertake doctoral studies was motivated by the opportunity to investigate an issue of real-world significance, provide recommendations with real-world relevance and make a contribution with real-world impact. In conjunction with PhD supervisors, I conceived the project and its design and was responsible for all aspects of its implementation. My role encompassed administration, acquisition of human ethical approval, management of study compliance, management of human and financial resources, registration of protocols, data collection, analysis and reporting.

Early in the research journey, a colleague provided a copy of the *Basics of Qualitative Research (3rd ed.): Techniques and Procedures for Developing Grounded Theory* (Corbin and Strauss 2008). The following passage reinforced the 'rightness' of the study and the PhD:

> Committed qualitative researchers…are drawn to the fluid, evolving, and dynamic nature of this approach… enjoy serendipity and discovery...It is not distance that qualitative researchers want between themselves and their participants, but the opportunity to connect with them at a human level. Qualitative researchers have a natural curiosity that leads them to study worlds that interest them and that they otherwise might not have access to. Furthermore, qualitative researchers enjoy playing with words, making order out of seeming disorder, and thinking in terms of complex relationships. For them, doing qualitative research is a challenge that brings the whole self into the process… (p. 13)

These characteristics of curiosity, organisation and complexity of thinking are those I have brought to the research process and to my work in public health.

3.2.8 Rigour

Qualitative research must be able to evaluate its trustworthiness, commonly described in relation to quality and rigour (Guba and Lincoln 1994; Pope and Mays 2006; Liamputtong 2009). As Silverman (2006) asks, "*have the researchers demonstrated successfully why we should believe them?"*(p.237). This study took specific actions to ensure that the research was trustworthy and to enhance rigour. The Consolidated Criteria for Reporting Qualitative Research (COREQ), guided reporting of process and results (Tong, Sainsbury et al. 2007).

Other strategies included:

- using the literature, stakeholder perspectives, key informants and observations to become familiar with and sensitised to the topic, participants and setting (Miles and Huberman 1994);
- significant time spent in observation and fieldwork (Lincoln and Guba 1985; Lincoln and Guba 1986; Creswell and Poth 2018);
- rich descriptions of data and giving voice to participants (Goffman 1989; Lincoln 1995; Slevin and Sines 1999; Denzin 2001);
- using several data collection methods and forms of data to substantiate findings and enhance the robustness of the research (Lincoln and Guba 1985; Patton 1990; Miles and Huberman 1994; Kuper, Lingard et al. 2008);
- publication of the research protocol and four additional papers in scholarly journals provided the opportunity for external peer review of the process and outcomes (Lincoln and Guba 1985);
- evidentiary adequacy by reporting on the breadth of the data and the use of memos and field notes (Lincoln and Guba 1985; Jeanfreau and Jack Jr 2010; Padgett 2012);
- reflective sessions with the research team and stakeholders to make sense of the data (Lincoln and Guba 1985; Lincoln and Guba 1986; Slevin and Sines 1999); and
- exploring biases and reflexivity throughout the study (Morse, Barrett et al. 2002; Patton 2008; Saumure and Given 2008; Palaganas, Sanchez et al. 2017).

These actions resulted in the creation of a rigorous study and research process that achieved the goal of qualitative research, as suggested by Melia (Bourgeault, Dingwall et al. 2010 p.572):

> If qualitative research produces analysis capable of explaining the data, and offers some theoretical insights, it is doing its job…it should show its true colours if it tells a story.

3.2.9 Ethical Considerations

Prior to commencement of the research ethical approval was obtained via the Curtin University Human Research Ethics Committee (details provided in thesis Declaration and Appendix F). Research followed the process as described in the published study protocol [Publication 4) and as approved. All ethical compliance processes including annual reporting were adhered to. The study received funding support from the Department of Health WA (via the WA AIDS Council) and from the Northern Territory Department of Health.

Ethical considerations for the study were outlined in the published protocol (see above). More detail on some of the key issues is provided below as they relate to the National Statement on Ethical Conduct in Human Research (the *Statement*) (National Health and Medical Research Council 2007). Relevant chapters of the *Statement* are cited verbatim.

Designing the study protocol

The protocol was designed with input from supervisors and WA-based stakeholders. This was to ensure that the process was respectful, based on principles of participation, demonstrated an awareness of key issues that may have arisen throughout the course of the research and that appropriate procedures were in place to respond to these.

Ethics of research with people in other countries

Whilst the study involved Australians, some data were collected overseas. Chapter 4.8 of the *Statement* outlines ethical considerations relating to research with people in other countries. The study complied with these requirements. Key considerations included:

- Design and conduct of the research reflected consultation with the local participant population and communities.
- Researchers had sufficient experience to enable participant engagement in ways that accorded them due respect and protection.
- Researchers knew enough about communities, and how to engage with them, to be able to assess the burdens and benefits of the research. Political and social factors that may have jeopardised the safety of participants were considered.
- Conducting research overseas could expose researchers to risks of harm. Risks were identified and provisions were made for dealing with them.
- Due regard was given to beliefs, customs and cultural heritage, and for local laws.
- Recruiting participants was respectful of the destination cultural context.

Illegal Activity

Uncovering illegal activity was not an objective of the study. Throughout the course of the study, some activities were described that may be considered illegal, particularly in relation to descriptions of drug use, crime and corruption and sexual conduct (under both Australian and Thai law). These were discussed with supervisors to determine if and when such issues may have required referral. Chapter 4.6 of the *Statement* describes ethical considerations relating to people who may be involved in illegal activities. The study complied with these requirements. Key considerations included:

- Research may have discovered illegal activity by participants or others, or may have discovered information indicating future illegal activity.
- Pseudonyms and removal of identifying features to protect participant identity.
- Researchers explained to participants the extent to which they would keep confidential any information about illegal activity.

Data management

Data were stored securely on the university research server with access limited to those directly involved in the study.

In-depth interviews

The participant information sheet and consent form are provided as Appendices G and H. Written or verbal consent was obtained. Some participants shared personal and occasionally explicit information about relationships, sex, mental health and drug use. To manage the information revealed and to maintain the flow of the interview, boundaries were set. These were based on experience in previous work with individuals who had disclosed personal information.

Participants were advised that the interview was not clinical or therapeutic and that I was not able to provide advice. Referrals were offered to any participant who may have demonstrated distress or discussed issues that may have raised concerns for their health or wellbeing. WA based participants were referred to local services for counselling or further information regarding testing, treatment or prevention (including websites). Thailand based participants were referred to local organisations for further health information and support.

Online forums

Ethical considerations relating to observation and data collection via the online forums were described in Publication 5 and are summarised here. To minimise the risk of influencing users' online discussion due to my presence, I did not make myself known on the forum and did not become a member. This approach was consistent with other studies in which researchers have taken on a remote or objective role and allowed conversations to continue unhampered by the presence of an outsider (Salzmann-Erikson and Eriksson 2012). Users were assigned pseudonyms and the forum de-identified to protect forum integrity and user anonymity in publications.

Observations

Observation was overt and I made no effort to conceal their note-taking or photography. Chapter 3 of the *Statement* addresses considerations regarding qualifying or waiving conditions for consent. This study adhered to these requirements:

- 'Limited disclosure' was used where it did not involve active concealment or planned deception as it was deemed that there were no suitable alternatives involving fuller disclosure by which the study aims could be achieved.
- Potential benefits were deemed sufficient to justify 'limited disclosure' and any risk to the community's trust in research and researchers. There was only low risk to participants and 'Limited disclosure' was unlikely to affect participants adversely.

3.3 Summary

This chapter provided a description of the research process for the thesis. A published research protocol is presented as the first component of the Chapter, the second part of the chapter expands on the content outlined in the protocol, providing a greater level of detail regarding the research paradigm, conceptual framework, methodology and research methods with supporting justification from the literature.

This study's research paradigm was interpretivist. I utilised SI (1969) as the conceptual framework for the study. SI was selected as it was most consistent with the researcher's worldview, for its consistency with the GT approach and for its ability to explore complexity of social action, interaction and participant perspective and experience. SI guided the interview schedule and data analysis.

GT was chosen as the methodology for this research, deemed to be appropriate to fulfil the research objectives as it had previously been applied to similar phenomena. The

approaches of Glaser (1967, 1992, 1998) and of Strauss and Corbin (1990, 2008) guided the selection and use of data sources, sampling, data collection and data analysis.

In-depth interviews, stakeholder interviews, in-situ fieldwork visits, observations and analysis of online forum data and a systematic review of the literature provided the data sources for the study. I provided detail on researcher reflexivity, sensitivity and professional context and outlined strategies to enhance rigour. Ethical considerations were explored.

The following chapter presents part one of the Results - an overview of observational data collected through fieldwork visits to SEA (Chapter Four).

4. In-situ Observations

Of all the delectable islands the Neverland is the snuggest and most compact, not large and sprawly, you know, with tedious distances between one adventure and another, but nicely crammed. When you play at it by day with the chairs and table-cloth, it is not in the least alarming, but in the two minutes before you go to sleep it becomes very nearly real. That is why there are night-lights.

- Peter Pan, J.M. Barrie, 1902 -

PRELUDE

In this chapter, findings are presented from the in-situ observational fieldtrips and agency visits. The chapter explores the destinations visited, assets and challenges observed in each location with relation to intervention for public health and provides a summary of the agency visits. Chapter content is supported by photographs and fieldnotes.
This chapter relates to the following objectives:

1. To build a deeper contextual understanding of culture and personal behaviour amongst Australian ELOFTs in Thailand and SEA.
2. To describe the socialisation process and pathways experienced by Australians (potential new ELoFTs) interacting with Australian ELoFTs in Thailand and SEA
3. To investigate the roles of Australian ELoFTs as mentors and potential change agents within ELoFT social networks in Thailand and SEA.
4. To make recommendations for further research including intervention research targeting ELoFTs.

Findings from the observational fieldtrips were critical to the development of the grounded theory and explanatory conceptual model that is presented in Chapter Seven. Findings supported understanding of:

1. how ELoFTs developed and sustained their social networks; and
2. how the networks could be used for public health intervention.

In particular, observations provided insights regarding potential places, people and points for intervention in situ in SEA.

4.1 Observational Fieldtrips

As described in Section 3.2.2, three observational fieldtrips were made to Thailand. The purpose of the observations was to better understand the settings in which ELoFTs lived, worked and played and to observe interaction within and between groups of ELoFTs. This section presents a brief audit of settings and summaries of agency visits. Maps, photographs, field notes and online materials are used as illustration. Settings have been considered in the context of potential assets and barriers/deficits for peer-based, social influence and other health promotion interventions. Potential assets and challenges are denoted using a plus (asset) and/or a minus sign (challenge) along with a brief description. Use of both a plus and minus sign suggests both potential asset and challenge.

4.1.1 Phuket

Much of Phuket's substantial tourist market centres around activities on the coast at Patong Beach and Karon. Discussion with locals and ELoFTs living on the island indicated a marked shift in the traveller type pre and post the 2004 Indian Ocean earthquake and tsunamis. Figure 10 describes my first impressions on arriving in Phuket which suggested a plurality of geographies, three interrelated domains: the landscape, the hardscape and the socialscape. These early experiences presented, as noted by Mitchell (2002), both the frame and what the frame contains; in this case a tableau of the diversity of migrant experiences (e.g. traveller, tourist, expatriate) all interacting within a mobility social field.

Figure 10. Field note – on arriving in Phuket, fieldtrip one

We arrived today in Phuket at around 2.30pm. It is very lush and green in parts and then very urban in others. It was amazing to see from the air- giant, ancient, vegetation covered monoliths rising from the bay. Many sections felt depressing, with faded grey concrete so densely populated and all selling the same thing-how can anyone make their way in the world? We arrived at the hotel at around 3pm. I then contacted the first contact for the research and arranged to drop in and see him at his bar on the 8th. I also attempted to contact EMPOWER, however the phone was engaged and it was after 5pm by this time. At around 5.30pm we had a drink and snack and consulted the hotel staff about our location and a map. We then travelled through the township until around 9.00pm exploring some of the Sois, having dinner and seeing the beach, the bar girls and kathoey. The weather was cool with late rain during the day. Foot traffic was energetic and the vibe was busy but relaxed. It is easy to see the attraction-cheap food, good weather and girls. There were many nationalities and many older and younger men with young Thai women. I saw fewer guys with young Thai men. Younger tourists and travellers seemed interested in the novelty of the bars and in drinking. They seemed to duck in and out of the shows. The bars are everywhere. Many seem to have the obligatory bar flies-the regulars catching up with others. European tourists, distinctive in their white, the Aussies in their t-shirts denoting beer brands, the English sporting sunburn. I imagine the difficulty in accessing the expats without the 'in' provided by T1.

Patong Beach

The majority of fieldtrip one was spent in Phuket and in particular in the Patong Beach area (see Figure 11). Patong Beach was also visited in fieldtrip two. This was the location that yielded the most significant data regarding ELoFT networks as well as provided an opportunity to audit the island's various popular socialising and entertainment hotspots for their intervention potential. Patong Beach is the hub of tourist activity on the island.

Figure 11. Patong Beach

Centred around the beach, the area is built in a grid pattern of major streets and 'sois', bars owned by expats are usually centrally located with easy access to other bars, the beach, restaurants, entertainment venues and guest houses (Figure 12).

Figure 12. Guesthouse in Phuket

Bars, Bars and More Bars (+)

There were bars and guesthouses with bar facilities popular with tourists and those that were regular destinations for ELoFTs (see Figure 13).

Figure 13. Bar in Phuket

Most were staffed by local Thai women. Through conversations with ELoFTs I learned about the women's role in attracting and retaining male bar patrons (see Figure 14). The image above shows one of the local bars with male patrons. This particular bar used Australian signage to engage patrons through a familiar symbols. The fieldnote describes the symbolic interplay between male patrons and female bar staff. This demonstrated the way in which women played roles in these spaces as companions, hosts and entertainer rather than just as staff. It seemed to suggest a social transaction of hospitality, designed to both encourage patrons to stay and purchase more drinks, but something else, represented by the game. Pool provided an opportunity for engagement with the familiar, minimal need to converse and appeared to be a tacit signal to all involved of interest in pursuing more intimate or more engaging social interaction.

Figure 14. Research team field note – a bar in Phuket, fieldtrip one

One of the girls, a slightly older woman, was having a drink of something (don't know if it was alcohol or not). Initially she was away from the men. She was playful with them but didn't actually sit with them leaving them to their conversation. Later she sat a bit closer and then set up a game of pool. She more or less invited them to join in. One man started playing with her and then eventually she set it up and they would play and she provided drinks and attended to other needs as well.

It was difficult to comprehend how so many venues were sustained and it was noted that a number of bars were advertised for sale. Bars that ELoFTs tended to frequent were in part based on nationality, although I did learn that a bar with an Australian flag or inference to an Australian animal or location (Kangaroo Bar etc.) did not necessarily mean that it was owned, managed or staffed by Australians. Nonetheless, there were several key bars owned and run by Australians who featured heavily in interviews. Within the vicinity of the Aussie Bar (a large bar), there were approximately 25 other bars, all relatively small.

Formalised networks do exist (+)

There was evidence of additional and formalised expatriate activity with a local, English speaking Rotary Club (https://www.rotary.org/en/about-rotary) (see Figure 15). Feedback from interviews and discussions indicated that there were a number of expatriate sporting groups as well as less formal groups that still met regularly both within the bar setting as well as for non-drinking related activity outside bars.

Figure 15. Rotary Club signage

Easy access through main entertainment grid (+/-)

Bangla Road is 'the main strip' of Patong Beach and popular in the evening with a densely populated district of bars, many of which put on shows featuring kathoey or go-go dancers. There was a frenetic feel at night with frequently changing weather and people shopping and eating until late in the evening (see Figures 16 and 17). The fieldnote here highlights the signs and symbols used to foreshadow sex. The interaction demonstrated a high degree of familiarity between staff and many patrons who appeared to be regulars. The behaviour was overt but couched as flirting, good natured. It appeared as a way for women to indicate

their interest but maintain some control, or at least a veneer of control, as it wasn't clear what played out later.

Figure 16. Research team field note – out at night in Phuket, fieldtrip one

Watching the interplay between people who obviously knew some of the girls in the bars and the sexual interplay. For example one of the guys said something cheeky to one of the girls and she grabbed his crotch in a, you know, not just suggestive, it was a full on grab. That's the sort of stuff that's perhaps building up the relationship over time and diminishing barriers and so on.

Bangla Road may present outreach potential. However, based on feedback from locals and ELoFTs as well as observation of the area it would appear that short-term tourists and those less familiar with Phuket comprised a large proportion of the people in this location. Given the likely differing nature of social networks of these individuals, interventions may focus more heavily on awareness raising or on engagement with bar staff and owners in the vicinity rather than travellers.

Figure 17. The research team out at night on Bangla Road, Phuket

Local ambassador program in place (+)

There were a number of volunteer community police or 'tourist assistants' including locals and expatriates who took on a role of providing directions and advice to tourists, particularly in the evening[10] (see Figure 18).

[10] https://www.phuket-tourist-police-volunteers.com/join.html

Figure 18. Tourist Police signage

Formal sex work and other health organisations exist but difficult to find (+/-)

Prior to the visit, the team liaised with EMPOWER (the Thai sex worker organisation) and arranged to visit with staff in their Phuket office. This visit proved challenging as the research team was unable to find the office, despite calls to staff in Phuket and Bangkok and consulting locals including police, expats and Thai women (including those working in bars) regarding the apparent location of the office (Figure 19). This search continued over the course of several days thus demonstrating the challenges for non-local health workers to set up programs without significant time and resourcing. The difficulty experienced finding the local EMPOWER office may suggest that their foothold in the local community may be more limited than previously anticipated and they may have less influence in accessing members of relevant networks.

Figure 19. Research team searching for the Phuket arm of EMPOWER

Pharmacies, health service and condom access (+/-)

A number of pharmacies and clinics (Figure 20) were visited to determine access to HIV or STI testing. Staff indicated testing was available and did not appear surprised to be asked. Despite the existence of a strong national Health Promotion Foundation, it was visually difficult to identify sexual health clinics or health promotion messages for either locals or ELoFTs.

Figure 20. Clinic in Phuket

There was a clinic located in the Patong Beach district that catered more to MSM. Most pharmacies that were visited throughout the trip stocked condoms in a variety of brands and sizes. Condoms were also readily available at convenience stores (Figure 21).

Figure 21. Condoms for sale in delicatessen

As part of the observations, I visited a Phuket public hospital. The hospital was easy to access and relatively inexpensive for basic treatment. The quality of care was unclear as was the level of specialist expertise. The team also received mixed information from ELoFTs about whether they would use the hospital and for what issues. For example, some ELoFTs indicated that use of the hospital was fine for issues considered minor-cuts, burns, dehydration, but for major surgery or setting bones use of a private hospital or a return to Australia would be preferable. For other ELoFTs particularly those who indicated a more laissez-faire approach to their health, the local hospital would be used for whatever health issues emerged. For some this also reflected a lack of financial resources to use a private facility or a lack of interest in returning to Australia despite awareness of universal healthcare.

Phuket Town frequented by Thai people rather than expatriates (-)

Phuket Town was also visited. It had a completely different feel to the beach location and there was no clear sense of ELoFT community and far fewer ELoFTs in general seen. It appeared to be a location for locals to shop and conduct business.

4.1.1.2 Karon

I visited Karon as part of fieldtrip one to Phuket. Karon Beach (Figure 22) and town is located on the western coast of Phuket, Thailand. Karon Beach was substantially damaged by the tsunamis which followed the 2004 Indian Ocean earthquake.

Figure 22. Beachfront at Karon

Observations in Karon indicated:

Less density, Australian expatriates and longer-term travellers less visible (-)

The geographic location was smaller, as were the number of bars. A much slower pace with fewer people was observed in comparison with Patong Beach. There appeared to be more families and people staying at resorts, with fewer young tourists or ELoFTs.

Smaller bars, different feel (+/-)

Observations and interaction with locals and ELoFTs suggested evidence of a bar culture but one which had a different feeling to that of Patong Beach. Bars were generally quieter and smaller with different clientele. The research team spent time in Karon visiting various bars, including one owned by an Australian. Of all the ELoFTs that we met, this bar owner most clearly articulated the reciprocal benefits of providing Thai staff with English language skills and responsible service of alcohol training which they completed in Australia. He highlighted the value to the business and locals as providing tangible positive outcomes for employment, profits and social connection. This was of interest as it suggested some level of interest in health and wellbeing and an information and training mentality that may be harnessed for intervention.

Invisibility of health services and agencies (-)

In comparison to Patong Beach and Phuket Town, there was little evidence of health clinics or health agencies and we saw no overt evidence of sexual health messages or related health hardware such as condoms during our visit there.

4.1.2 Bangkok

Bangkok was visited on the first and final fieldtrips. The four-day visit to Bangkok during fieldtrip one comprised meetings with stakeholders from the following organisations:

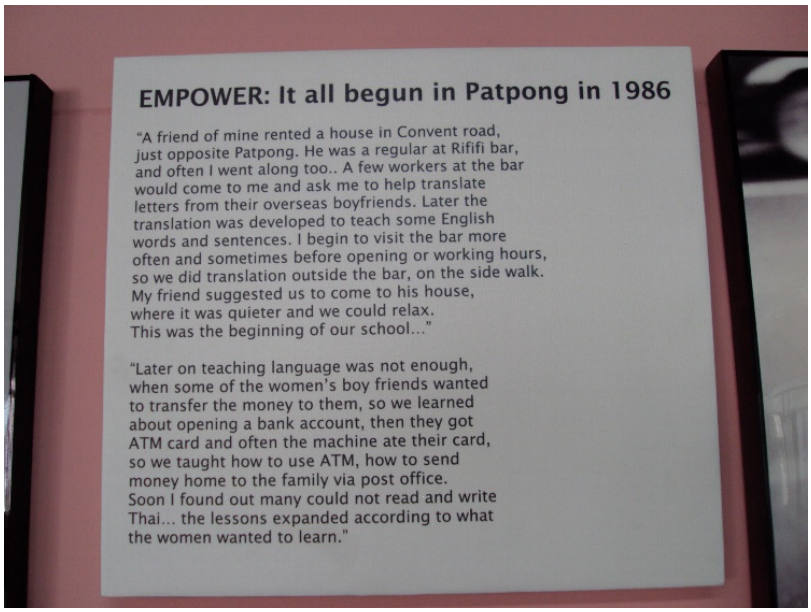
- EMPOWER (Bangkok arm)
- RSAT
- SWING
- UNAIDS Thailand
- UNESCO Thailand

Visits to Bangkok were insightful, providing me with a sense of challenges of and opportunities for an in-country intervention. In comparison to coastal and island tourist precincts, Bangkok hosted a large and disparate ELoFT community with a higher number of

overseas aid workers and those attached to international social and health organisations. The sex industry was visible, but only within certain areas, and as much a tourist attraction as anything else. I visited both EMPOWER[11] and SWING[12] (Figures 23 and 24).

Figure 23. Entrance to SWING in Patpong, Bangkok

Figure 24. Exhibit text from EMPOWER museum



[11] EMPOWER is a sex worker organisation based in Patpong, founded in 1985 - www.empowerfoundation.org
[12] SWING uses outreach, clinical service support and education to promote HIV and STI prevention among sex workers in Bangkok and Pattaya - www.swingthailand.org

The team were privileged to receive a night-time tour of Patpong (Figure 25), led by some of the staff from EMPOWER who formerly worked in bars and as dancers. This provided a unique opportunity for the research team to spend time with sex workers in Patpong.

The research team was also fortunate to spend time with an Australian HIV consultant who lived and worked in Bangkok. This individual spoke fluent Thai which made some of the visits, particularly with the staff from EMPOWER, much less challenging. Whilst language posed difficulties, it was clear from these visits that more research needs to occur with formal and informal sex workers to determine the role of female-identifying bar staff within the social networks of ELoFTs. Feedback reinforced the importance of projects that are gender transformative. Specifically their feedback suggested that sex workers, sex worker organisations and women who work in bars should be at the centre of projects, have the opportunity to actively contribute to projects (including being part of decision making processes) and to directly benefit (economically or socially) from projects. There was a suggestion that projects should focus on power and culture as well as education. Staff indicated that projects should be supportive to and understand the needs of Thai sex workers including their social, economic and cultural needs.

Figure 25. Visiting Patpong

The research team also visited staff from the UNAIDS Thailand[13] program, including staff who had previously worked in the field of HIV in Australia. The scope of HIV-related work in

[13]The main advocate for global action on HIV, UNAIDS leads, strengthens and supports an expanded response to the epidemic - www.unaids.org/en/regionscountries/countries/thailand/

Thailand is significant with high prevalence in a number of vulnerable populations posing considerable challenges. There appeared to be a lack of engagement with issues related to the Australian epidemic, which was disappointing but not unexpected. The team visited the HIV program in the Bangkok office of UNESCO Thailand.[14]

UNESCO staff proved to be helpful, providing an overview of their program as well as potential networks for further information. They noted the potential of online networks and forums. The team also visited Rainbow Sky,[15] meeting with a volunteer staff member, so it was difficult to determine the potential role this organisation might play in any further research or intervention. The organisation did appear well connected with the LGBTI community and to the HIV sector in Thailand as well as to AFAO and ACON in Australia, thus providing a potential avenue for information gathering and networking.

4.1.3 Pattaya

Whilst in Bangkok, I spent time speaking with individuals working in the HIV sector. Pattaya was suggested as a potential destination to visit due to its proximity to the capital as well as its reputation as a tourist precinct with a strong bar and club culture and visitations by 'Westerners'. I visited Pattaya during both the first and second fieldtrips with one other member of the team. The first visit during fieldtrip one occurred over one day and the visit during the second fieldtrip took place over four days.

Strong online/offline connection (+)

The following excerpt (Figure 26) is from an online forum specifically focused on Pattaya and linked to an accommodation provider. This is one of a number of ELoFT online forums (e.g. Thailand Forum, Expat Blog) that provide information to ELoFTs about retiring, relationships with Thai men and women and social opportunities specifically for ELoFTs. As indicated by this excerpt, blog content tends to cater for a male, 'Western' audience with a focus on enticing men, disenfranchised with their current circumstances to leave it behind for something better in Pattaya. This blog post was typical of the way in which Pattaya, Phuket and Thailand more broadly was often framed by foreigners – as an escape from the mundane or from past relationships. This framing was reinforced both on and offline through forums and in the bars and social spaces frequented by ELoFTs.

[14]One of UNESCO Bangkok's major focuses is aimed at reaching children and young people who are especially vulnerable to HIV. The program has a focus on MSM and people who inject drugs - www.unescobkk.org/
[15]RSAT promotes HIV prevention and overall MSM health through behaviour change communication, counselling services, public awareness raising campaigns and condom/information distribution to promote safer sex among MSM in Bangkok www.pactworld.org/cs/thailand/hiv_prevention_in_thailand

Figure 26. Excerpt from the Pattaya Secrets Forum on visiting Pattaya

> *"Why should you come for a holiday to Pattaya? Interesting question, but one with a very simple answer. If you answer 'yes' to any one of the following questions, you would most benefit from a trip to Pattaya.*
>
> *1. Are you recently divorced and at a loss what to do with the miniscule amount of money you were left after the divorce settlement?*
>
> *2. Have you just discovered your children are plotting to have you certified legally incompetent so they can get Power of Attorney over your assets?*
>
> *3. Have you won a lot of money and don't know how to spend it?*
>
> *4. Is the only female companionship currently available to you over 200 pounds and over 60, with a face like a sack of prunes and an attitude to match?*
>
> *5. Are you constantly being told you are too old, fat or ugly?*
>
> *6. Have the feminists and moralists controlling your country reduced your ego to zero and your self-confidence to somewhere below that?* www.pattayasecrets.com/pattaya/

Bars (-)

Bars seemed more dispersed than in other areas of Thailand and on first glance less 'friendly'. Yet, on visiting Walking Street during the evening the bars were livelier. A number of bars were busy during the day; overall they seemed quieter daytime locations than in Phuket and less clearly identified as Australian or frequented by Australians.

Day and night activities (?)

Daytime activities in Pattaya centred in and around Beach Road and Pattaya Beach (Figure 27). From early morning, beach chairs were rented to tourists who 'set up camp' for the day. Night-time activities centred strongly on Walking Street, Pattaya's version of Patpong in Bangkok or Bangla Road in Phuket. The team observed beer bars, discos, go-go bars and restaurants as well as numerous hotel rooms that charged by the hour for services.

Figure 27. Men at the Beach, Pattaya

BoyzTown (+)

There was clearly a defined precinct catering to MSM in the Boyztown district (see Figure 28). Easily accessible from Beach Road in Pattaya Bay, this was an area in Thailand where clinics for STI testing were highly visible.

Figure 28. Entrance to Boyztown entertainment precinct

Local ELoFT Demographics (?)

There appeared to be fewer Australian tourists in Pattaya in comparison to Phuket, with larger numbers observed to be from Europe. Travellers seemed older (over the age of 50) and there seemed to be fewer couples and young families. Older men accompanied by younger women were very visible and appeared common. There was a large stretch of road (Beach Road) where young women situated themselves every 10 metres or so on low walls and bollards. This appeared to be where they were solicited (see Figure 29).

Figure 29. Man soliciting woman on Beach Road, Pattaya

Expatriate enclave (+)

A taxi tour allowed the research team to observe a marked change in the environment the further away from Beach Road the team travelled. High-rise apartments and significant construction typified other areas of Pattaya. Whilst ELoFTs cannot own land in Thailand, they are able to hold titles to condominiums[16] which may in part explain the huge growth in development outside the beach location.

Existing health promotion (+)

The team observed the restaurant *Cabbages and Condoms* amongst these apartment buildings. It was unclear whether those who visited saw this establishment as more of a tourist attraction than a public health intervention as it is set within the "Birds and Bees" resort.[17]

4.1.4 Summary

A number of tangible assets and challenges were revealed across the observational sites. Insights were gleaned about ELoFT behaviour, culture and networks and about the location of risk and possible avenues for intervention which are developed further in Chapter Seven.

Generally, there was evidence of connection between ELoFTs through formal (Rotary Club, sporting groups) and less formal (congregating in bars) mechanisms. This was particularly the case in Phuket where cultural identity was also on display in bars, guesthouses, restaurants and bars through names, flags, TV viewing options, beer types and food options. Most venues were centrally located therefore appealing to other ELoFTs interested in spending time with peers as well as more opportunistic travellers looking for a brief connection to home. These locations may be considered as assets for potential interventions and as mechanisms for the development, maintenance and extension of social networks. Furthermore, ELoFT enclaves in Pattaya suggest the formation of social networks by virtue of proximity and housing arrangements. These may provide vehicles for outreach. Additional investigation is required to understand and explore the density of social networks, in particular accessing Australians based in Bangkok requires further consideration given the disparate nature of the ELoFT diaspora there.

[16] According to the Thai Condominium Act (No.4) B.E. 2551 (2008)
[17] Cabbages and Condoms, see: http://www.communityfoodenterprise.org/case-studies/international/cabbages-condoms

Pattaya and Phuket boasted modern facilities, suggesting convenience for ELoFTs. Hotels, restaurants, and other facilities appeared purpose built to cater to this market. There was a range of accommodation options available; from expensive five-star hotels and resorts, to inexpensive guesthouses and four-dollar-rooms for rent in townhouses. There was a range of food options and activities for both expatriates and travellers who had a limited budget, thus overall, it appeared that Pattaya and Phuket met needs for those seeking a range of experiences; providing both an inexpensive trip for shorter-term travellers and an appealing destination for those seeking lifestyle migration. Observation suggested a range of options for those living in Phuket and Pattaya, specifically to make their income go further and to enjoy the comforts of home 'on a shoestring'. Because of the proximity and density, it is easy to see how ELoFT networks could form in the beach locations of Phuket and Pattaya. It would appear that, for retired or semi-retired Australians, operating a small bar could provide additional retirement income in a way not possible in Australia.

The presence of Tourist Police, provided an interesting opportunity to examine their use in potential interventions via their role as insiders in ELoFTs social networks. Similarly, influential bar owners may be important actors in possible interventions, particularly in Phuket. Whilst there was some evidence of the presence of health clinics (more so in Pattaya than in Phuket), which may be useful points for dissemination of health information, testing, treatment and sexual health hardware (see Glossary), health agencies were less visible. There was strong evidence of formal health agencies in Bangkok.

Settings in which ELoFTs were observed participating in leisure activities were also settings in which sex and the sex industry were highly visible. This created a sense of the legitimacy and acceptability of sex in a somewhat permissive environment. Individuals appeared aware of and comfortable in these sexualised spaces and may have been more receptive to messages around safety. The team observed venues that were more or less explicit about sex available for purchase or negotiation. The ability to rent rooms by the hour, to solicit sex from the beach or at a bar created a permissive environment for pleasure-seekers. The range of facilities and convenience may mean that it is attractive to those seeking sex, and these factors may also provide opportunities to support clinics and outreach. There was evidence of a more complex dynamic of relationships between ELoFTs and Thais (mainly women) that appeared to go beyond short term sexual encounters to more social and emotional connection. There appeared to be no official record of the number of sex workers in Pattaya or Phuket because sex work is an illegal occupation in Thailand. Notwithstanding, observation and discussions with stakeholders suggested significant

numbers of formal and informal sex workers across all locations visited during fieldtrips. This provides challenges and opportunities. Sex workers less connected to formal agencies may be more difficult to engage. However, Thai people, including kathoey working in bars that cater to ELoFTs, may be important members of ELoFTs social networks.

The stakeholders described above were generally empathetic and knowledgeable about likely HIV transmission dynamics. There was some willingness by agencies to be involved in possible interventions, while recognising the enormous local issue of HIV and other STIs and the accompanying resourcing constraints. Staff exchange or hosting appeared to be possible. Working more closely with EMPOWER appeared critical to the success of any potential interventions.

5. In-depth Interviews

Don't you know that I'm the type of man who is always on the roam
Wherever I lay my hat that's my home
Wherever I lay my hat, oh, that's my home, mm yeh
That's my home

- Wherever I Lay My Hat (That's my Home), M. Gaye, 1962 -

PRELUDE

Findings are presented from the in-depth interviews with ELoFTs. The first section presents an overview of the participants and their characteristics. Subsequent sections use thick, rich description to present key concepts that emerged from the data. Key concepts were:

1. Becoming Expat: (re)creating identity and self-concept amongst ELoFTs
2. The Journey: pathways and motivation for expatriation, longer-term and frequent travel
3. Exotic, Erotic and Mundane: ELoFT experiences of, and relationship with, Place
4. A "New Normal": how ELoFTs experience and make meaning through the adjustment process
5. Reward, Routine and Ritual: perceptions and experiences of risk and risk-taking amongst ELoFTs
6. Being a Mate: how ELoFTs experience and make meaning through support
7. At Home on the Move: ELoFT perceptions of country of origin and destination and the liminal space between
8. Community – Communitas: creating meaning and identity through ELoFT connection

Chapter content relates to the following objectives:

1. To build a deeper contextual understanding of culture and personal behaviour amongst Australian ELOFTs in Thailand and SEA.
2. To describe the socialisation process and pathways experienced by Australians (potential new ELoFTs) interacting with Australian ELoFTs in Thailand and SEA.
3. To investigate the roles of Australian ELoFTs as mentors and potential change agents within ELoFT social networks in Thailand and SEA.

5.1 Participant Characteristics

The majority of interview participants identified as heterosexual (88%; n=22), had a current partner (76%; n=19); and were aged over 45 years (68%; n=17). A third worked in hospitality (bars, guesthouses) (36%; n=9) and just under a third worked in technical or trades professions (engineering, web design, logistics, advertising) (32%; n=8). The remainder worked in higher education or were retired. Participants had travelled to SEA multiple times; more than half had spent less than 10 years there (see Tables 2 and 3). Key words (Table 3) were used as a heuristic to support emerging understanding of identity.

Table 2. Interview participant characteristics

Characteristics	**n (%)**
Age	
25-34	3 (12.0)
35-44	5 (26.3)
45-54	8 (32.0)
55-64	8 (32.0)
65+	1 (4.0)
Sexuality	
opposite sex attracted	22 (88.0)
bisexual	1 (4.0)
same sex attracted	2 (8.0)
Relationship status	
married/defacto	18 (72.0)
single	6 (24.0)
divorced	*8 (32.0)*
Country of birth	
Australia	23 (92.0)
UK	2 (8.0)
Current occupation	
Technical and Trades	8 (32.0)
Higher Education	4 (16.0)
Hospitality	9 (36.0)
Retired	4 (16.0)
Current country of residence	
Australia	10 (40.0)
SEA	15 (60.0)
Length of time in SEA	
one year or less	2 (8.0)
1-5 years	6 (24.0)
6-10 years	8 (32.0)
11-15 years	3 (12.0)
16-20 years	5 (20.0)
ELoFT* status	
traveller	3 (12.0)
expatriate	14 (56.0)
both	8 (32.0)

**ELoFT: expatriate, longer-term or frequent traveller*

Table 3. Participant characteristics, pseudonyms and keywords

Name	Age	Born in	Occupation	Relationship status	Current Residence	Years in SEA	ELoFT status	ELoFT Type	Key words
Daniel	45	Australia	Higher Education	Single	Australia	20	All	Authentic	Culture expert, world citizen
Derek	45	Australia	Hospitality	Divorced, 2 children, Partner	Thailand	9	Expatriate	Second chance	New life, reinvented, the helper
Trent	59	Australia	Technical & Trades	Partner	Australia	1	Expatriate	Family	Volunteer, the retiree
Stewart	52	Australia	Technical & Trades	Divorced, Partner	Australia	3	Traveller	Authentic	Seeker, giver, structure, certainty, helper, culture, spirituality
Craig	48	UK	Technical & Trades	Divorced, 2 children	Australia	1	Expatriate	Professional	World citizen, family, security, 'expat'
Andrew	27	Australia	Technical & Trades	Partner	Thailand	2	Expatriate	Family	Putting down roots
Jim	52	Australia	Hospitality	Divorced, 2 children, Partner	Cambodia	20	All	Authentic	World citizen, conspiracy theorist, lives like a local, restless spirit
Gavin	35	Australia	Technical & Trades	Partner	Australia	6	Traveller	Professional	Restless wanderer, the transient
Marty	43	Australia	Technical & Trades	Married	Australia	15	All	Professional	Experienced, worldly, Aussie in Thailand. Journey not destination
Tom	44	Australia	Hospitality	Single, 1 child	Thailand	5	Expatriate	Quality of life	Bachelor, hard man, Aussie in Thailand
Bruce	56	Australia	Higher Education	Partner	Australia	13	All	Professional	Culturally and spiritually connected
Jackson	27	Australia	Technical & Trades	Single	Thailand	5	Expatriate	Professional	The loner, at the crossroads
Peter	54	Australia	Technical & Trades	Divorced, 2 children, Single	Australia	20	All	Authentic	Cultural connection
Kyle	52	Australia	Higher Education	Divorced, 1 child, Married	Australia	20	All	Authentic	Local or foreigner, wisdom giver
Declan	58	Australia	Retired	Married	Thailand		All	Quality of life	Semi-retired, sense of purpose
Jake	65	UK	Retired	Divorced, Partner	Thailand	8	Expatriate	Quality of life	Citizen of the world, an Australian overseas-failed patriot
Mark	47	Australia	Higher Education	Married, 4 children	Australia	7	Traveller	Family	Family traveller, seeking connection, love, change, cynic
Dylan	56	Australia	Retired	Partner	Thailand	5	Expatriate	Second chance	Slower pace, thoughtful
Ivan	55	Australia	Retired	Married	Thailand	10	All	Authentic	Seeking travel opportunities, the reflector, considered
Adam	38	Australia	Hospitality	Married	Thailand	6	Expatriate	Second chance	Cynic solution, serious, structure
Dougie	57	Australia	Hospitality	Divorced, 2 children, Partner	Thailand	15	Expatriate	Second chance	Hard man, bar fly, good life, larrikin
Dom	60	Australia	Hospitality	Single	Thailand	10	Expatriate	Quality of life	Cynic, bar fly, the bachelor
Graham	33	Australia	Hospitality	Married	Thailand	5	Expatriate	Family	Bar-fly, sensitive, new wave expat
Simon	37	Australia	Hospitality	Single	Thailand	3	Expatriate	Authentic	Bar-fly, engaged, thoughtful
Trevor	56	Australia	Hospitality	Married	Thailand	10	Expatriate	Second chance	Busy-bee, pragmatic, bar-fly

5.2 The Expat: (re)creating identity and self-concept amongst ELoFTs

Identity was explored in relation to country of origin, destination and status (expatriate, frequent or longer term traveller). Narratives revealed the dynamic and fluid nature of identity and the influence of migration journey and of place and home on identity. Themes emerged regarding:

- Relationship with country of origin
- Identity categories (quality of life, authentic, second change, family, professional)

5.2.1 Relationship with country of origin

Some participants clearly classified themselves as Australians and described strong feelings of *heimat* or connection to 'homeland' which more broadly than term linked to German nationalism, has been use in the geography and mobility literature to evoke a sense of belonging or identity related to origin (Römhild 2018). Here Marty (43), wiped away any sense that he could be seen as something other than Australian, noting, *"Well, I'm pure Australian"*. The word "*pure"* evoked a strong sense of being Australian *"through and through"* and a particular view of what it means to be an Australian. This was echoed by Ivan who described amplification of 'Australian-ness' when in other locations:

> I label myself an Australian. When you travel your nationality or your ethnic background becomes more apparent. I'm more Australian in Thailand than in Australia. (Ivan, 55)

Others noted that the development of identity was not straightforward nor fixed, "*my identity is not entirely simple"* (Kyle, 52). Being labelled by country of birth was only part of a more nuanced experience of labelling, influenced not just by geography but by their life experiences which meant many of them considered themselves to be *"global citizens"*:

> This is a shades-of-grey question. I consider myself an Australian who lives overseas. I see a big picture world where Australia is part of Asia, not separate. Australia is a country where I grew up and where my natural family live. I could be considered a failed patriot. (Jake, 65)

Participants demonstrated a love-hate relationship with Australia as their country of origin. There was a sense that whilst there were many things wrong with Australia, giving up a connection was not an option *"It's still my heritage and true home if a crisis overtakes the world"* (Dylan, 56). There was still a need to maintain connection to country of origin:

> Oh yeah, I am always going to be an Aussie…If something goes bad, you are always going to go home…No matter how much you hate the place, you always go home. (Tom, 44)

No participant indicated total assimilation into destination culture and customs (even those who had lived there for 15-20 years). Indeed, ELoFTs frequently positioned themselves somewhere 'between' SEA and Australia. They noted that they were unable or unwilling to become, for example, Thai, "*I'm a human being living on Earth…but here I'm considered a farang… foreigner*" (Jim, 52), but wanted to be more than just an 'Aussie tourist':

> …the most a foreigner can get over here is a residency, you can never become a Thai citizen, and I wouldn't anyway I would keep my Australian citizenship. (Declan, 58)

Participants described whether they considered themselves to be an expatriate, longer-term or frequent traveller or something else. Responses highlighted the complexity, or the porous boundaries of identity when overlaid with mobility and migration:

> I guess I am an expat…I guess an expat is someone who has a home and proper employment, or a source of income they can use to stay longer term if they want to. If you are a traveller you are more transient, you are going to want to see more things, move around, stay in guest houses. If you're in my position you are living in one place, you've got responsibilities-working and running a business and have debts. I guess for some people it might be quantified based on how long they are here, if they have a network of friends, if they know the ins and the outs of business communities and social communities or maybe they have contact with like, the consulate or the local police. (Andrew, 27)

5.2.2 Identity categories

Here I have focused on identity in its SI context and as it relates to the qualities, beliefs and experiences of self and of the migration journey. I have paid particular attention to the framing ascribed to identity and experience as identified by participants to recognise the importance of an individual's definition of their situation and circumstance (consistent with the perspective of Thomas 1928) and Serpe and Stryker (2011) who suggest that *"self-definitions, in particular, mediate the relationship of society to social behavior"* (p.232) and that individuals have "*multiple identities, potentially as many as they have organized sets of role relationships in which they participate"* (p.233).

Participants were categorised into broad typologies developed by researcher through the data analysis. These assisted to understand differences and similarities between participants and their motivations, pathways, experiences and self-concept as ELoFTs.

Quality of life

Quality of life ELoFT described participants seeking to live more comfortably towards retirement. This was predominantly explained as making income or a 'nest egg' go further, *"I've always loved travel, later lower prices in Asia was a big plus. I live far better here than I could in Australia"* (Jake, 65). It was also about a perceived reduced stress lifestyle and the ability to gain and extend the creature comforts of home:

> Yeah, cost of living. The women are attractive. I'll just come out and say it. Up here you get laid a lot more than you do back home. [Laughter] I mean you've been to Pattaya, you know what it's like. Yeah, and I mean it's cheaper…everything is very convenient. It's almost like having all the benefits of living with your mom without having to actually do it. (Jackson, 27)

This included access to low-cost healthcare. A majority of those in this category were retirees. Most had local partners and had social networks which included both 'Westerners' and locals. Some had lost financial security in Australia and felt relocation was the only option. For others it was about the opportunity to be *"living like a king"*. Some of these participants could also be described as seeking *authentic* experiences or *second chances.*

Authentic

Authentic ELoFT primarily described those who had both lived and travelled throughout the SEA region. For them, living and peregrinating throughout SEA was about integration, cultural and spiritual awareness and for some, a desire to *"give back",* be useful, or seek deeper connection with individuals (including sexual or life partners) or a particular country. Learning language, engaging with locals and understanding history were commonly described objectives. These participants were often employed in positions that could be viewed as community-service oriented.

Social networks of *authentic* ELoFTs included both 'Westerners' and locals, but predominantly locals. Often travel was motivated by a restlessness, a desire to find something new or different including new relationships. These participants were potentially active risk takers (seekers) and potentially looking to engage risk practices that had shared meaning and interests with others in the country of destination. Some of these participants could also be described as *family ELoFT* or those seeking *quality of life*. Here Peter differentiated between what he saw as a more traditional expatriate (one who was defined by high levels of income and potentially by their education) from his own experience of *"living locally" (*smaller income, lower levels of education but engagement with the local community):

> I didn't go in as an expat. I was hired by a guy in a Thai company. I was paid half of what an expat gets paid. I still got a lot more than the Thais got in a similar position, but I didn't have long enough schooling, I didn't have a car, I didn't have a driver, I didn't have the apartment paid for, I didn't have trips home. But I mean I wasn't fussed, I was living locally… I lived in local places, I didn't live in apartments bought by inheritance. I bought my food from the train and I didn't buy all my stuff from the expat supermarket. (Peter, 54)

Second chance

Second chance ELoFT described those relocating due to a change in life circumstance, often related to work or marriage. These participants generally continued the work and social practices previously established in Australia, but perceived these practices, conducted in Thailand, as free from supposed overregulation in Australia. Some were those seeking to disengage from the strictures of the 'Western', Australian *"risk society"* described by Beck (1992). Many indicated that part of their motivation was intimacy. Risk was often part of early experience in SEA, framed as part of decision-making for a new life with both positive and negative outcomes. For some, the route to their new life was via travel throughout SEA with friends. These participants mostly continued to work, a number in hospitality. Social networks were predominantly 'Western', and echoed experiences and lives in Australia. Some were also motivated to relocate by *quality of life*. Derek, who was running a guesthouse after several relationships had broken down and a business venture running a salon had gone *"pear-shaped",* was looking for a fresh start but also an opportunity to continue working:

> I travelled around Australia, all me life. I had a marriage break up and I got offered a job to start a newl business, it was nearly 90 hours a week to get it established. It really took it out of me. I wanted to go overseas, someone mentioned Thailand. I came over here and was like whoa, a whole weight off the shoulders. When I first had the first business I'd probably spend three to four months over here. It wasn't until after all that [finishing with the previous business], we had the business still in Australia, and we were looking not to have all our eggs in the one basket. So we looked at this [guesthouse]. I had the opportunity to come over here and run it. A business like this can't run itself. There's that much accommodation here, you need someone that they come back to visit. (Derek, 45)

Family

Family ELoFT was used to categorise those who had a partner from SEA. Many had returned to Australia to live but travelled frequently to SEA to spend time with their partner's family. Networks in SEA were predominantly local. Often these participants had made financial

contributions to their partner's family and a number of participants had plans to relocate to SEA to be closer to their partner's family upon retirement. The experience of these participants intersected with the *authentic* ELoFT experience:

> I am thinking about purchasing some land, a small town house or farming land. My father in law, he has split up with his ex-wife and my brother in law, he stays with them from time to time which is a little bit demanding so we try to help out. (Ivan, 55)

Professional

Professional ELoFT was used to categorise participants who might be described as 'traditional expatriates'. This included those working for a multi-national organisation, who were highly skilled and qualified, travelling with their 'Western' family and living and working predominantly with other expatriates. Often the destination was not purposefully selected, with some interest, but little buy-in to the culture (*"a stop along the road"*). Some stayed in Thailand longer term and for those, there was overlap with the *authentic ELoFT*:

> They offered me a job in Bangkok for six months. I wasn't particularly interested or never really thought about Bangkok, but there were basically no other work options in Perth. And I had two small children and a wife to support. And the money was good. It was also a good opportunity to see a different country…very different. I hadn't heard of it. (Craig, 48)

5.2.3 Summary

Participants indicated strong relationships with their country of origin (both positive and negative). ELoFTs had an enduring but uneasy relationship with Australia. Despite this, Australian-ness formed an important part of their self-concept. Five identity categories emerged which were dynamic with some overlap (Figure 30).

Figure 30. Expatriate and traveller categories

5.3 The Journey: pathways and motivation for expatriation and longer-term travel

Participants articulated a range of pathways to Thailand and SEA. These were generally motivated by a transformational event such as a relationship breakdown, personal revelation, offer of a better job or other change in life circumstance.

5.3.1 Pathways and Motivations

Pathways generally fell into one of four categories:

- *self-initiated* – participants in this category were purposeful in their migration or travel. This was often based on research and previous experiences.
- *assigned* – generally in this category participants were sent overseas through work. Control over location was limited.
- *encouraged* – participants in this category were generally supported by friends, colleagues or family to migrate or travel.
- *opportunistic* – participants were already travelling or looking for a new opportunity. Travel and migration were not purposeful.

Most experienced their migration as self-initiated and encouraged by others. Some undertook migration via a relatively traditional expatriate pathway; with travel due to work opportunities. These experiences differed depending on the type of work undertaken and the level of control or choice related to the country of destination. For those professional ELoFTs, much of the transition occurred via a third-party intermediary; the workplace brokered many of the elements around living and working arrangements, income and support to navigate customs and culture. For some it was their first time to SEA and very much an opportunistic experience.

Participants described a range of motivations for expatriation and/or longer-term travel. These motivations could broadly be categorised as:

- *security* – the opportunity to improve personal or family circumstances or become more financially secure
- *escape* – events that led to a need for change or to escape difficult circumstances
- *wanderlust* – restlessness and a desire for something new
- *challenge* – the opportunity to extend themselves professionally or personally

Assigned and Encouraged Pathways

For Craig, the pathway to SEA highlights a financial motivation (*security*), with minimal interest in the country of destination prior to travel. His pathway was assigned and smoothed. Craig's was a relatively short experience (less than one year) with no stated intention to stay on or to return at a later date (he was back in Australia at the time of interview). Work provided the opportunity to engage in a new culture and to travel, while continuing to work in a professional role and provide security for his family:

> I was working for a consultancy in Perth which was like a branch of this Thai based engineering company but they couldn't get the engineering done in Bangkok. They couldn't get the people, they couldn't get the quality, so they opened up a branch office, in Perth. The Aussie dollar was relatively low. Over a short period of time relative to the Thai Baht, the Aussie dollar went up so suddenly doing engineering in Perth seemed a really bad idea. So they offered me a job in Bangkok. I wasn't particularly interested, never really thought about Bangkok, but there were basically no other work options in Perth. And I had a two small children and a wife to support. And the money was good. The tax was a lot less and it was fun because it was a good opportunity to see a very different country I hadn't appreciated before. I hadn't heard of it...staying in a serviced apartment in the centre of Bangkok, trips to interesting places. It was like a great working holiday. (Craig, 48)

Peter's experience echoed Craig's. Peter's experience was an *assigned* and *encouraged* experience. The decision to travel was straightforward and related to a work opportunity:

> In late 91-92 I got a phone call from a company in Thailand saying um we just we need someone to teach a database. Um I said I did, and they said okay and I got on a plane and went there. *[And had you been there before?]* Nope. (Peter, 54)

In contrast, for Bruce (another professional ELoFT), travel to SEA was a natural extension of his work in Australia, an opportunity to expand his professional skills and personal interests. His experience was less financially motivated and more motivated by a new *challenge*:

> I applied for a short-term consultancy. They wanted me to run a training session in four countries. I was about to take a year off and go traveling and they didn't consider whether I would do an international work opportunity after the traveling. When they interviewed me they offered me an ongoing job coordinating programs in Asia. It was up to me where I would base myself. I basically decided to take over [from] my predecessor and she was based in Bangkok. It was an enormous change. I had never worked overseas. (Bruce, 56)

For Craig, Peter and Bruce, the destination country was new and for two of them, the process and transition period was described as a time of considerable change. Jim was

more contemplative about his pathway to SEA. Early life experiences and family heritage meant he felt it was not unusual that he had ended up *"seeing what the rest of the world had to offer",* presenting himself with a personal challenge:

> I've got relatives around the world who likewise at different stages in their lives ended up in Australia because they decided that UK wasn't the best place. So it wasn't so strange, that I should start heading out to see what the rest of the world had to offer. (Jim, 52)

Self-Initiated and Opportunistic Pathways

Another pathway to SEA described related to *escape*. This generally related to a change in life circumstance precipitating a need for change or a need to get away. For several of these participants, SEA represented their first overseas travel experience. For some, change was a purposeful process of progressively moving their life to the country of destination, while for others the process was described as *"karmic"*. Andrew, for example, had experienced failure and loss through the breakdown of a business and a personal relationship. A series of related events led to time in Thailand where he met his partner:

> I was living in Brisbane when I was 25 and I just ended a relationship and a business so I decided to take a few months off to travel around Southeast Asia. It's pretty funny…I had a one-way ticket to Singapore and I went to check into the flight…they said that they couldn't let me on unless I had an onward ticket somewhere. So I bought a ticket to Bangkok for three days later so that they'd let me onto the flight for Singapore. I ended up spending three days in Singapore and then I went to Bangkok. I didn't like Bangkok so I went up north and spent a month there and made some friends. I got a girlfriend and I was trying to figure out what I was going to do, if I was going to live in Australia or Thailand or somewhere else entirely. And I just kinda settled into X cos she started a business here. (Andrew, 27)

Derek too sought change, describing a sense of exhaustion related to both a marriage ending and starting a new business *"I just needed to, you know, just wanted to get away".* Derek's experience clearly showed a process of resettlement with time spent traveling to and from country of destination and origin, as he described "*…yeah, since that first trip it was, yeah, one step after the other then. Yeah."*

For some, the self-initiated or opportunistic pathway appeared to be motivated by *wanderlust*, described variously as restlessness and a desire for something new. For several of these participants, transition to SEA occurred after other travel with different motivations. For Marty, initial travel to Asia was partly financially motivated, partly about a

personal challenge, whilst travel to Thailand appeared to be to try something different and also represented a series of smaller, in-country transitions:

> I left WA when I was about 30. I thought, "*Oh no, I'm going to turn 30 and not leave the country*". I went and lived in Japan and taught English. I was there for about four years. You went over there and you just taught, and the money was good. Some other teachers I worked with were teaching in Thailand, they said it was a great place. A year in Bangkok… that was intensive. There was a job going in Phuket at a beautiful resort as an English teacher. I went down for a job interview and checked it out and it was just remarkable. So, I applied and got that. And then I moved to Phuket. I went down to a local beach, a buffalo is on the beach. Just where I was taking a swim. I really rejoiced in that…nature. (Marty, 43)

For Stewart, the first trip started a love affair with Asia spanning several decades and represented a self-initiated pathway. His pathway started with a holiday which led to frequent visits, romantic relationships and eventually moving there:

> When I was in the ambulance service I had three and a half months leave and went on a backpacking tour around Europe. Coincidentally part of the trip was a stopover in Thailand, and after arriving in Bangkok I really fell in love with Asia. You know and I met a girl, you know it was very heady. A very heady experience you know the go-go bars. You know you get inundated with gorgeous girls…and I do like very much Asian women. (Stewart, 52)

For some, *wanderlust* was facilitated through advice from and travel with friends. This pathway appeared to consist of an initial holiday which was experienced as enjoyable, followed by a swift relocation. For ELoFTs like Tom (44), Thailand represented their "...*very first trip overseas*". This experience was motivated by advice from friends and was a positive experience, so much so that migration happened quickly:

> First big overseas trip. I was going to go to Vietnam but friends said, "No go to Thailand, its better." This place blew my mind a bit when I got here [*And you had come over for a holiday and so you are back here for six months. That's pretty quick…?*]. I couldn't get here any quicker. [*And you would have if you could have?]* Absolutely. (Tom, 44)

Gavin's narrative demonstrated an opportunistic, self-initiated pathway influenced by friends and an interest in trying new things *(a challenge)*:

> Yeah, probably around 6 years ago, I went there for a holiday with a friend of mine. He was very keen to go to Asia, I hadn't been before. I thought, yeah okay, I'll give it a go. We went to a couple of different countries around Southeast Asia. I came back and I really, really loved it. About a year later, there was an opportunity at work to go into Thailand, one of the towns outside the cities to basically commission one of the lines over there, a steel

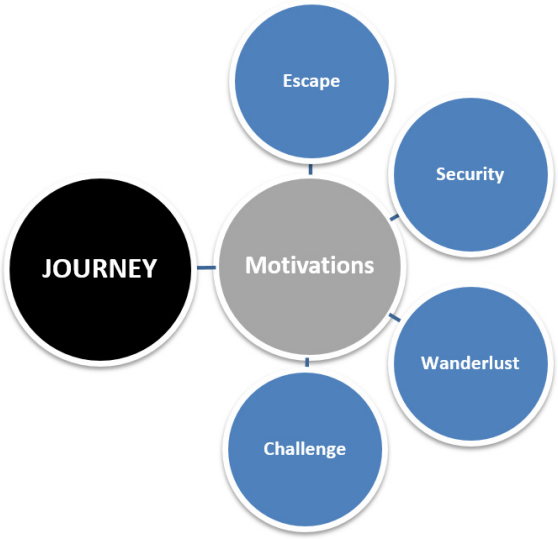
producer. And since my company has a couple of different steel plants around the world, I thought the opportunity was pretty good. I had been there before. (Gavin, 35)

5.3.2 Summary

Pathways generally fell into one of four categories (see Figure 31): *self-initiated*, *assigned*, *encouraged, opportunistic.* Participants described motivations for mobility (see Figure 32) broadly categorised as: *security*, *escape*, *wanderlust* and *challenge.*

Figure 31. Pathways to SEA

Figure 32. Motivation for migration



5.4 Exotic, Erotic and Mundane: ELoFT experiences of, and relationship with, Place

Participants' relationship with and representations of place and their role in influencing experiences, identities and interactions are explored. Meaning emerged through participant interactions in place with others and the environment. Place was represented as a socially constructed location, with both physical and symbolic attributes (Kyle and Chick 2007). The three themes explored here are:

- Mythical
- Emotional
- Commodified

5.4.1 Mythical

The narratives of participants constructed Thailand and SEA as a liminal, permissive space. Liminal here is used as per the description by Turner as a sense of being *"being betwixt and between"* (p.359) within and between environments linked to ritual and rites of passage, raising issues of identity and belonging (Turner 1969). This definition is extended to liminal personae *"threshold people"* (p.359) wherein ELoFTs are a constant state of transition with endless possibilities to re-invent self. SEA is presented in the narratives of participants as an erotic and exotic imaginary, reminiscent of participation in the European Grand Tour, a position held by participants, but not necessarily shared by those from the destination country. This imaginary however presented more than sex it encompassed fantasy, escape and freedom.

For some it seemed to evoke an impermanence-an ephemeral affair with place, albeit a stereotype or facsimile of local culture. Bell (2010) describes the idea of 'comfort zones' that combine both spatial and sensual experiences. Thailand was constructed as a place free from the strictures of Australia*, "Um…it's fairly loose…it's not very restrictive, I mean. I like the people, I get on well there"* (Peter, 54). Place itself was humanised; feminised (in the socially constructed sense of gender roles) as a place of nurture, companionship, desire and sexual fulfilment. This was juxtaposed with the presentation of Thailand and SEA as a masculine (as a socially constructed gender role) place of adventure where men could be men and extend boyhood fantasies. Inherent in this framing was a traditional description of masculinity and hegemony and the implicit power that this entails. As described by Tom

(44), *"This is a man's world over here"* and Jackson (27), *"Yeah, it's sort of a young single guy's paradise*".

Place became inherently risky; a motivating location to participate in social practices that performed this version of hegemonic masculinity that was socially sanctioned. Participants spoke of their own or others' situational disinhibition (Eiser and Ford 1995), a feeling of being a different person where the place itself became a space for danger and excitement:

> A lot of times they just don't care, they are almost untouchable. And just let themselves go, they are up at 9am getting their first beer from the 7/11 and by 2 o'clock in the afternoon they are passed out in their condo then they are up again at 7 o'clock and they are back down in the bars. And it is the climate as well, especially the places that they go. It's a party atmosphere and they get into the party mood, you know, she'll be right mate. (Declan, 58)

Risk was habituated in the place itself:

> But, yeah, people come over here and they just get wrapped up in Thailand, cos it is a beautiful place, and you know, where people get themselves into trouble. (Derek, 45)

For Jim, the place was described as a revelation, free from moderating influences or rules:

> Sometimes when people go to places like Thailand they get themselves into trouble. They behave badly because it's such a revelation to them. You know what I mean? So, you know, because there's nobody to reprimand them for their bad behaviour. (Jim, 52)

Living it up was a common theme in narratives with participants suggesting that non-normative behaviour was accepted, encouraged or rewarded:

> In Thailand, there was a percentage of ex pats who were living it up, you know, behaving a little bit like a Molly Meldrum [Australian music commentator] on vacation. (Craig, 48)

> …when I came to Thailand, a lot of people over here were refusing to grow up. Yeah like it's a way for them to escape responsibility and societal pressures and um obligations to employers, obligations to other family members. And you just kind of get to realise your fantasy a bit because you get to do all the things you want to do without the judgement. There are a lot of expats who are sort of misfits or whatever, it's like they thrive over here, it's like all of the pressures that were like keeping them back, keeping them down in their own country are kind of taken off when they are here. (Andrew, 27)

Thailand and SEA as place was highly sexualised and stereotyped as "*One big brothel so to speak…full of prostitutes, on a map which is magically long*" (Gavin, 35). The male gaze (Mulvey 1975) was evident in participant narratives, reinforced through observational

fieldwork visits. Men were presented as voyeurs and women as spectacle (Weeks 2005). Place provided an opportunity to live out personal notions of men as highly sexed:

> Whether it be Asia or Russia or Europe you know they live like single men. And I used to really wrestle with that for a long time. And now I see that's the only way it's going to work. They can't do it any other way. And my mate, he said *"Don't try and work it out. We're born to root [have sex] and that's all we're going to do"*. And I can see why. It's about the lifestyle and women are very much a part of that. You know whether that's churning through them like some guys do…just churn over a different girl every day… (Stewart, 52)

In this permissive place, sexual or relationship fantasy became reality. Women were represented as playthings, their bodies modified for pleasure:

> For single guys, it's like Disneyland. Yeah. Anything you want, however you want. For bugger all. Like I went to the Russian bar with my mate, he loves Russians and so we went up to the Russian bar and the Russian girls were dancing and all that. She comes up, sit and you pay 250 baht for a drink then she pisses off, see you later. Give you a tip, lose some more weight. I'm not going back until they weight 40 kilos, see you later. (Tom, 44)

Declan described this experience of place as one where you would receive royal treatment, both sexually and in employment. The male and the post-colonial gaze were represented here where interaction with place created opportunities to be personally elevated which was predicated on constructed gender roles and a privileging of 'Western identity':

> I've had my fair share of girlfriend experiences and it's wonderful, you feel like a king. As I was told by my best friend, *"you will be treated like a king, but you will be expected to act like one. Don't act like the palace fool, act like a king and be treated like a king"*. (Declan, 58)

Place as mythical provided the opportunity to reinvent self as successful, interesting and to access the fantasy:

> I went over there and got so much attention. Am I a good looking man? I would say I'm probably average to slightly above average in looks…You sort of get swamped by all these women. You know, you think, oh you know, this sweet little girl. You just fall in love with this fantasy, you know? (Gavin, 35)

5.4.2 Emotional

Participants demonstrated emotional connection to Thailand and SEA, framed as a better or more authentic life. Attributes of place were bestowed on its people (Torkington 2012). For example, 'the land of smiles' in the country of destination. Participants used phrases such as *"the weather is lovely", "the beach is beautiful", "the culture is special"* and *"the*

people are wonderful". For some, this manifested as better health, "*My blood pressure self-rectified and my psoriasis clears up."* (Jake, 65). For others it was about *balance*:

> I picked Thailand because it was warm and good. Just the way life is here it's very relaxed. I mean it sounds very lazy but it's 2:30 here and I think I got up a couple of hours ago. I know it's very lazy back home but that's what everyone does here. Most people's working day starts at 11 as every night there's a lot of night life, whereas in places like Hong Kong and Singapore people work a lot and don't do much else. I didn't really like that. (Jackson, 27)

This was echoed by Stewart who cited the charge of the landscape, the cultural attractions, proximity and social scene as important emotional anchors:

> I actually prefer Pattaya. It surprised me. The beaches are nice, Jomtien around the corner supposedly is the biggest gay beach in Asia. But the beach is lovely. And I guess you've got Walking Street in Pattaya if you want that and you've got the bars. But you've also got some great restaurants and you've got that lovely big temple on the hill…And you got a great view out over the bay and yeah I love it. I really prefer it. It's close to Bangkok. (Stewart, 52)

Themes emerged around negative events in Australia that made Thailand and SEA seem an appealing refuge, particularly for those who may have been viewed as on the fringe or who *"are not the most successful people from their own home society"* (Kyle, 52). Several participants described feeling marginalised at home. In Thailand these individuals found acceptance and solace. Even those who professed *"deep connection"* to place acknowledged a broader idea of Thailand as a place for the disenfranchised or deviant:

> People thrive here who aren't able to keep up with the Joneses or live, quotations marks, like a normal life I guess. Or even they are just not, yeah the amount of effort they put in, people who just feel like they are living someone else's life or something. (Andrew, 27)

Place thus became an enclave of connection between those who were like-minded, creating opportunities for new beginnings while retaining a sense of familiarity. This was noted by Kyle who described connectedness in local ELoFT communities:

> I think Phuket, um, quite a lot of comfortably well-off middle class people who have got nice houses, not too far from the beach, with what the semi-retirement, so there's a strong sense of almost belonging for most foreigners… (Kyle, 52)

Descriptions of place often [positively] reinforced more primitive ways of being, consistent with Echtner and Prasad's recurring myths (2003) about travel to low- and middle-income countries; which includes the myth of the uncivilised. Jim, for example, suggested an

emotional connection to place to disconnect from what he saw as problematic, modern ways of life. He framed place as wilder, freer and less advanced:

> We either learn to coexist with it, with the environment, or it'll be goodbye human beings. But since the human race stopped being hunters and gatherers, we have been nothing more than a virus on the face of the Earth. Well, it's one of the reasons why I'm in this part of the world -My ten year old still has family who live on land and work land in Cambodia without electricity -But we're living in a society that doesn't encourage people to do that. We live, where we live, we live in the age of mindless consumerism. (Jim, 52)

Participants who represented Thailand in this way reinforced post-colonial stereotypes, Orientalism (Said 1979) and hegemonic masculinities. Certain locations were reinforced as masculine playgrounds, ones from which *"good"* women should be protected, *"yeah you don't go with your wife or girlfriend"* (Tom, 44) (and in contrast a space in which bad girls existed for pleasure). Places seemed to allow, or at least facilitate, different or amplified erotic experiences because they created a space-time for freedom, fantasy or amenity that they usually didn't allow themselves or that was not usually allowed in the places and moments of their daily lives.

5.4.3 Commodified

A strong theme of commodification emerged through the narratives of participants. Place was commodified, (re)configured as a setting and social space for both production and consumption, of people, sex, pleasure, leisure, aspiration, fantasy. It has been suggested that the ELoFT or traveller gaze may also act as a kind of symbolic consumption of Place linked to the consumption of cultural goods (Urry and Larson 2011). Commodification is also used to describe the way in which value and capital is framed including social, cultural and human capital and the sign-value or cultural representation and signification of signs and symbols related to Place (Young and Markham 2019, Urry and Larson 2011).

Language was used that suggested an interest in Thailand because it was cheap or affordable with a strong focus on amenity. Thus place was commodified as economical:

> I'm serious about the fact that the cost of living here is very much like it was in Australia forty years ago, and you've got to ask yourself the question, well, if some places in the world that can still live, that, where a system still works… (Jim, 52)

Place was somewhere you could pay for pleasure, an economical way of *"living like a king"*, and in a way often not possible in country of origin, as noted by Mark:

> Australian women, in my experience, are very picky. They want good looks, a rich husband, a nice car, a house with a pool. That's just my experience. I have got a fairly good job but I have this appearance and I used to drink a bit. When I went to Thailand they're all interested in me. Yeah. He's a rich man, he's white and that's it. (Mark, 47)

Place was transformed into a symbol of fulfilment where services (and pleasure) could be sourced easily, purchased freely and readily consumed. This included food, cleaning, housing, jobs, women, and for some participants, drugs or other illicit activities. Here Kyle described connection to place in relation to convenience:

> Most foreigners who go to Thailand, as far as I can see…they tend to go to Thailand because they see it as an easy option, or they want to retire, but have something to do… (Kyle, 52)

Experiences were often contrasted with those in Australia; whereby in Thailand choice around the sexual services you could purchase was endless, more generous and cheaper:

> You're sort of overwhelmed by the sex tourism and how available the women are and how cheap in comparison they are. (Gavin, 35)

Participant narratives suggested that they engaged in behaviours that they could not in their country of origin either because of cost, availability or access, or because the deviance of such behaviours makes it inaccessible. Thus, Thailand, became a *"pleasure periphery"* (Bandyopadhyay 2013, p.2) where ELoFTs were free from the usual social sanctions.

5.4.4 Summary

Meanings associated with SEA were the product of interactional processes involving individuals, the setting and their social worlds. In this section themes most strongly emerged as mythical, emotional and commodified (Figure 33).

Figure 33. Themes associated with place

5.5 A "new normal": how ELoFTs experience and make meaning through the adjustment process

Participants described their experience adjusting to their country of destination. Adjustment was a strong influence on ELoFT identity formation and their socialisation to their new environment and networks. Adjustment, for most participants was a process, usually of acculturation (incorporating behaviour, culture and identity) (Schwartz, Unger, Zamboanga and Szapocznik 2010), whereby they became accustomed to, integrated in and for many enamoured with their country of destination. This occurred as a result of intercultural contact (Gibson 2001). Key domains emerged which described factors that influenced adjustment:

- Early Experiences
- Managing expectations and difference
- Participation and Embedding

5.5.1 Early experiences

The process of adjustment was shaped in part by early experiences of the country of destination. These were formative learning experiences that changed and shaped future behaviours and the formation of identity. Often these early experiences set up continued and consistent patterns of behaviour. For some, their early experiences led to a sense of isolation and helplessness, while for others there was a sense of adventure and new beginnings. Participants described a range of early behaviours and experiences from difficulties navigating their host environment to heavy drinking and engaging in various risk activities. The ways in which people in the country of destination environment responded to these early participant behaviours provided a range of (often conflicting) signals as to the appropriateness of these behaviours being continued.

The term 'cultural distance' has been used to describe the way in which some countries appear more difficult to adapt to than others (Church 1982). This was true for a number of participants, particularly for whom Thailand was one of their first experiences of travel. This was described varyingly as *"culture-shock", "enormous change", "overwhelming", "the cliché", "mind-blowing",* and *"awe-inspiring".* For some this early phase was positive:

> Um, it was pretty awe inspiring actually. It was about what I expected back in those days the only thing I had to go by was the lonely planet guide. Yeah and it was, I just loved it. Fell in love with the place straight away. (Declan, 58)

A positive early period was echoed by Ivan who described a sense of connection felt in Thailand that he hadn't encountered in his previous travel through Europe:

> Well, uh, at first when I started traveling I went to Europe but didn't feel like settling down or belonging, I suppose. I visited Thailand the first time and, uh, strange enough I found it immediately comfortable there. It's friendly and, uh, well, vegetarian so a lot of veggie food**.** It's an interesting place even, uh, individual provinces, you know, you could be in a different province and it's, uh, a different culture. So it's quite, quite varied. (Ivan, 55)

Other participants described their early experiences more negatively *"I found that culture shock a bit much. I'm a bit scared of living in Bangkok to be honest"* (Marty, 43). Similarly, Bruce described the overpowering experience arriving in Bangkok. He described the myriad challenges of settling in, with the added barriers of lack of language skills and the hierarchical structure of the workplace:

> It was very exciting and new and wonderful, but it was challenging to get enough rest, deal with the physical discomforts, the pollution levels and adjusting to it all. Where to shop and each kind of food, language barriers. I'm hopeless at languages. I had never been in a city that huge and it was very noisy and very hot. It was exhausting. It was enormously complex and physically demanding to settle into a routine. (Bruce, 56)

Participants highlighted activities which demonstrated their growing confidence in navigating their new environment. For some, this meant being able to drive in Bangkok while for others it meant taking on tasks and developing personal coping mechanisms:

> Look, I found it, being away for a couple of years, getting through all that, I could tackle anything. I needed like…some navigation and…I just got resilience. And you learned a lot about yourself in those journeys. (Marty, 43)

Mark contrasted his initial negative experience with his determination to acclimate:

> Initially I hated the joint. It was so hot, thick and stuffy and smelly, disgusting smell. Big rats running through the sewers, through the restaurant areas. I thought this is not for me at all. I went back to my hotel and I just sat in there and had a couple of drinks and read my book. I was thinking, when my mate gets here tomorrow, we will go somewhere else. But then the next day when I woke up thought I'd have another look and a mood swing and acclimatised and thought it's not so bad - got myself a tuk-tuk to take me somewhere. (Mark, 47)

A number of participants described their early experiences as times of excess, abandonment, hedonism or a lack of caution. Tom (44) for example, described his early experience, "*I had already been here for almost a year and did absolutely nothing. Oh I blew*

about $60,000". In the early days, adjustment was *"all about attitude. Smile and be happy and nothing will go wrong."* Most, reflecting on early experiences, indicated their behaviours had changed significantly to effectively manage their life in Thailand and SEA, "*Yeah, I got over that, the bar scene and the gogos, in the first two years."* (Declan, 58).

Gavin described adjustment and early experiences in relation to learning from mistakes:

> The only thing I would have done differently is I would have probably been more cautious in the bar scene. What happened is on my first trip, I ended up meeting a bar girl. And for the next 3 to 6 months, I was actually talking to her on the internet, sending her money, and having one of these fantasy relationships. I openly say I did that and I'll learn from my mistakes. The amount of money which I lost in that 3 to 6 months probably would have been 3 to 4,000, right? And, to me, 3 to 4,000 is a drop in the ocean to what I could have lost if I was more naïve and probably moved over there and bought her a house. (Gavin, 35)

Andrew noted that for him, his early experiences were ones of pleasure, fitting in and getting away from his perceived failings back in Australia. He experienced a reduction in feelings of guilt for the behaviours he undertook, behaviours he felt were viewed as inappropriate in Australia. Andrew's early experiences suggested a period of release:

> My first nine months, smoking a lot of cigarettes and drinking a lot of alcohol and doing drugs and stuff. I was genuinely happy and what I could measure on my physical health didn't seem to be that detrimental, even though I was doing it every day. I was just a young guy that was not really too straight, I was someone that liked to party on weekends. Going to Thailand my behaviour didn't change that much. I feel a lot less guilty. Because I was living in Brisbane and I was bummed out having to interact with all of my friends that had nine to five's and stuff and I felt that I was behind in my development in terms of acquiring assets and more mature relationships. (Andrew, 27)

5.5.2 Managing expectations and difference

Participants described expectations and practices they navigated as they adjusted to their new life. Much of this adjustment related to activities of everyday life including establishing routine, work, relationships, socialising and participating in their host society. For Marty, the pleasures of everyday life were exemplified through his description of food and health:

> The food is good. My health was very good in Thailand and maybe that's probably why I never got sick because really it's only wet season and dry season. You're always eating very fresh fruit and vegetables, and the more Thai diet that you eat, the healthier you become. You keep away from Western food. You're eating lots of vegetables and herbs and things like that. So, it's very healthy. (Marty, 43)

Jackson also described his experience of food as part of his routine. Conversely, this centred on the ability not to cook, or to cook by choice. For him, part of adjusting to life in Thailand was a recognition that there were better economics in eating out (which may also be due to its perceived social aspects) than cooking at home (which may be generally more isolating):

> Here I don't cook. I cook not because I have to, but when I'm bored of going out for dinner. There's very nice Western food here, it's 15 dollars a meal. So, it is almost no point in cooking if it takes you two hours to cook and one hour to go out to a restaurant and it's only 10 dollars more to go to a restaurant, you're better off going to a restaurant and then working an extra hour. (Jackson, 27)

Tom also described his adjustment to food; holding to customs from his country of origin:

> I have been up all the north east part of Thailand and I won't be going back there. I didn't eat for two days, no Western food. *[So you don't eat Thai food? You don't like it?]* Country born. Three meat and veg. I got that from me old man as well. Tom Yum Gong or steak sandwich? Steak sandwich. (Tom, 44)

Routine was also an important way of successfully functioning to avoid, as Peter described, "*destructive behaviour*" borne of "*nothing to do*". Stewart highlighted the challenge of making discipline part of his long-term routine:

> You need to be very disciplined and focussed, that's probably the greatest challenge. In the early days that's easy. You know three to six months that's easy, because you want to get focussed and established, get a place to stay, get a job, go to the gym. (Stewart, 52)

For him, discipline and focus were required to *"stay clean and fresh"* and presumably free from negative impacts of drug use or to effectively manage his HIV.

Many participants described the process of adjusting over time to a new way of life and routine as 'slowing down' after a range of fast paced activities in their early experiences of the country of destination, or finding strategies to avoid fast paced activities:

> So, the time of year I hate the most in Songkran cos there is water all over the place so um last year we went to the Philippines during that crazy period, the year before that we basically stayed indoors for four days. You will never see me at a full moon party. Well I have never been to one…it's a little bit too crazy for me. (Declan, 58)

For some, this meant managing expectations by establishing new rules and boundaries in relationships. For Stewart, who was moving back to Thailand with a new Thai partner, adjustment meant spending more time with his partner than in his previous relationships.

Adjustment also related to managing income, and managing expectations about the boundaries of their relationship including whether his partner would work:

> I want to live like a Thai and live cheaply. I'm going to have to live off my savings for a while. I'm doing an ESL [English as a second language] course so I can supplement my work with some teaching. I'll need to be conservative in my spending. I don't really want to support her right now, so she's going to have to go back to the bar. I've thought I'd be okay with it. Because it was just sex. I understand that she's got to survive until I get over there. So I know for the next couple of weeks she's going to be working in this bar and it's excruciating. I'm trying to keep it objective. I've fallen in love with her…it's not a business thing anymore. She sees me as her boyfriend and I see her as my girlfriend. I want to sit down and explain that to her, it'll be different this time. It won't be a daily rate. (Stewart, 52)

A significant aspect of adjusting to life in the country of destination was coming to an understanding, and to a certain degree an acceptance, that things were done differently than in their country of origin. Participants highlighted a number of local stressors, everyday annoyances and perceived differences between country of origin and destination. This was described varyingly. For Andrew, it was represented as a *"culture clash"* and required being willing to *"conform"* and *"to be part of the pack"* which meant "*sacrificing a certain amount of individuality"* which he reportedly struggled to come to terms with. For several participants, such key differences had led to a somewhat philosophical perspective on life in their country of destination. Tom and Jackson each articulated this differently:

> Normal stuff is not a problem. It's when you want something different. Something different from Thailand, you want something Australian...that's where you get frustrated. Same, same but different. It's always the best phrase I reckon. It covers everything. (Tom, 44)

> It's just different things making you annoyed the same way. There is a Buddhist saying I heard in The Sopranos recently, "you've got to joyfully participate in the suffering of life". You know you just deal with it. It's not a big deal. (Jackson, 27)

Declan suggested a level of pragmatism was required to adjust to life in SEA. It was a natural and foreseeable part of life in the host culture and to expect otherwise was foolish:

> Thailand is not what you see in brochures and not what you experience on holidays. It is a very conflicted culture. A completely different mind-set to Australia. You don't get a sense of that unless you spend a lot of time over here. You just gotta shake your head sometimes and walk away in complete disbelief and say *"well, this is Thailand, get used to it"*. One of my biggest gripes are expats who bitch and moan about everything Thai. I say *"well if you don't like it why did you leave your home country?" "Well I hate it there too".* (Declan, 58)

5.5.3 Participation and Embedding

Many participants suggested that living in their country of destination meant adjusting to different forms of social interaction. This provided an opportunity to learn new ways of doing things and different ways of understanding. Embedding here is consistent with the views of Korinek et al. (2005, p.780) who define it as *"social relationships that foster a sense of rootedness and integration in the local environment".* This included navigating culture, perceptions of spirituality and the role of language. Wessendorf and Phillimore (2019) present embedding as a process, highlighting *"sociabilities of emplacement"* which they infer relates to *"more engaging social relations which contribute to a sense of belonging"* (p.4).

Differences in conceptions around time, family, traditions and hierarchy were all described. Some participants cited a lack of understanding of culture as a reason that Australians may not 'fully' integrate into Thai society and this covered a range of issues (explored further below). Variations on this theme were described by most participants:

> Yeah, it's obviously a very different culture and a lack of understanding could be one of the reasons why a lot of people don't consider themselves as you know Australians living in Thailand, you know for as long as it's convenient to do so…easy and whatnot. (Jackson, 27)

Participants described various ways of 'being' that they had learned from Thai culture. Learning had both cognitive and social elements, as described by Dylan:

> Thai culture has taught me that I don't need to rush and overload my plate to have a fulfilling life...being busy doesn't have to include being a bossy shithead. That everything can be done with grace and a smile and simple politeness and that most of our endeavours just don't matter...they barely scratch life's surface. That one can be happy with very little. That when you yell at somebody it's you that actually look bad and achieve less. (Dylan, 56)

Most participants viewed this social and cognitive learning positively and as something that was personally enriching and helpful to them adapting and living in their new environment. A number of participants rationalised various practices or activities in order to make sense of them in their own lives. Many of the ideas participants integrated into their own lives were those that fit with their personal conception of their new life:

> Your lifestyle is much more relaxed. You're not time-driven and you just take it easy. I speak a few languages to varying degrees, if I ask how are you in Thailand, it's *"Are you comfortable"* or *"Have you eaten yet?".* It's a very social culture with more focus on social agreement…agree to agree. Australians don't usually seek to achieve that very much. You

> know, like we would have a great time disagreeing with each other when we're sitting around and having a wine and a chat. (Marty, 43)

For Jackson, this meant accepting and participating in a less rule-bound, *"interfering"* culture; a positive experience by comparison to the perceived rigidity of Australian culture:

> Another reason why I prefer it here…you might have heard the phrase mai pen rai (sp). It just means "no problem" but it's sort of a good way to describe the Thai attitude towards everything. They don't interfere where it doesn't concern them. Like if you have a fetish for batting yourself over the head with a baseball bat, a Thai person doesn't care. You can do whatever you want as long as you don't bother them. Whereas, in Australia I find that everywhere you turn there's rules for this, rules for that. You can't do this. You can't do that. And I mean some of those rules are good, but a lot of the time… (Jackson, 27)

Learning was also described as understanding the temporal aspects of local culture. Patience was something highlighted as part of their understanding of the Thai way of life. This proved to be an important and positive part of adjustment as it related to acceptance and ultimately respect. The idea of patience was central to describing being able to understand the other's point of view and to develop a deeper appreciation for culture. Understanding, giving and receiving respect was also posited as an important component of adjusting to life in the country of destination. The idea of respect as it related to life in Thailand was described variously. For some, respect was about demonstrating conservative practices in daily life such as grooming and dress or being active participants in community life. Behaving appropriately reaped benefits such as *"preferential treatment"*:

> A lot of expats have a bad name over here cos they come over here to the bar scene, they don't involve themselves in the community and they let their dress standards and their hygiene standards just slip out the window. So I have always made a point to be clean shaven and wear decent clothes, speak politely, never be seen out drunk as a lord, especially at 10am in the morning. So I get a lot of preferential treatment, they call me Phi Declan, Phi means older brother, and if you hear a Thai speaking to an expat that they don't have respect for they won't use the term Phi. (Declan, 58)

For others, respect was conceptualised as it related to seniority and wisdom, which for older participants appeared to be important, particularly those who felt disenfranchised within Australia. For them, respect was not just about demonstrating respect for local culture, but receiving respect as part of participating in local culture.

Spirituality was discussed in the narratives of most participants. For many, this meant contrasting their perceived 'Western' view of religion (Christianity) with their experiences

of what was described as a more Eastern philosophy, namely Buddhism. For some, spirituality and Buddhism were part and parcel of life in Thailand. For others, there was a stated interest in exploring their own spirituality during their time in Thailand and taking on some or all of a perceived Buddhist way of life:

> I've joined in with rituals, funerals and visits to the temple for various reasons, so I engage in some of the Buddhist practices, as her husband and part of her family. I'm not a Buddhist. I know enough about Buddhism to know there are certain things about it that I cannot accept. But I'm sympathetic to Buddhism, and I can certainly participate in aspects of Buddhist ritual and life comfortably, and I think my wife's family is happy that I do. (Kyle, 52)

Several participants identified as Buddhist and described this varyingly. For Ivan (54), the philosophy was more to do with a perceived 'better lifestyle', "*As a Buddhist I don't drink don't smoke, I'm a vegetarian".* But for Bruce, who had been a Buddhist in Australia prior to his time in Thailand, and who was in a long-term relationship with a Thai Buddhist, the connection to religion was an important part of being accepted by his Thai family:

> I mean Aran is very devout Buddhist. Our relationship was acknowledged in the very beginning by his mother who sent a Buddha for us to have in our home as her way of saying she was supporting our relationship. And to convey something of her expectations I think about it being an honourable relationship. We couldn't have a talk about that, but she did it symbolically and in a powerful way I think. (Bruce, 56)

A number of participants noted that they had abandoned organised religion after their early life. For them, Buddhism represented a way of life, a part of local culture and customs and something that they were willing to participate in as required. For those, such as Stewart, a self-described *"seeker"*, who had been involved in varying forms of organised religion across his life, Buddhism provided a less institutionalised framework for navigating spirituality; an important part of adjustment to life in Thailand:

> In a secular sense, a sense of spirituality if that kind of makes sense. I do like their approach to life. It's very gentle. I love the respect that they give to monks. Even though I don't believe in Buddhism. I still don't like organised religion in any shape or form. (Stewart, 52)

Participating in new social networks, including mixing with locals, required consideration of language. This concerns the language within social networks, and importantly, the local language. Most had experience with local languages, predominantly Thai, and indicated that they had enough language competency to *"fumble along in basic ways"* (Kyle, 52). Engagement with local language provided an avenue to enhance personal and professional

relationships and to create a sense of belonging. For some, the ability to speak the local language, or at least attempt to do so, was vital and a key part of their adjustment:

> Language barriers are frustrating. X's been here 11 years and I speak twice as much Thai as him. Me and X take the piss out of him because he never tries, never studies, never does anything. I suppose both me and X are single, we learn the most. A lot of them use their girlfriends and wives to translate, where we've gotta use ourselves. (Tom, 44)

For others, particularly those who viewed their time in the host culture as temporary, an ability to speak the local language was considered useful but not vital:

> It's a good idea to learn the language. [But] because Thais can speak reasonable English anyway, you have to learn so much to get to the point that you're improving your communication with them. It's like if someone went to Sweden and tried to learn Swedish. There's almost no point because Swedes speak such good English, you need to learn x amount before you start improving on your communication. Especially slang. (Jackson, 27)

Many participants highlighted a difference between those who had language ability, or were willing to learn, and those who did not. Those foreigners (who did not learn the language or were not willing to learn) were often viewed with some level of contempt as not being genuine in their intentions or not demonstrating respect for the local culture:

> I would say 90% of the expats who live life in the bar scene - all they learn is Thai slang. And some of it is really impolite to use in public-you might use it with your best mate at the bar, but you definitely wouldn't say 90% of those words in the presence of their parents. So they learn a version of Thai, all the naughty words, the slang words, then go into a bank to open up an account and the look of shock that the teller gives these people… (Declan, 58)

This stylised or adapted version of local language was a way to maintain separateness or connection to country of origin, leading to perceptions of distance. Conversely, developing local language ability was described as having potential to engender local acceptance:

> I see opportunity to network not just with expats, but with locals. I love the culture and people and it gives you so much more when you can understand and speak their language and they love it. How many Westerners can read and write Thai? We all think it's too hard. I did too until I started learning. You know it's wonderful. I love that. (Stewart, 52)

Language provided a mechanism to speed up the adjustment and adaptation process, providing a level of confidence in navigating local culture and customs. This included managing risk and healthcare. Learning and engaging with language formed a critical component of ELoFT integration into local community life and often reinforced a feeling of

being anchored to place. There was some sense that using the language provided access to a more authentic experience and helped move participants from 'outsider' towards being an 'insider' and to more ably participate in day to day experiences, *"it's just a richer experience"* (Stewart, 52). For many who had Thai partners, whilst there was some interest in learning language, there was a low-level need to learn. Such participants acknowledged that this lack of language created a reliance on partners and others and had the potential to reduce social interaction and connection:

> Like my fiancée is quite a good English speaker, so there is no need in our relationships to kind of bridge that gap by me getting better at Thai. But it isolates you, not that many people for me to speak English to in this town, and I can't speak Thai. (Andrew, 27)

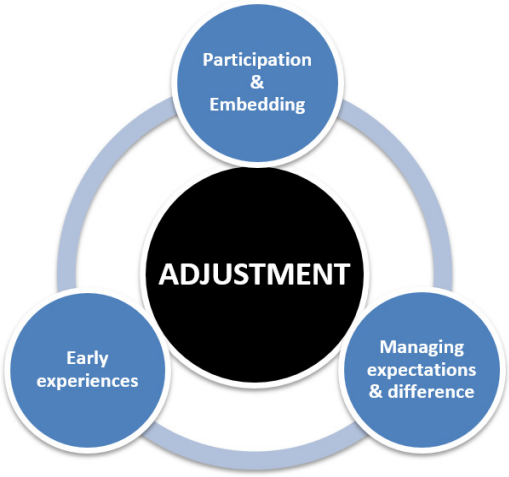
Some saw their English language skills as comparatively far more advantageous in the local environment, though they indicated that they had picked up enough local language "to get by". Others noted the difficulty in learning new languages at a later stage in life, a factor that was perceived as problematic by a number of the older participants. Several participants who worked in professional roles noted that learning Thai was unnecessary because English was used as the dominant language in the workplace, *"Everyone I dealt with knew English…they didn't prepare us for any sort of language skills"* (Gavin, 35). There was also a perception from some that the local language was, to a degree, impenetrable:

> I know expats who have been living here since Vietnam and they'll say you will never really understand it and you'll never be able to completely speak the language. (Declan, 58)

5.5.4 Summary

The adjustment process, which was ongoing, allowed participants, iteratively, to form and reform their sense of self and the way in which they presented this to others. Key domains emerged which described factors that influenced adjustment (see Figure 34 below).

Figure 34. Factors influencing adjustment



5.6 Reward, routine and ritual: perceptions and experiences of risk and risk-taking amongst ELoFTs

This section presents themes emerging from participant narratives that related to risk and risk-taking. Content is articulated through several prisms related to risk, using a broader sociocultural perspective and a more specific public health behavioural framing. Both experience and construction of risk shape social experience in the ELoFT context. Understandings of risk are framed both as they relate to individual cognitive processes and decisions and broader social processes and cultural constructions (Taylor-Gooby and Zinn 2006). Experiences and narrative reflect a broader tension between social expectations and regulation and individual expectations, practices and responsibility. Here the focus is on lifestyle, medical, criminal, economic and interpersonal risks (Lupton, 2013) reflected as risks of pleasure, risks of reward, risks of the body, risks of deviance and of 'Other'. Experiences and constructions of risk reflect Lupton's (2013) insights regarding the *"'always becoming' and transitory nature of risk"* (p.10). Findings explored the risks taken by male ELoFTs in SEA and how they managed, constructed and located risk. Participants described how they learned about risk, causes of risk, and past and present risks they experienced. Themes emerged relation to:

- Perceptions of Risk-takers
- Motivations for Risk
- Awareness of Risk
- Types of Risks
- Managing Risk

5.6.1 Perceptions of risk-takers

Participants described who they considered to take risks or to be at risk (for a variety of issues) which sometimes, though not always, included themselves. A number categorised the types of foreigners in Thailand, specifically as (a) those like them (ELoFT who were perceived as much less at risk) or (b) 'others'. Others were described as *"the stereotypes"* or *"holidaymakers"* and language often described their behaviours as *"reckless".* This included younger men, tourists, fly-in/fly-out workers with high disposable income and 'other' Australians or new longer-term residents. Kyle described such individuals specifically:

> It seems that men from Switzerland, Germany, Japan, Australia, a couple other places, go there to get drunk, hang out in sexy joints, and be kind of vulgar consumerists. (Kyle, 52)

Such foreigners were delineated from those more like themselves; who understood how things were done or who had *"stable relationships".* Gavin, for example, described the difference between tourists and expatriates, as he saw it:

> The expats I hang around with, they're professionals. They have a sense of how things work and what life is about. Ninety-five percent of the tourists I try and avoid like the plague…they've got no idea. They get into trouble. I think most of that stuff, most of the articles you read where foreigners get into trouble, most is their own fault. (Gavin, 35)

Declan described two distinct types of tourist: those who invite harm or risk and those who do not. For him, as for several participants, the first category was of most concern due to a propensity to engage in risky activities, not abide by rules and be disrespectful:

> Family orientated tourists, they have kids, so they're not going to put their kids in harm's way. Young blokes from 19 years to 40, it is as though they left all their brain cells at Tullamarine Airport. Things they would do here they would never even dream of doing back in Australia. Hiring an 1100CC Triumph motorbike, driving around in shorts, singlet, no helmet, no shoes and the most they would have ridden was a trail bike out the backyard of a farm [at home], drinking way too much. It doesn't matter where you are in the world, if you are walking down the street absolutely plastered, someone is going to steal your wallet. They say, and act in a way they would never dream of doing back in Australia. (Declan, 58)

Tom was more specific in his description as to who takes risks. His impression was least positive of young men who he viewed as those most problematic:

> Oh yeah, they have a budget but they blow it half way through the trip most of them. That's when they quieten down and I go, "Oh good." They all run out. The 20 and under always run out of money. *[Then what? Do they still come down to the bar?]* Yeah, but it's only to have a few beers or borrow; borrow off their mates. Ring up mum for more money. (Tom, 44)

5.6.2 Awareness of risk

Participants had varying levels of risk awareness. For some, risk was evident which they made conscious decisions to manage. For others, risk-taking was described as naïve, something that they should have known about. Awareness was also described in terms of rules or cultural differences and in relation to visibility. For most, there was a temporal aspect; in that risk awareness either increased or decreased over time depending on who they came in to contact with and their sense of the type and severity of the risk-taking. Participants described relationships, use of condoms, engaging sexual services and awareness of risk as it related to HIV and other STIs.

Gavin described risk awareness in relation to rules (both spoken and unspoken):

> There's definitely things you can and can't do. The moment you get off the plane, you walk around and you'll say, my God, this is the most lenient country you've ever been in. I think most of Asia is like that. There is a sort of lenient attitude in the whole scheme of things. But there's certain rules which you must follow. The penalties if you don't follow those rules are far worse than you could possibly imagine over here. There's a lot of rules you have to follow, if you don't, you'll find yourself in a lot of trouble. A lot of trouble. (Gavin, 35)

Dylan (56) also talked about rules, commenting they are "*often circumvented by bribery or ignored*". He described his perception of risk as higher in Thailand than in Australia *"Less stress but tropical and heat related illnesses, plus more dangerous traffic etc.".*

Lack of awareness of risks or the potential negative outcomes of risk-taking, was often described, framed as naivety. This was particularly the case for those describing early experiences in the destination country. Naivety related to relationships, concurrency of sexual partnerships, greater risk for STIs and use of condoms consistently for sex. Derek's risk related to trying to maintain and develop a new relationship without understanding, or perhaps not wanting to understand, the local context. For him, connection derived from paying money outweighed potential concerns:

> I'd come back and forward the whole time. We had an apartment, the car, motorbike. As long as the apartment and the car was paid for, the rest was hers, she could do what she wanted, but she thought that wasn't enough. She used to go to [Bar] once the salon finished and then take guys home and back to the apartment. The other girls could see what was happening and they didn't like it so they told me, which was good of them. But looking back, you could read between the lines that you were naïve. You knew something was happening, but, *"Oh no, it's all right. It's all right"*. (Derek, 45)

This sentiment was echoed by Gavin who highlighted a lack of understanding about the way things work in some relationships in Thailand:

> But what guys are sort of naïve about is that because they think that they're paying this girl to stop work, they think that they have exclusive rights to her body, so to speak. And because of that, they think, well okay, if I'm the only one and I'm completely clean, then we don't need protection. Whereas she has a boyfriend on the side and the boyfriend just doesn't use protection and he never has…it's just a circle of disaster, really. (Gavin, 35)

Bruce, an experienced practitioner in public health, described his shock when in the first month, *"I actually caught an STI… that was a rude awakening."*

He described transplanting Australian sexual health standards "*where I don't get STIs"* to an environment where *"…background assumptions don't apply because suddenly I was in Thailand in a situation where there are a significant number of people who have untreated STIs"* (Bruce, 56). For Bruce and others, experience in Australia was amplified in an environment of higher risk in SEA; something of which they were peripherally aware, however the reality proved to be something different entirely. Sexual rites and rituals performed in Australia were changed. Understandings of safety had shifted dramatically.

For Bruce, the objective, expert knowledge that had proven effective for staying safe in Australia somehow changed to a more subjective, lay and personal experience of risk which required re-examination:

> …you know condoms for anal intercourse. And that had worked for me in Australia. I think I'd gotten one STI in my entire sex life up to the point. I had been in Thailand a month and had to see a doctor and I had two STIs from one sexual encounter with no intercourse at all. I was like holy shit, I had to re-evaluate all of that along with everything else. (Bruce, 56)

This highlighted the interaction between different rationalities, both expert and lay (Bourne and Robson 2009). These multiple rationalities demonstrated the complexity of sense-making around risk. His expert experience was challenged by his new context leading to a feeling of inadequacy *"I felt a bit stupid, really. Just like oh God-I should have been a bit more savvy than this".* Jackson described an early lack of experience tempered by academic knowledge but knowledge not drawn on in this situation. In talking about STIs and HIV he talked about his experience of having a scare:

> I came back after a one week holiday pissing razors with a pussey[sic] eye and a scab on my face. That was probably luck that that happened on my first trip and not after two years. You hear about that stuff, but you don't really think about it. So that trip I didn't use condoms. It didn't click at all. I've taken health in high school and all that sort of thing, but it just didn't... It took me doing a couple of days just reading around online to go okay, wow. I won't be doing that again. (Jackson, 27)

Marty described awareness of risk as it related to the warnings or cautionary tales received from others (locals and expatriates) about the 'right' thing to do:

> At the time, well, AIDS, HIV was important, so there was certainly a message that if you were going to go with a prostitute or, you know, bar girls, the message you might expect was, you know, "Oh, I wear a condom." You know, never, never sleep with a bar girl without having protection…you really should be careful. Unless she is nice and clean. But even then, you don't want to get her pregnant anyway so… (Marty, 43)

Marty's narrative suggested relatively poor awareness of transmission mechanisms but also presented a consistent expectation of women as objects and responsible for both pleasure and protection. Further his comments *"nice and clean"* suggest a corollary which is pervasive in the HIV narrative which is that it is something that bad and dirty and by association something that only bad and dirty people acquire. Risk awareness here was positioned as absolute; there was a definitive message about sex, which if ignored would pose a risk for HIV, couched another way, 'avoid at your own peril'. Gavin furthered this notion, going on to suggest that ignorance is because *"even if you give out the message, like I said, love is blind. That is scientifically proven".*

For many, risk was described as visible or invisible. If the risk was visible or "obvious" (a person, an action or a symptom) it was something that could be addressed. However, some risks were described as less visible or less talked about. Jackson, for example, explained his perception of why protection is often not used in sexual encounters:

> I look at all the hotels and every night guys are in these hotels taking girls home. So many of them aren't using protection. Especially given the fact that maybe you just don't see it because the Thai girls disappear and don't talk about it, but if it was a real problem wouldn't it be obvious to people who live here you know that you'd be seeing this person disappear and that person could die, and this person caught things. (Jackson, 27)

Risk awareness related to reputation and perceived cleanliness of bars, availability of condoms and the veracity of the local HIV / STI testing system. Declan, for example, highlighted the availability and ubiquity of condoms suggesting:

> Oh yeah everywhere. Tesco has got them right next to the chewing gum, seven eleven has them near the cigarette lighters. So, there is absolutely no excuse for not having it. And 9 out of 10 times the girls have got them on them. Most of the bars have boxes of them for the girls who chuck three or four of them in their handbag before they go off. (Declan, 58)

Risk awareness also related to the body and physical signs and symptoms of infection which, if noticed, had the potential to keep you safe. For Declan, awareness of risk represented a biomedical understanding of disease, expressed here as hygiene:

> The other thing is that the girls are very hygiene orientated so you have a shower before and after um and the girls, especially these days, demand you use condoms. No condoms no sex basically. The more reputable bars, gogo places, get the girls tested every month um, whether the girls actually get tested or give the doctor 500 baht to get the doctor to give them a certificate is another story. So, it is something that is on the back of your mind, well

> it should be on the back of your mind. But yeah, and you get to know 'em, what do they call them? At the coconut bar up in Phuket, Pattaya and Jomtien, the ladies of the night will freelance and just walk up and down the footpath underneath the coconut trees. Now most of those ladies from what I hear um, don't demand safe sex, ah, you know. (Declan, 58)

Applying knowledge from previous life circumstances influenced risk-taking. This included applying expert knowledge as well as lay knowledge gleaned from personal, past experience or from stories from others. The extent to which a situation was viewed as risky, was based on an ability to contextualise it within their sphere of knowledge. Daniel, for example, described how knowledge and past experience related to awareness of risks around food and his perceptions of how foreigners made decisions about food safety:

> Experienced expatriates would understand what foods you can eat according to local culture. But they would also have the benefit of experience coming from Western culture. So, for example, Indonesians only eat black dogs because, apparently black dogs is safe. They're more nutritional and it's nice. White dogs, no. Whereas for Westerners we're like, *"Okay. Does colour really matter?"* Or pigs, for example, a lot of cultures say *"keep right away from them,"* because, swine flu and other things. So, a lot of Westerners say, *"Okay. I understand why we should or should not, based on how pork is prepared..."* (Daniel, 45)

5.6.3 Motivation for risk

Participants rationalised risk based on context. There were complex ways in which motivations for risk were viewed and navigated. Sense-making around risk often appeared contradictory, both bio-medically driven as well as socially constructed.

Several participants cited underlying motivations for travel to Thailand as contributing to risk, *"It really goes back to who they are or why they are there…a lot of people go there and they just get silly"* (Daniel, 45). This related, for many, to a lack of respect for the culture of the country of destination. Gavin also described the lack of respect shown by foreigners:

> I think they drink too much. They party too hard and I think, the nationals are starting to get sick of us. Because they say that we don't respect their sort of culture. You know, we go over there and we just do our own thing. We eat our food, you know, we don't respect their whole culture. And you can sort of understand it. I mean, if you've got a lot of community that comes to Australia doing all these things, we'd be doing the same. (Gavin, 35)

Biomedical risk was highlighted by a number of participants. Stewart, who was living with HIV, described risks related to drug use and the management of his condition:

> You know ever since I started meds my viral load's always been undetectable and my CD4 count's always been over 700. I had just had a blood test that was over 1000. The only issue tends to be when you're high on meth you might miss a few doses, you know. You might go a couple of days, which is a problem. (Stewart, 52)

Such practices might be viewed by others as dangerous, but were described by Stewart as a *"problem".* His perception and action around risk was complicated by his HIV status and his drug use as well as his knowledge of risks of transmission and of contemporary and historical approaches to HIV prevention. Here Stewart described his knowledge of, or perception about, the reduced risk of having unprotected sex with an undetectable viral load, a good CD4 count and no STIs:

> I know these guys who, you know are saying unprotected sex is okay. And it doesn't sit well with me, but what it is reassuring if the condom breaks or when I was doing methamphetamine in Nam Pin or in the Philippines. I still don't like setting out and deliberately not using protection. It still doesn't feel right. I still don't want to put my partner at risk. (Stewart, 52)

Stewart's risk-taking was predicated on his knowledge of the environment, the impact of drug use, desire for emotional connection and understanding of HIV transmission:

> It happened with the girl that I was with in the Philippines. It was far out. We were smoking crystal …there was a really strong bond. I guess when you're doing drugs, heavy drugs like meth and you're having sex you do bond very quickly, very intimately. It's very intense. You know and there was a couple of times where she said don't worry about a fucking condom, it's alright. And I would not cum. She wanted me to cum inside her. Well I didn't know whether she was still fertile or what, so I didn't want to risk that. And there's no way I wanted to risk infecting her. And she's saying it's okay. And I'm going no, no. But I did feel that I was able to withdraw and ejaculate. I know that I've got no STIs. I know my viral load is negative. I know my CD4 counts. I know those things. (Stewart, 52)

He was quick to highlight that while he would not set out to have unprotected sex, the emotional connection and drug use may be a facilitator in such practice. However, the biomedical knowledge, supported by the feedback from others living with HIV provides a level of reassurance and a perception of a failsafe and enhanced safety. His desire for close emotional connection appeared in part linked to a desire for condomless sex, highlighted in his description of a relationship with another individual who was also living with HIV:

> To have sex unprotected - I really miss that. Because with my previous partner who was also, had HIV, you know we had a very great sex life for 12 months, totally unprotected.

> Because we were both positive. So, that was okay. We had great sex. *[Was that a relief?]* Yeah, it was nice. You know there was no issues around disclosure and yeah. *[Was that freeing?]* Very. Yeah, you know worry less these days about outright rejection. (Stewart, 52)

Risk for Craig was positioned as dangerous. Risk was situated in the context of employment and supporting his family. He was aware of risks involved in an overseas work assignment and took it on in order to better himself financially and professionally. However, his experience suggested a lack of control as he described the situation as something required of him by the company. Contrasting his time in Thailand which was assigned, but generally welcome, Craig refers to his time in Papua New Guinea as *"forced"*:

> I said to my company I'm not going. I won't do it…that was extremely challenging to be away from my kids and yeah it was horrible. PNG, specifically Port Moresby is a very dangerous place and the hotel, it's like a military compound. You go between compounds in a big heavy four-wheel drive because if there is a disturbance on the road ahead - say a car crash - because there's so many people - there would be a massive congregation happening. And the reason one has a four-wheel drive is not to go off road, it's so that you can drive up over the verge or whatever in any circumstance to get away from a gathering. You can't drive along with the door unlocked or the window down. Someone will reach in and cut your arm off for your watch. It's an incredibly dangerous place. (Craig, 48)

Several of the participants suggested that risk taking was normative, related to pleasure and to a fatalistic attitude towards aging and death in relation to risks around sex, condom use, HIV and other STIs. Jackson, for example, suggested:

> A lot of the guys here are older and you know didn't grow up with condoms. And I know a lot of them have the sort of attitude of "well I'm 65 anyway. I'm going to be dead in 15 years. I might as well enjoy myself while it lasts". (Jackson, 27)

For these men, the pleasure of condomless sex outweighed any perceived negative consequences. This fatalistic attitude was something common to the narratives of many participants and was often linked to the cultural practices of their host country, particularly Thailand. Jackson also perceived that the environment was one that inherently did not support safe sex and one where emotional safety and desire for connection may outweigh practical safety concerns:

> You see her once then see her again, the second time if you want you don't need to use one (a condom). They won't ask. They won't suggest. They're just not bothered anymore. I think it's probably from a feeling of knowing you. (Jackson, 27)

A lack of common sense, stupidity and a sense that they should know better were also frequently cited as factors in taking risks. Gavin described the risk-taking behaviours of foreign visitors to Thailand:

> To me, that's stupidity. It's just completely a lack of awareness, being stupid, and common sense out the window. Sorry. But, I mean, the jet-ski scam has been on the islands and this as much as Phuket has been going on around the islands even in Pattaya 10 years maybe longer. There's so much documentation, there's so many news articles, and there's so many people that tell you, don't go and rent a jet ski. That if you were to go off and rent a jet ski, you just have to be absolutely stupid, that's my opinion. I mean, one of the problems that foreigners get themselves into, I just reckon it's just common sense, you know? (Gavin, 35)

5.6.4 Types of risks

Examples of risky behaviours described by participants included alcohol and other drug use, reward-based risks, risks associated with transition and adjustment, new relationships, unprotected sex, driving or scams, *"Riding a motorbike fast, unprotected sex with some Thai women, swum to an island alone in rough seas"* (Dylan, 56). Some examples described by participants were very specific and narrowly focused, for instance: *"I am aware of some health aspects such as Hep B, which I am immunised for"* (Trent, 59).

For many of the participants, the physical and social context of their new environment was inherently risky, as Kyle explained:

> Well, simply going to live in Thailand is very risky. And I've suffered from it, because of corruption, nepotism and things like that. I'm not corrupt myself, but it's very hard to survive unless you're corrupt. If you're clean, dirty people feel uncomfortable because they can't trust you - and I'm talking high level respectable people with titles here, that's the fundamental risk for me, in Thailand. Um...so living in Thailand is the big risk. (Kyle, 52)

These risks were viewed both positively and negatively, for some as just part of everyday life in the country of destination. For many, the risks associated with 'freedom' in the country of destination were identified as consequences (such as law enforcement) that were often poorly understood by ELoFTs, as articulated by Gavin:

> The way I see it, third world countries give you more freedom, but they give you more responsibility that comes with that freedom which most people don't know how to handle. So, they'll say you can do all these things, but there's consequences. The consequences are a lot harsher than what they are back home. You know, drug use or alcoholism. (Gavin, 35)

Jake summed up the broad range of risks that ELoFTs may be exposed to in SEA. For him, as with several other participants, risk was frequent, often sought, and had payoffs in relation to new experiences, pleasure, thrill-seeking and danger:

> I'm not into adventure sports but I like to travel to new places and possibly place myself at risk. Next year I plan to go through Myanmar to the Chinese border, an area that has seen civil war for many years. I've had issues with the army in two countries, gone into areas with a high risk of crime and while drinking would have often placed myself in risk situations frequently. I've has STDs twice from sex workers through not taking precautions while drunk. I no longer indulge in this type of activity and haven't for many years although it is readily available locally and I know people who do. (Jake, 65)

A number of participants described the types of risks as actions of chance or fate. Jim (52), for example, contextualised his risk using language which positioned it as karma, *"I mean, I'm a big believer that everything happens for a reason, even if that reason isn't, doesn't become obvious until much, much later in life."* Craig also described motor vehicle crashes as part of the risk of living in the destination country. He too touched on the role that fate played in the way in which risk is positioned within the host culture:

> One of the first ones I learned was *"slow down, you're going too fast".* Because they drive like nutters, they're Thai Buddhists and, if you go hurtling on your motor bike at a ridiculous speed wearing shorts, a singlet and thongs and no crash helmet and you happen to crash and die, it was going to happen anyway because it was fate. There's no point in wearing safety equipment. There was no point in slowing down for safely, because if you're going to die, you're going to die. It is a fatalistic culture which is fascinating. I've never experienced that and I hadn't even imagined that such a culture could even exist. (Craig, 48)

Health related risks described by participants included tattoos, drinking local water, food related illness, alcohol and other drug use, HIV and other STIs and BBVs. Risk-taking around these issues often came about through a lack of knowledge or awareness of local conditions, whereby participants transplanted behaviours from country of origin to a country of destination that had higher risks. Declan, for example, described the relationship between alcohol use and sex and perceptions of HIV:

> It's the drinking that leads to other big problems too, like unprotected sex. I know for a fact that my mate was over here in 1998, we visited four gogo bars in walking street… Four out of ten girls at those gogo bars were positive for HIV. (Declan, 58)

A number of participants described bringing their Australian expectations and practices to their country of destination without making changes to their behaviours which might have assisted to manage risk. Bruce, for example, described this is relation to infection control:

> I had Australian assumptions that I thought were suitable in a new country. Another example of just the whole level of infection control is needed to not be acquiring STIs. I mean I was probably always blasé around HIV really. In retrospect I don't think I took HIV transmission risks really seriously. But that's not good enough in countries where there's a significant amount of untreated STIs. But you know, so there were not a lot of partners involved in that period of time. It kind of put me in front of the whole situation as having to have a much, much stricter standard of infection control. (Bruce, 56)

There was a sense, from many participants, that there were risks associated with not following local rules and customs and instead applying Australian assumptions and customs to new situations. This often centred around 'letting loose' with other ELoFTs. Gavin, for example, described foreigners and drug use at a well-known event where risk-taking was high and rules around drug use were harsh:

> I had offers to buy drugs, never took that up. But what I find is a lot of foreigners go to these Full Moon Parties and they see foreigners around them and they think, oh my God, this is like being back home. The fact is you're on Thai soil, you need to respect their rules. Now, the cops over there usually they'll turn a blind eye. All the foreigners are shooting up drugs and taking pills. But the moment the Full Moon Party stops, if there's drugs they'll arrest you, you're looking at hard time in jail. And I don't think foreigners realise that. (Gavin, 35)

Most participants described risks related to relationships (romantic, employment-related or social) in their country of destination. Such risks usually had significant rewards such as better jobs, reduced social isolation or emotional connection. A risk for many appeared to be the somewhat stereotypical notion that foreigners were generally scammed by locals for money and would end up losing everything. This was described by Declan:

> Oh definitely. And they come from, you know, a Western country and they've come over here, they have got their redundancy pay out, they have bought a house or a condo and the minute he says *"you know money is starting to get tight, I can't go out every night and party, and we can't go out and dine at fancy restaurants, we need to start living like Thais*", It's like *"you're joking, I didn't start going out with a Westerner to live like a Thai"* and they have basically had to pack up, go back home and get on a pension. (Declan, 58)

Such stories were part of the narrative of most, though not all participants, many of whom had been personally affected or were aware of many examples where others had been

"scammed" this had been the case. For these participants, the risk was time limited; they learned their lesson and tried to manage or avoid this risk in future interactions.

Participants articulated risks associated with hard living. Hard living included significant levels of alcohol and other drug use, often as part of the process around making friends, connecting with others or around work. Andrew, who ran a bar, described the consumption of those around him as *"living a bad life"*:

> But like these are people that I know well, like there is a lot of fucking people that you see at bars and stuff and it seems like they are living a pretty bad life. My friend he's like 26, 27 so he's quite a young guy and he owns a bar and I think owning a bar is affecting his health quite a lot. When I go there the place ends up staying open til like 6 in the morning. He is up until six in the morning smoking and drinking and then goes to bed at 6 or 7 and probably wakes up at two in the afternoon or something and has like four hours to spend with his wife and his baby and then he is working again. (Andrew, 27)

It appeared, for many participants, that these risks dissipated over time as alcohol and other drug use was moderated or reduced, often because of an incident or concerns about health. Still, the initial alcohol and other drug use was often substantial with the potential for significant negative outcomes. This was articulated by Stewart:

> I've had a fairly chequered history with drugs. And fuck, I've done some stupid shit. I had amphetamines and pot and had a lovely time. Jesus. I would never do that again. I was very lucky that I wasn't set up or taken advantage of. In hindsight I think fuck that. (Stewart, 52)

5.6.5 Managing risk

Participants described a range of risk management or mitigation strategies, which were sometimes conscious, but often not. Key individuals appeared to support the management or understanding of risk and social networks and relationships often acted as moderating influences. A number of participants described risks associated with accessing and using local healthcare services. For these participants, there was a distinction between public and private and they were generally of the opinion that the quality of care was based on cost and willingness to pay. There was also a distinction about the type of issues for which an ELoFT might seek treatment for in Thailand compared with Australia:

> Well it all comes down to costs here. If you want good treatment you have got to go to a private hospital and pay, pay, pay, pay. If you've got money. Yeah it's got to be private. The local hospital, I wouldn't take me dog up there. They can sew you up and get a stitch if you get a cut or something. Other than that...don't go there. (Tom, 44)

Travel to and from country of origin was reportedly vital, for many of the participants, in order to access essential services or to see a doctor, "*Every time I'm home. I go and I just say test me for everything"* (Jackson, 27). This included accessing trusted medical advice or subsidised treatments via the Pharmaceutical Benefits Scheme. For some participants, such as Stewart who was living with HIV, this continued access was an important consideration. This connection to the Australian health system provided an important and trusted anchor for many participants and was a way to manage risks that may have been taken and to reduce the likelihood of risks occurring in their new environment.

Participants described active risk management strategies which included research prior to or during their travel. For some, this was about personal protection, while for others it was about protecting their family and mitigating any foreseeable risks, particularly related to health. Craig, for example, talked about insurance and particular websites:

> Before we went we found out about all sorts of things but specifically we investigated and sorted out medical insurance cover. I mean we've never gone there, I didn't really know what vaccinations one would require, what the health situation was like. Went on the government website, the travel advisory... So from not knowing to quite a lot of knowledge about medical cover, we insured ourselves to the hilt and off we went. We had some significant medical issues so adequate medical cover was important. (Craig, 48)

Jackson described the process of learning about HIV transmission and risk mitigation:

> I just Google and look at the first 20 results, some of them might be full of shit but most of them are pretty accurate. If there are any outliers in the information you can just discard them. You get a general feel for your risk and what not. I Googled HIV infection, HIV in Asia. Apparently the sub type in Asia can be 10 times more infectious, but that is sort of the highest rate of infectiousness I have heard so it can anywhere as the same as the normal HIV to much more infectious. (Jackson, 27)

For many participants, safe sex was inconsistent over time and usually increased or decreased depending on their relationship status or other practices around STI testing for example. For some, there appeared to be a period of redefining practices that they had previously applied in their country of origin, while for others practices remained constant. Gavin, for example, highlighted his consistent condom use:

> I've never actually done it myself, never, ever in my life have I gone without protection. So, I've got sort of a clear mind. My girlfriend, on the other hand, she didn't 100 percent believe me. She said, well you've been to Asia, you've been in the tourist areas, I want you to get an

> HIV test. And I said, look, I will but I know I'm clear because I know that I've always used protection. And I've gone off and done an HIV test and I'm clear. (Gavin, 35)

Jackson described mitigating risk in terms of using post exposure prophylaxis (PEP) to reduce the likelihood of HIV transmission. PEP provided him with a safety net in case his other usual practices failed. Jackson, as with several other participants, had a working knowledge of HIV risk and used this to calculate his likelihood of becoming infected and adjusted his behaviour (PEP, hospital, condoms, partner testing) accordingly. The perceived impact of PEP on his liver was a trigger to shift his focus to condom use:

> When I was living here I had a condom break. Normally I would tell the girl we need to go to the hospital and get a check. But if I couldn't get in touch with her the next day, I'd get a course of it (PEP). That was the first time it happened, the second time I was coming to Pattaya for a holiday and had one break and I was leaving the next day so couldn't get to the hospital. I was going to Singapore for a visa run and I went to the hospital there for a course. I got to the point of if the condom broke and there was no blood I wouldn't worry about it. And if there is blood I would go the hospital and get checked. So, for now and the foreseeable future I use condoms, not for oral sex but for penetrative sex. I want to be enjoying this place if it's still here when I'm 57, not dead when I'm 37. (Jackson, 27)

For many, STI testing was normalised, particularly in an environment where condom use was often reported as inconsistent. Testing was described by some as a requirement related to employment. Being able to access frequent testing, including self-testing was an important consideration for some, even those who espoused safe sex practices:

> I practice safe sex. Until about four years ago, when I stopped going to those places, they had a self-test HIV kit. So I test, every month. No scares, no rashes or anything.. (Dylan, 56)

For some, STI testing of others was used as a way to keep themselves safe:

> Um, but look it's the same anywhere in the world you go, almost all the bars I know of in Thailand test the girls. And if the girl fails the test then she is gone. (Peter, 54)

Participants often described life as an ELoFT in their country of destination as frenetic. For many, particularly those who were single or those who worked in hospitality, risk came in the form of alcohol and other drug use. Reasons for a reduction in use included poor health, a particular incident or watching others. For some, slowing down was linked to the ageing process, as noted by Dylan (56), "*I have naturally slowed down. I have a steady live-in partner. My eczema precludes drinking and smoking"*.

For most, alcohol and other drug use was described as heavy in the beginning and declining over time. This reduction in use was articulated by Andrew, who described some concerns about health, but also about wanting to establish a meaningful relationship with a partner:

> I just decided one day I was going to stop (drinking, smoking, doing drugs). *[There were no motivators?]* Just kind of a fear of getting older and not really getting anywhere. Like this is great and I am happy right now but I can't do this forever. There was no drastic health thing - I could foresee that gradually my health was going to decline. *[If you kept going that way?]* Yeah, a lot of the girls I knew, like maybe they drink once a week or less. So I guess at some point going to nightclubs was pretty unfulfilling and didn't seem sustainable. (Andrew, 27)

For a number of participants, reducing harm while continuing behaviours was essential, particularly among those who worked in hospitality. Being 'in control' was an important strategy to manage risks, particularly those related to sex and drug use. For some, practices around drinking evolved over time as a strategy to reduce harm and minimise risk. For Tom, this related to the location, type and volume of consumption:

> *[Has your drinking changed?]* Yeah. Less. *[How much would you have to drink when you first came up here, on an average day?]*. A bottle of Jim Beam a day. Now I don't drink spirits, only beer. If I can't drink any more beer I go home. *[How many would you have done last night?]* A dozen. I never drink when I go home. There's never beer in the fridge. It's a hard thing to crank that over night and day. (Tom, 44)

5.6.6 Summary

Risk was viewed as part of life in SEA. Risk was viewed, practiced and normalised through the context of experience in the country of origin and destination. Five domains of investigation were revealed: risk types, perceptions of risk-takers, risk motivation, risk management and risk awareness (presented in Figure 35 below).

Figure 35. Domains relating to risk and risk-taking

5.7 Being a mate: how ELoFTs experience and make meaning through support

Giving support and receiving support emerged as two key themes from participant interviews; often framed as 'being a mate'. Here support is used as per the categorisation of social support by Cutrona and Suhr (1992) who suggest categories of support comprising emotional (affection, encouragement, listening), informational (advice and feedback), social network (actions to promote belonging), esteem (validation, compliments) and tangible (physically providing resources - financial, emotional, goods or services) support (Cutrona and Suhr 1992; Ko, Wang et al. 2013). Characteristics of these themes are outlined below:

- Giving support (Helping as a source of advantage and helping for its own sake)
- Receiving support (reasons for access and sources of support)

5.7.1 Giving support

Many of the participants recalled instances in which they had provided support to other ELoFTs, colleagues or friends. This was primarily in the form of tangible, informational or social network support. Most of the informational support provided appeared to be in the form of advice regarding transport, safety and 'dos and don'ts', *"Every single day. How much the rent, how much this, what do you pay to buy a bar, da, da, da? Same old shit."* (Tom, 44).

Tangible support was explained mainly as it related to willingness to help or direct tasks. Bruce described support as *"…mentoring them actually".* He explained further:

> We did the market shopping and we took them and we showed them how it worked. We helped them get settled so we were kind of the people who were inviting them and supporting them…. (Bruce, 56)

Participants described instances of providing financial support:

> …he's got no money, so S1 buys him a ticket back to England and his other mate, he'll send his brother $1,000 Aussie dollars to England to look after him when he gets there. (Tom, 44)

Other examples included showing other 'newbies' around and introducing them to people and places. Dylan (56) suggested a range of activities from dispensing information online, "*I give advice on websites such as Thai Visa",* to direct tasks, *"I pick up friends from airports, orient them and take them on tours, accompany aged friends to hospital etcetera."*

Social network support mainly presented in the form of providing access to others in ELoFT social networks or providing direct companionship. Derek, for example, suggested:

> …and you know, like we have got a good network with X and you know, all the guys from the [Bar] and you know, there's a heap of us around. (Derek, 45)

Types of support provided appeared to be predominantly in two forms; *Helping as a source of advantage* and *Helping for helping's sake.*

Some participants described support provided as having personal rewards. Motivations to provide support appeared extrinsic and in part because the provision of such support had external benefits for the giver. For example, Peter noted that support was given as part of his role which for him provided respect:

> I get a lot of respect for being a senior trainer. I can go up to students, from back in 1992 and talk to them and they would show me respect. In Australia I can go back to students and talk and they will say 'f*ck you'. In Thailand being a teacher is a big deal. (Peter, 54)

Peter received esteem support from these encounters via the provision of respect and confidence from others in his abilities. Marty also talked about helping others in terms of being liked, in order to get ahead:

> My students love me. That is very key. And I used some tricks, you know. So it was very important for me to, in my business, to be able to speak and be a Thai to get them to identify with me. Oh yeah-you have to make yourself liked. (Marty, 43)

For Derek, the owner of a guesthouse, providing support was seen as a savvy business strategy to stand out from other providers and encourage repeat custom:

> There's that much accommodation here, you need someone that they come back to visit. You know what I mean? I'm not saying I'm the be all and end all of this business, but people will come back to see you, they'll come in and say *"Oh where's Derek?" "Not here"* and then they'll go. So, you need to have that presence in a business over here, especially people that come here first time. They try and talk to a Thai, and they're smiling, they're happy, and they're friendly, but what they try and get across isn't the advice I'd give to you. (Derek, 45)

Here he delineates the support that he provided from that provided by locals, indicating its legitimacy by focusing on protecting others from local hazards. While this support was not novel, it was important in two respects. It positioned Derek as a 'good bloke' looking out for the interests of others like him and also built rapport and credibility with clientele:

> Like the guys that come here, you know, I'll get a map out, show them where to go, and see what to do, and then I'll tell them, you know, the things to look out for. You know, if you're going to get [Road], you're going to walk back. I said, *"Walk in a group or get a taxi motorbike or a tuk-tuk because sure as anything you'll be targeted by the lady boys you know, either physically throw you on the ground, or try and pick pocket you"*. We've had maybe six blokes here that have been done in nine months, and four of them have been physically thrown to the ground, they've been drunk…(Derek, 45)

Declan, who was semi-retired and helped a friend who was a local travel agent, also suggested the provision of informational support such as *"the best areas in Phuket to stay in or the pitfalls of jet skis and all that sort of things…"* which was important for repeat business. Stewart's desire to be a 'go-to' person also appeared to be predicated on his desire to get ahead:

> I've got colleagues approaching me, *"Look while you're there I want you to try and source this for me. I want you to try and source that for me",* you know? I want to be a Thai specialist for Australian companies, businessman wanting to do business in Thailand. I want to…know the culture inside out and be fluent in the language. (Stewart, 52)

Helping for its own sake appeared intrinsically motivated and tied to the participant's sense of self and their background. Some of the participants described themselves altruistically, as *"helpers"*. Jim, for example, noted:

> I'm the sort of person that will help anybody. That's the way I was raised. I was raised in the country. Christian upbringing. Raised to help people when needed and the belief it will all come back to you someday. Treat others as you would have them treat you, not fuck everyone before they fuck you…. (Jim, 52)

Here the idea of respect emerged again. Providing support was also seen as something that may have a positive karmic outcome later. Gavin spoke of the sort of advice and support he provided to friends and travellers though for him this appeared to be in the form of a 'reality check':

> I think I give the more cynical side of Thailand. And it sort of dampens the spirit, you know? Like, one of the guys will say, *"my God, I just went through Nana Plaza in Bangkok. My God, there's all these women, they're all over me."* I wouldn't even think about it, maybe I'm so desensitised. They're all after you, but they're not here because they think you're Brad Pitt. They're here because they want your money. The moment the money runs out, they don't want to know you. I tell everyone that…single males, families, I tell them places to visit to do the tourist stuff because they won't be frequenting the bars by themselves. (Gavin, 35)

Daniel, who noted that he didn't really see himself as a helper, suggested it was just something he did from time to time:

> …every now and again, I will get a phone call from an acquaintance or a friend of a friend who'd say, you know, *"I've heard this might be happening. Do you know anybody I can talk to"*, I'd say *"give this person a call here"*. It's interesting that you do get, especially in Indonesia, for example, you get NGO people who hang out with NGO people. (Daniel, 45)

For Kyle, a professor, support was mainly attached to his job with no apparent personal, external benefit, which may have been in part due to his status:

> So people want a job, they want connections for business. I'm like this with everybody. In Perth, half my students come to me for advice on their career, so I help, that's why I'm a teacher. I'm like that in Bangkok, too… a lot of foreigners come to me for friendship or advice, connections, or they want references, help on some practical thing. (Kyle, 52)

Jake (65) also seemed to have little in the way of extrinsic motivation, *"Through social media I do give a lot advice to other expats. Friends who live locally will occasionally ask me for advice in person."*

5.7.2 Receiving support

The majority of participants articulated that they had received or sought social support upon their arrival in SEA. Participants described a range of reasons for needing, seeking or accessing support. Gavin (35), for example, noted receiving network support, "*What advice did I get? They were more around showing you the social scene"*.

Several participants suggested high levels of independence and lower level need for support about "*how to get around and what to do*", *"I'm pretty independent and naturally inquisitive. I'm not someone who needs a lot of support or relies on others for it" (Jake, 65).* The importance of personal experiential learning was also highlighted.

Bruce, in contrast, described the culture shock of arriving in Bangkok and the barriers of posed by lack of language skills and the hierarchical structure of the workplace. He indicated difficulty accessing early support particularly from subordinate staff:

> For the first while you know I was very much by myself with no support. With my supervisor in Melbourne and hardly any contact with him. And that was challenging because I was lonely. I had no one to advise me. It was kind of awkward developing support from the people I was supervising. (Bruce, 56)

For him subsequent support was framed as *"survival"* and differentiated the type of relationships that became important, *"But some of those people I dealt with much more really and they were really helpful and I started to get some survival tips off them, I guess."*

Few participants described social support as it related to esteem (messages that promote intrinsic value) and emotional (i.e. caring, love, sympathy) support (Cutrona and Suhr 1992; Ko, Wang et al. 2013). Stewart had received these forms of support, via mentors and peers who provided friendship and events where he could connect with likeminded individuals:

> I've got some really great mentors around me and two guys I work for at the moment who are great business mentors. One is a very close friend I've known since I was 13. I try and get to most of the [events]. I'm lucky I guess being bi, I can sort of dip my foot in both camps, the hetero stuff and the gay stuff. Because there's nothing really for bi people. But yeah, I've got some lovely friendships-a lot of positive guys that I'm close to… (Stewart, 52)

Participants described sources of support. Support was delivered by individuals or groups face to face, online communities, blogs or websites and via books, newsletters and newspapers. Personal experience and a degree of pragmatism qualified sources of support as *"something that I would just take with a grain of salt"*. This was articulated by Declan:

> I didn't take it as gospel but it was another point of view to be taken into consideration. As I said I don't take anything as gospel unless I have experienced it myself and I can honestly say he is spot on with nearly everything. (Declan, 58)

Many of the participants accessed or received support online. As Jim (52), articulated, "*you're looking for advice, you go online, you start searching to see what other people have found".* This often appeared to be in the form of informational or network support including places to eat, buying properties, business and relationships. As Dylan (56) described, websites and forums provided opportunities, *"to study wider opinion, to read complex matters I'm not familiar with, to learn about costs and seek bargains".*

For most participants, online support appeared largely about accessing information, particularly from those viewed as credible. Several of the participants cited Stickman, an online blog (stickman.com) as a critical source of information. The value of the site appeared to come from Stickman's personal experience in Thailand and his clear, unvarnished messages for foreigners, noted by Gavin:

> I read his articles religiously. I've never met him, but I do speak to him frequently on email. He's got his wits about him. He's probably a diamond in the rubble. One in a million that's

> gone over and made his life successful. It's very rare to see that. He gives out level-headed advice. 80 percent, or 90 percent of the advice he gives, I totally agree with. Very good, sensible advice. His site is generally about Thai bar girl and foreigner relationships. He just pounded and pounded how it's a bad idea. It was like looking in the mirror. It took me 6 months to realise. I could have gone on his site and worked it out in 10 minutes. (Gavin, 35)

Jackson, who had experienced several sexual encounters which he believed may have made him vulnerable to HIV infection, frequently sought informational support from online sources. He accessed information about HIV and risk and used the information to calculate his odds of becoming infected and whether he should seek post-exposure prophylaxis:

> I l looked at HIV rates in Thailand and I think in freelance sex workers its quite high, can be about as high as 1 in 10, 1 in 7 whereas in commercial sex establishments it's about 4%. After the first trip I caught a little nasty, and I had read a lot online. I found it (PEP) online. I crunched the numbers and went I can't be taking those pills once a year just because a condom broke, it's not doing good things for my insides, my liver. After that, I did a bunch of reading, it's obviously not the most pleasant month, not healthy at all. I'm not sure if you know but after two weeks they check your liver to see if it's still functional. (Jackson, 27)

Jackson described accessing support in the form of information online as providing a way to access support without necessarily reciprocating:

> It was started five years ago. A bunch of guys, whenever they were here on holiday would all drink in a bar and whatnot and one of them started the forum. He owns a bar somewhere and he has this forum. I don't hang out with any of the guys who post on there. I don't really post on there much, but I read through it. There's all sorts of stuff. Everything from hotels, restaurants, places to eat. You know bars, nightlife, hotels. The forum names generally give it away. There's a business owners forum and items for sale or rent. Buy houses, land and condos and health and fitness. All that sort of stuff. (Jackson, 27)

This also appeared to be the case for Kyle who primarily used online support to untangle the complexity of Thai laws around marriage and property. In contrast to some other participants who sought their support online, Kyle raised some concerns about the quality of the information available-mainly in the forums and blogs:

> …I was trying to understand what the Thai laws were, regarding marriage, and property rights. And I couldn't get a straight answer from anyone, even lawyers I talked to, each one gives me a different story. And I look up the Thai government websites, and I read the Thai laws, myself, the English translations, just a mess of a time trying to work it out looking on websites trying to get answers. I came across three or four blog type of places where foreigners talk about life in Thailand, this is where I hear stories about property being

> absconded and that kind of thing. I didn't hang out on those sites, and I don't participate in them, but I've looked at them a bit. Most of it's half-brained rumour mongering. (Kyle, 52)

Support was also provided offline, via personal connection or through written materials including the newspaper, books or newsletters. Declan described some challenges with online sources, citing his preference for face to face and hardcopy written materials:

> There's a Pattaya expats newsletter that comes around once every month. I read that. I have been to a couple of their Sunday meetings when they have a guest speaker who is going to speak on a subject that I am interested in. I don't go onto the online forums anymore because, honestly, it is just a bunch of expats moaning all the time. (Declan, 58)

Gavin cited a book, *Private Dancer* as a source of informational support*:*

> It was one book which I found very interesting after years of living in Thailand and going there for holiday. I found the book quite extraordinary. I think the guy that wrote the book is been living in Thailand for 20 years before he actually wrote the book. (Gavin, 35)

Certain people played a key role in the provision of support. As noted by Ivan (55), *"there's always a go-to person or persons, in most places you go who's reliable".* Participants described either themselves or another key person that they may have obtained advice from or who was important in providing support to others. This was noted by Kyle:

> Um...people come to me for help a lot, not necessarily information, but they see me as like an important person who can arrange things for them or something like that. (Kyle, 52)

Several participants cited the owner of a particular well-known bar as important in showing them the ropes. Declan for example suggested:

> S1's always got a titbit of information, *"Don't go to X, there is a road check there, so go this way"*. He knows the legal system down there very well. So he is always a good point of contact. (Declan, 58)

Support from individuals was viewed as more or less wanted or trusted depending on the source. Andrew, for example, was less impressed with unsolicited advice noting, "*People who worked in bars and people who drank in bars - people were always giving you advice".* Mark, on the other hand, suggested that it was the cautionary tales shared by a credible figure in law enforcement which resonated:

> The first day I was there I went out in Bangkok by myself. There was a street corner policeman in this tourist zone, and as a local policeman, he's looking out for all the white people. He could see I was there by myself looking a bit dazed and confused. And he come

> over and asked *'Why are you here you just want sexy girl or you want to find a wife?"* I said *"I am just here waiting for a mate".* He gave me a bit of talking to, *"If you want a nice Thai girl don't go for the bar girls because they all want to rip you off, they want to get married, take your money and then come back and give your money to their family".* (Mark, 47)

Partners and friends were key source of support. Trent (59), a very recent ELoFT, noted that his partner *"teaches me the ropes".* This was echoed by Jake:

> My first long term Asian country was the Lao PDR, I had a relationship with a Lao woman and she taught me well. If I have a problem I ask my girlfriend or a neighbour. (Jake, 65)

Other ELoFTs, workplaces and employers as well as locals provided support. For Marty, this was a mixture of his employer and other ELoFTs who provided informational support:

> Yeah, I was just an English teacher, I wanted to get a better career. So, it was a chance to work for hotel as a training manager. The beauty of the hotels is the hotel will take care of a lot of things for you being an expat. They'll look after you…will set you up with the stuff you need to know cos you'll need to go for a health check and so they'll send you to the hospital. Also, there's lots of other expats working at hotels and they know how things go. So they tell you, they give you advice. Lot of word of mouth. (Marty, 43)

Marty's experience contrasted with that of Craig who received most of his support from other ELoFTs, many of whom had Thai partners who provided a range of support:

> Some of the expats, they had Thai partners. They weren't just sexual partners, they were also translators, guides, and they would tend to go to the less touristy popular places because their Thai partners enabled that. The company I was working for was a Thai-Bangkok based company so they didn't have the HR mechanisms in place to handle the expats. I learned it all from other expats. The company was useless. (Craig, 48)

Participants described differences in the type of support provided by locals versus other ELoFTs. Sentiment was mixed as to who was more likely to provide effective support. Trust and credibility also emerged as important considerations, as described by Marty who explained the impact of the small network:

> That happened everywhere I lived. And that's interesting cos Phuket-it is a small place...it's kind of word of mouth in a way because if I trust you and then you tell me that Gemma is trustworthy, I'll trust her. (Marty, 43)

The length of time an ELoFT had been in the destination country, and their perceived authenticity, were key factors in determining whether they were deemed to provide effective support:

> Well obviously, if you knew them for a while…you would have built up trust. Other ones, that will take a little while. If someone passed a comment that I thought was inappropriate, then I'd soon move on. Also, I ask them *"how long have you been here?"* and if they're just off the boat, then obviously you discount. (Marty, 43)

Implicit in this account by Marty is the belief that 'newbies' are of less value with regard to social support as they do not have the lived experience (of the country of destination or the relevant social networks) to give them legitimacy. Whether an individual was afforded respect and credibility appeared for some to be a function of time, as described by Derek:

> We get a lot of people coming in here asking advice. And, you know, like X's been here a long while, S1 from [Bar], and you know, well they've been here, S1's been here for 16 years or something. So he's really good too. Very well respected. (Derek, 45)

This was echoed by Tom:

> Well everyone has their own opinion of how everything works. [*So who do you believe?*] Mainly S1. He's been here a long time. *[So he's credible?]* Yeah most kind of people spin bullshit. He's always sort of been the straight ambassador. Always has. *[So how did you know he was a good guy?]* Gut feelings. S1 will bend over backwards for anyone. (Tom, 44)

5.7.3 Summary

Support provided to others was intrinsically and extrinsically motivated. Here findings are presented that relate to giving support (identified as helping as a source of advantage and helping for its own sake) as well as receiving support (including sources of support and factors which influenced support) (see Figure 36).

Figure 36. Factors relating to social support

5.8 At Home on the Move: ELoFT perceptions of country of origin and country of destination and the liminal space between

The way in which participants conceptualised and made sense of home appeared to be an ongoing and active process whilst being on the move. In describing home, participants presented their relationship with Australia, with the country of destination and with the process of movement between the two locations. Key themes explored here are:

- Ambivalence about Australia
- (Im)permanence
- SEA as Utopia
- Relocation and Return.

5.8.1 Ambivalence about Australia: love it, hate it

Participants described various levels of connection to home. This feeling was in concurrence with a strong connection to 'home' in their country of destination. This connection to home (Australia) manifested in different ways. For some, the connection was limited and seen as relatively negative*, "Even if people have a bad time in Thailand, going home's even worse"* (Ivan, 55). Country of origin for such participants held none of the nostalgia or comforts derived from a definition of 'home'. For many, Australia was perceived as over-regulated, expensive and isolating, as Stewart described:

> I'm really over this nanny state, this mentality in Australia. I'm tired of it. It's not that I don't love and appreciate what we have here and the standards that we have, because I do. And it'll always be home and I'm proud to be Australian, but I just want a change. (Stewart, 52)

This idea of lack of freedom and belief in an individualistic approach to life was prevalent in many narratives, often at odds with the stated interest in participation in community in country of destination. Jackson, for example, railed against compulsory voting and strict weekend trading laws. Ivan highlighted concern over excessive alcohol taxation.

For many, ongoing connection to country of origin manifested as safety, a mechanism to draw on if things *"go south"* often despite a stated dislike for country of origin:

> Because of acts of stupidity. Some guys get themselves into trouble in Thailand or Cambodia. Money, women, a combination of both. None of these guys would contemplate giving up their Western citizenship. The visas, passports, access to get out the country in case there's a problem. (Ivan, 55)

Tom also articulated country of origin as a safety net. He was ambivalent about his relationship with Australia, using home to describe both country of origin and destination:

> *[Where is home?]* Yeah that's a good argument that one. I go back to Australia for a holiday now and then and come home. Australia is still...If something goes bad, you are always going to go home. No matter how much you hate the place, you always go home. (Tom, 44)

Safety, for others, was about access to services or financial security. For Stewart (52), connection to country of origin was pragmatic. It was somewhere he could bring his partner for periods of time while he was getting himself set up for his new life in his country of destination, but also somewhere he needed to be every six months to access his free medications and access to specialist HIV care. For Jackson, Australia as home represented growing up and becoming responsible, something he felt was important as he got older:

> The reason I'm thinking about coming home is the financial security. I don't particularly want to be 40 years old you know in another five to ten years, and not have much money, not have set up a life, not have a home. Which I could see happening maybe. (Jackson, 27)

A number were more positive about the role of their country of origin in their conception of home. Gavin, for example, described things he missed. His description highlighted home as comfortable, a place that he understood and could easily navigate. Other participants echoed the positive aspects of home being country of origin, viewing Australia with nostalgia and contrasting its physical beauty to that of country of destination:

> I am always amazed when I land in Hobart airport how clear the sky was, how blue the sky was and how fresh the air was. I live in X right on the beach but it is extremely rare to get a crystal clear sky, there is always haze or cloud or someone is burning something off. The crisp clean air I miss that. (Declan, 58)

Even when highlighting the positive aspects of their destination country, and the lack of perceived connection to their country of origin, Australia was still described as home, with participants noting important materialities that anchored their connection, *"So in some way, apart from the expense of living in Australia these days…Living in Australia in many ways is much easier"* (Jim, 52). Declan provided examples of how he remained connected to home and to his Australian-ness, rather than specifically to his country of origin:

> There's not a lot I miss about Australia. I still watch a lot of the same TV. I'm looking forward to the Grand Final. There's always a bit of connection. I still I read the newspaper every day from home online. So it is not as if I am completely removed. (Declan, 58)

Thus, country of origin was mythologised. For some, the most positive elements of home were their past experiences of cities such as Perth from their childhood (i.e. nostalgia):

> I'll just say Perth now is, uh, not so friendly place, very money-oriented. Used to be perfect when I was a kid. But now people judge you with your money. Thailand is much more relaxed. I don't feel all that connected to Perth anymore, apart from a few people. (Ivan, 55)

Positive and negative connotations of the mythologised home existed concurrently in the narratives of most participants, with a sense of changing emphasis over time and space.

5.8.2 (Im)permanence

Permanence, or impermanence, is a key feature of mobility. All participants described their relationship with the country of destination, in terms of their intention to stay, in varying ways. Some participants spoke of this as a permanent decision. For example, Declan described a careful and considered decision made over time:

> This was the big move, yes…my mind was already here. After about the fifth or sixth trip here I found it harder to acclimatise to when I went back to Australia and every time I came back here I felt more and more at home. (Declan, 58)

Others, such as Andrew, spoke of impermanence, *"putting down roots, but at the same time would kind of like to leave the option open to go somewhere else if I get over it".* Some participants, such as Jackson, articulated concern about a prolonged stay in Thailand impacting on his ability to *"set up a life".* For him, and for others, life as an ELoFT presented as a stepping stone, part of a journey rather than a permanent destination:

> *[So, is this a long-term move?]* I've thought about it. Actually at a bit of a crossroads with it at the moment whether when I come home at the end of this year I should stay there and go to Uni and get a job or whether I should just stay here. (Jackson, 27)

Gavin, who was back in Australia at the time of interview, was more ambivalent about permanent migration to Thailand:

> As a holiday, it's a very nice place to visit. I totally recommend it. To live there, it's very questionable because the longer you stay there, the more you learn about the culture. You really learn what it's all about. And you think, well it's…no smiles at all, at all. (Gavin, 35)

A number of participants were in their country of destination on a retirement visa. Whilst this was a somewhat permanent way to stay in the country, it also demonstrated the precarious nature of such migration. This type of visa needed to be renewed each year and required individuals to demonstrate income or savings. For most participants, this did not

appear to be a problem, though some participants cited losing funds to broken relationships, partners or bad business decisions. This loss of finances meant they had to continue to work or that their expected way of life in the country of destination had been depleted thus they may struggle.

Home was also considered from the liminality of a transnational relationship. Stewart described this challenge in attempting to make his relationship with a Thai partner work:

> It became apparent to me that to continue our relationship, which we were conducting between two countries, we either had to get married - which was the last thing I wanted to do, because I had just come out of a marriage, or I had to live in Thailand. At that point I just could not see how that could ever happen. How I could live and work in Thailand. So she'd come out here for a period of time. We'd go back for a holiday together. (Stewart, 52)

Here concepts about home derived from the immediacy of finding solutions to a long-distance relationship. Home became the space where the relationship could effectively take place at that point in time for Stewart, neither in country of origin or destination, but somewhere in-between.

5.8.3 SEA as Utopia

Most participants described their new home in the country of destination in terms of freedom, a release from schedules and rigidity and about connection. Equally mythologised, country of destination was described for the most part in terms of a utopian lifestyle and as 'different' to county of origin. A place or space of amenity that participants reported made them "happy". Kyle articulated his sense of home in Thailand as a *"deep commitment"* to place which he highlighted as meaningful participation in the economic, socio-cultural and political life and environments in the country of destination which provided him with personal satisfaction and a sense of pride*:*

> So I have made a commitment maybe twice now to become a deep part of Thai society, as myself, I don't try to be Thai, so I take it seriously. I live there, but also I work there, I'm not just enjoying the place like a holiday or a retirement. I'm contributing to the world and functioning of the society, and I try to understand what's going on in the society at multiple levels, politics, culture, language, economy, science, and find some way that the usual kind of work I do can fit in and can play a role in some way. I take a certain pleasure in just understanding how people think and live and operate, and think little things like the way houses are organised, and streets are organised, and people move and spend their time, sort of interesting actually. I get satisfaction from discovering these things (Kyle, 52)

This deeper connection was reflected similarly by Bruce. He described feeling at home in the country of destination as being about enhanced connection via family relationships which is augmented via regular contact through social media. For him, home was conflated with 'family', 'acceptance' and 'belonging':

> I love going to Thailand and we go every year and often spend two to three months. I feel very at home in Thailand because I've got family. I have regular Facebook and email contact. Sometimes I think I'm closer to them than my biological family in Australia. (Bruce, 56)

For Ivan, the diversity experienced in his new life in SEA and his closer connections provided a sense of happiness not experienced in Australia (since his childhood):

> It's a perfect mix, big and diverse. It's got a vibrant expat community ranging from scholarly expats all the way from the Bush administration to, I call them deadbeats living in the jungle. It's got everything. *[So when you went to Thailand it made you feel?]* Happy. (Ivan, 55)

Participants' narratives around their new home also focused on an idealised lifestyle, somewhere *"healthy"*, *"cheap", "loose"*, *"relaxed"* and *"free"*. This contrasted a view of country of origin as repressive, restrictive and expensive. The focus here was on achieving a better way of life with less structure and more convenience. Ideas about the idealised lifestyle emerged in several ways. Participants frequently articulated 'ideal' as healthy and stress free. Here, Dylan described his new home in SEA in relation to a better lifestyle:

> I don't have a job anymore. I have no stress - if I'm late, I don't worry about it. I read more and exercise more. I travel lots. I spend less time shopping or partying. (Dylan, 56)

For many this new conception of home presented as a sense of freedom: financially, socially, and for some, sexually. It continued to establish their new life and home in a liminal space, allowing a sense of life without limits and a perpetual holiday. Living in SEA also allowed participants to afford the material comforts of home as well as extra services that they may not previously have had access to in their country of origin.

All of these features contributed to the mythologising of the destination country as a utopia with few negatives and many positives. This concept was often reinforced through comparisons with country of origin or expectations about the kind of life they were searching for-an idealised Australia, one with amenity but without limits:

> Um, the best things about Thailand is a sense of freedom, Australia is so politically correct and so many rules and regulations, so much a sense to conform in society. You don't have that over here in Thailand. It's a sense of freedom that you have over here, and that sense of acceptance you have over here. (Declan, 58)

5.8.4 Relocation and return

Home was also conceptualised as relocation or return to country of origin. For some this was considered a permanent migration back to Australia after having *"experienced the world"*. For others, once again, return brought with it a liminal idea of between-ness, or *"for now".* The majority of those who had returned home at the time of their interview had done so with their partners (mostly Thai) who were now living with them in their country of origin. This created a range of challenges related to re-adjustment, for example: of compromise, of loss and of giving up something, while for others of gaining something, belonging and being part of something. The latter is described by Bruce in his transition from Australia to SEA to Europe and back to Australia. In returning to Australia, Bruce and his partner sought to re-create a sense of community achieved in SEA, something he felt not achieved in Europe. This was represented as not only connection with people but also with nature, and for Bruce, the importance of his partner's happiness which in their new environment in Australia he reported they had been able to achieve:

> We ended up in [Europe]. The [Organisation] was very supportive, very close. We made lots of friends and it was a very comfortable life for seven years in that sort of very protective way. Neither of us wanted to stay for the rest of our lives, feeling like you never really belonged-they keep reminding you. We decided we would either go back to [SEA] or come to Australia. Aran had gotten into growing his own food and wanted some land. Friends were selling the house we live in now [in Australia]. We live in a rural community. It has the flavour of the groups that we got used to in the latter days in [SEA] and in [Europe]. We're settled. Aran knows how a village works. He's part of the community. I can go away overseas… and he's perfectly alright. There's a support system around him. (Bruce, 56)

Marty described the dual challenges of returning to country of origin. For him it was a necessary journey; not by choice:

> I came back cos my father was dying. Financially, it wasn't a good time for us to come back. We should have stayed another couple of years but I wanted to see dad before he disappeared. And I got a couple of years out of that, so it was worthwhile. But I didn't have as much financial resources. And what was also difficult was that the Australian market didn't seem to understand my experience. I tried catching up with a few different groups of people. Some of them stuck, some didn't, and I did make some new friends. And, you know, the couple of old friends, they're always there. But some of the groups, I've tried re-establishing and they've kind of moved on…it didn't really quite fit. When you got a family, you have to do things that fit in, to hang out with other families. That makes life much easier. So, I mean it was a long time being away…it's a big adjustment. (Marty, 43)

Peter described his attempt to return to Australia to be with his family. His marriage breakdown in and lack of connection to Australia were motivators to return to Thailand, where he had remained. This meant significant loss as he no longer saw his children. But, as he explained, home for both he and his ex-wife became what they were searching for- comfort and security. For Peter, this was in Thailand, while for his family this was Australia:

> I tried moving back but my ex-wife and me, we had a lot of court cases which was not my way of doing things so we said ok that's fine. The kids were actually living with my father at the time because he had a big house and he was happy that his grandkids were there. My wife was happy she had somewhere to live, she wanted to stay in Sydney but I never liked it and never wanted to move back. So, we just called it a day. (Peter, 54)

Jackson, who was undecided about his continued migration to Thailand but who returns to Australia each year, noted his threshold for his stay in country of origin. Despite his stated interest in returning to Australia, he reported that he found extended periods of time in country of origin difficult. He did not elaborate on how he thought he would manage the realities if he was to live in Australia permanently again:

> *[Do you come back to Australia very often?]* Every Christmas for about two or three months to see family. Also around Christmas time it's high season here (in Thailand) and I don't like it at all. It's too many people, so I come home. Which it fits nicely. Well, the first four weeks it was kind of like a holiday. So, being there for a while and seeing friends and seeing family and then I'll go alright, I have to book my flight soon. (Jackson, 27)

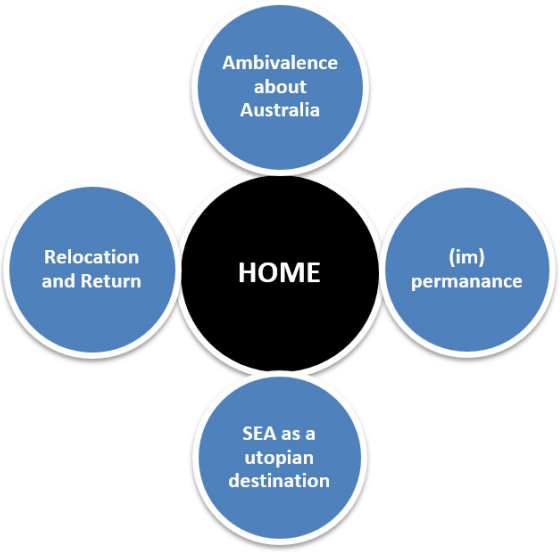
Kyle, who had returned to Perth for work and family reasons, was philosophical about home. For him relocation was primarily about good employment opportunities which also supported the needs of his partner. He contrasted his return to Perth with his time in Thailand, Germany and the US where he was also a citizen. His perception of both the US and Thailand related much more to feeling at home. Time in Australia in contrast was based on making a home built on convenience and proximity to 'home' in Thailand:

> I don't have a sense of homecoming, like most Perth people do. You know, most people who are immigrants have this notion of home, which is where they came from, and they yearn for home. I don't have this feeling. I'm happy here, but I don't come here because it's home. I had a family reason for being here, and practical things to do with my marriage, and life in Asia, so Perth is okay. It makes it easier for us to live together, also Perth is in the same time zone roughly as Bangkok, and the travel time is a little bit easier. So having a life that involves two countries is slightly easier here, so that's the key reason why I live in Perth actually, because it makes my life with Thailand a little easier. (Kyle, 52)

5.8.5 Summary

Home was a continued and active process, constructed as both sedentary and mobile, in that migration to SEA was not fixed nor always the endpoint. In this section, four key themes emerged: ambivalence about Australia, (im)permanence of home, SEA as a utopian destination and relocation and return (see Figure 37).

Figure 37. Domains on home



5.9 Community – Communitas: creating meaning and identity through ELoFT connection

ELoFTs sought, built and maintained social connection through the creation of community and communitas. Communitas is a term used in conjunction with liminality. It is described as per Turner (1969) the social relationships which emerge in opposition to formal normative structure, to describe instead conceptions of fellowship and shared social experience and ritual associated with outsider status or 'otherness'. It provides a useful framework to examine ELoFT social networks as it provides a framework to consider the emergence of community and shared social identity that had emerged from what might be considered deviant experience and the liminality of the migration experience.

Social networks created strong social capital and network sanctioned behaviours, some of which may have been considered deviant in their country of origin, but in their country of destination created important trust and reciprocity. These included shared social spaces and membership in organisations which helped to establish and maintain identity. It would appear that identities were constructed by aspirations of social integration rather than social exclusion (Farrer 2008; Beaverstock 2011). The following concepts are explored here:

- People
- Network features
- Social Spaces
- Activities

5.9.1 People

All participants reported that they spent time with local people as well as others who were part of the broader ELoFT community. The amount of time spent with locals versus other ELoFTs was often reported to change over time as participants became more embedded in their new cultural context, established new ways of being and belonging, and grew more confident in their local environment. For most, social networks were diverse and participant narratives indicated that they were highly networked. A minority, mostly those for whom expatriation was a recent experience, were not networked at all beyond their partner, due only to the fact that they had only recently migrated.

Other ELoFTs were named as friends and were a regular part of social networks. For these participants, other ELoFTs ensured a continuation of connection to their country of origin. Here, Gavin outlined his reasons for maintaining connections to other like-minded ELoFTs

when describing some of the challenges of behaving according to Thai customs in order to retain his job, but needing to *"let off steam"* without fear of judgement:

> You've got to be who you are, you know? Sometimes you feel a bit pushed and strained. Just constantly putting on these company faces. Acting like a good boy, you know? But, having said that, I think they gave us time away from the Thai people. Because they knew, deep down that we needed the foreigner time together. So you have two lives. (Gavin, 35)

For most participants, particularly those based in Pattaya and Phuket, there was strong evidence of connection to other ELoFTs, including Australians. This was particularly apparent amongst participants who worked in hospitality. For these men, work and social life was interconnected as they spent their time socialising with one another in their bars, predominantly with other ELoFTs and 'Western' travellers. This time spent together working and socialising reinforced their ties and sustained an informal, but well-connected network that was consistent with a microcosm of Australia.

Participants formed enclaves with other ELoFTs by signalling their likeness through a range of symbols such as serving familiar food in their bars, using flags and names that signal that others like them will be welcome ("*Aussie Bar"*, *"European foods"* etc.), or showing 'Western' or Australian sport on television. For most participants, their initial contact in Thailand was with other Australians and for many this carried forward in the development of their communities. All participants could describe other key Australians in SEA, even those who generally only socialised with family and locals. Participants who were more likely to be categorised as second-chance, quality of life or professional ELoFTs appeared more likely to spend time with other Australians and ELoFTs. Participants who were based in the tourist locations of Phuket and Pattaya, who were connected to hospitality or who were retired also appeared to have a substantial number of other Australians within their social networks. Craig, a *professional* ELoFT, noted a keen relationship with other such expatriates and their wives, most of whom were not Thai:

> My ex-wife had tremendous opportunity to make friends with the other expat wives. Very much an expat wives community there. She had a lovely time, as I do generally, I socialised with the people I worked with. Some were family men, some were single men, some were older expat men…it was a very egalitarian cloud of contacts, albeit a few nodes. (Craig, 48)

Declan neatly summed up the experiences of the ELoFT enclave in their shared activities and the individuals who featured prominently:

> Basically, that's our meeting place whenever we go down to Phuket. Meet mates at the [Bar] at 7pm then go and get something to eat. [He] always runs a tight bar, he has always got security so if something happens it is taken care of then and there. S1 was also the go-to man…ten years ago, you could not get Australian TV, but he had a system of being able to piggy back off the satellite system from PNG. So if you wanted to watch Aussie Rules and cricket and things like that you got in contact with S1 who had somehow managed to find this satellite dish that somehow managed to pick up the satellite over PNG and then somehow magically you're sitting there with your mates watching the footy. (Declan, 58)

Information about key individuals was frequently offered by a number of participants as important elements of social networks. Individuals who were cited as important were highlighted as being *"well-known",* people who can procure things (*"magically"*), who could get things done, had respect for and some social contact with the locals, spoke some Thai, was seen to be *"fair"* and *"helpful".* Some of these influential individuals were described almost with reverence, as legends and heroes. For Jackson, who was in his 20s, the perceived difference in age and work status represented challenges to socialising with other ELoFTs:

> Most of the people here are retired. So, there's a huge age gap. Yeah, you just don't really meet them for that reason. They're doing different things. You know I'm out at 8 o'clock at night, they're out at 3 o'clock in the afternoon. They're playing golf during the day. I'm working, that sort of thing. You just don't bump into them all that much. (Jackson, 27)

Some participants were less likely to count other Australians as critical components of their networks. They reinforced a way of being inconsistent with their professed new identity:

> I've noticed in my travels, most people who are immigrants like to hang out with their own kind from the place they come from, this is true no matter which ethnicity or country of origin. My closest relationships in Thailand are with my wife, her family, and her immediate circle of friends. I've got better knowledge than most foreigners about life in Thailand. Because I've lived in it from the inside. (Kyle, 52)

This was echoed by Marty. For him, reducing contact with those from home was due to their existing norms and attitudes which were no longer consistent with his new identity or life circumstances. Reducing contact meant reducing exposure to negative norms which existed through previous strong ties:

> I'm disappointed with them because they're pretty chauvinistic mates. Well not only chauvinistic but racist, very much so. And I was not really racist but I would joke along with them and call them slope head and fish head and all that sort of stuff. But now it's my wife

> and it's my family and they shouldn't say those jokes around me anymore. You know I got married and they came to my wedding and that's virtually the last I seen of 'em. (Marty, 43)

For others, such as Peter, social networks in Thailand were much stronger than in Australia, something which sustained his connection with the new environment as it reduced social isolation. He described the impact of time on the evolving nature of his relationships with locals and with other Australians:

> I mean I have a lot of networking friends in Thailand where in Australia I don't have that sort of, uh those sort of networks. Originally when I was first there it was more with the expats than the Thais. But now it is mainly Thais. Most of the expats are dead. (Peter, 54)

Most participants, though less frequently those in hospitality or based in Phuket or Pattaya, spoke of the importance of local relationships, with both men and women. Peter described relationships formed over decades with local Thai women as critical to his social network:

> They're friends. They have been with me for 15 or 20 years. We just go out and have fun together, um, nothing sexual or anything like that at all but in the end it's a case of um something to do, go out to the bar and have a drink. (Peter, 54)

The tension between establishing relationships with locals and maintaining relationships with other ELoFTs was also highlighted. Often this was presented as a frustration or a necessary component of life in Thailand:

> Well, meeting people is very easy. There are many places, uh, guys sitting on tuk-tuks making gossip yakking on about a party or something. It's actually difficult to mix long term with locals. It's actually a bit of the language. It's very- it's tiring to translate in both directions. That's the big problem with mixing socially, most of the time. The cliché about Buddhists and Asians and the way they see things is actually true. I mean, sometimes when you're talking about one thing and suddenly you realise they're talking about something entirely different. I would say it takes longer to become, much longer to become friends with local Thai people than it does with Australians. (Ivan, 55)

Time was most frequently spent with partners, for those participants who had them, or with friends. Partners were an important vehicle for ELoFT socialisation. Participant descriptions of relationships with partners demonstrated complex negotiation, attitudes and perceptions. Many had multiple concurrent partners. Partners who had started as bar girls had become girlfriends and for some wives. A long running theme across this was the transactional relationship that existed, at least in the beginning, for many participants:

> So these marriages have convenience, not that they may not be without love, but certainly the ground rules are that in Australia, they kind of take care of certain things and make sure the house is clean and tidy and food and they can pretty much do what they want. The ground rules would have been sorted out over a number of trips to Thailand in the bars or in the cafes or wherever they work. You know, *"this is the way that I'd like to live"* and the other person would say, "*Yes, I'm happy with that, I like to live like this,*" and it would go from there. They're often an older guy, and they've got a younger wife or partner. She often had another marriage. And that's reflected in their Thai friends in Australia. They've got married young. They've had a couple of kids and now they sort things out for him and then he just goes to bar and drinks, or he plays a bit of golf and he's got mates and if he's Australian, then there'll be an Aussie bar, If they're French, they're going to the French bar. That's how it is, they mix in terms of their cultures a bit. (Marty, 43)

It was difficult to be certain as to the extent that partners were selected for companionship, caring roles, sexual fulfilment or a more equal, partnership-based relationship:

> Thailand seems to be unique in that way. I have used working girls a lot over the course of my life and I do have a high libido and a high sexual appetite. I've used working girls in Indonesia, Singapore, Europe, but Thailand is so different. I'm not immune to it either. You know like as we get older I'm not interested in children. I'm not really interested in marriage. I struggle with long-term relationships. Maybe I haven't met the right girl. I don't know, but guys my age I mean we become invisible to women especially younger women. If you're penchant is for younger women, not too young but, you know. (Stewart, 52)

These relationships were important features for some in their embedding to the local culture and networks. Expectations and norms around relationships dominated conversations for all participants. Participants identified women (and occasionally men) as important brokers into local customs and ways of doing, knowing and being. Craig described the important role played by local partners in smoothing the path into local community:

> …funny old thing because they had Thai partners, most of them. The Thai partners, they weren't just sexual partners, they were also translators, guides, and they would tend to go to the less touristy popular places because their Thai partners enabled that. (Craig, 48)

Trust was an important consideration here with most participants exhibiting a somewhat cynical view of such relationships, particularly amongst those who were single or who had been in previous long-term relationships or marriages:

> Towards the end I got a bit more cynical and a bit less trusting. I said I will give you support but if you don't do this, well then l I will pay to go out and bring you with me but I am not

> giving you anything extra. I knew they were still working on the game or they had boyfriends on the side. I wasn't fussed. I mean I am not upset about that. (Peter, 54)

However, the role of local partners in creating social connections cannot be underplayed, as described here by Kyle, for their ability to create a "*comfortable life amongst friends":*

> Sometimes I'm sitting in pubs, reading and drinking beer and watching. I remember once being quite surprised by the tone of some of the Australian men or mining people. They didn't seem like these rough, red-eyed, lascivious...hungry kind of characters. That's the stereotype…this is what Australian men do in Thailand. But they seem like nice guys getting together with their friends in the pub having a chat. And there seem to be some Thai women who are not these desperate young girls looking after their daughter…older women, who were working women shall we say, in the pubs, and seemed to be familiar friends with these guys. There's something else going on I don't really know about, but have seen glimpses of, which is something like a comfortable life amongst friends. (Kyle, 52)

Jackson described the challenges of local long-term relationships because of their perceived transactional nature. For him, and others, such relationships were weighed up and on balance deemed not worth it, both emotionally and financially:

> It doesn't really work. I did when I first came here but I got rid of that pretty quick because it doesn't work. It's not like the girl has her own job and her own money and lives by herself. If you have a girlfriend she wants to live with you. You've got to give her money. You've got to give money for her family. It's more expensive and it takes more of your time. Whereas, I'm just not interested in a relationship at the moment. (Jackson, 27)

For others, such as Bruce, trust and openness were at the core of sexual and emotional relationships. His description of his relationship suggested a process of building and testing the boundaries of the relationship and of overcoming tests of trust and commitment:

> We have a monogamous relationship. That's unusual for gay men in long-term relationships or even short-term relationships. There's a kind of intimacy that comes with that type of commitment that we both like. Well to Aran it was a really important thing. He was suspicious that I was the stereotype of gay men who go to SEA. So he was quite tricky about it. He put it to me that we should have an open relationship. He didn't want that, but that's what he put to me. I said to him, *"look to be honest with you I've reached a stage in my life where that's not what I'm interested in. So, you're going to be the person that I'm having sex with".* On the basis of that reply he decided that he would commit to me. (Bruce, 56)

An interest in carving out or seeking a relationship that was based on their own terms was evident amongst the narratives of many of the participants. Here Stewart described the

importance of being accepted, with the partner described as soft, pliable and generous, and the relationship as non-conditional:

> The girl I've met now is lovely and soft and loving and generous and accepts all that. If you want to get pissed, if you want to go to the club and smoke pot, if you want to have a cigarette you know well that's fine. You know she'll get pissed and have a cigarette too, from time to time. She's very accepting and I just find that so refreshing. So many of my relationships have been very conditional. But look, I want to tread really carefully. I don't want to promise her too much and get all excited about this great life together and then it all turns to shit. My last relationship six months in I was shattered when…I was in love then too, and I don't fall in love easily. (Stewart, 52)

This was echoed in other descriptions of sexual and emotional relationships between ELoFTs and locals. The desire for a non-conditional relationship is juxtaposed with the transactional nature of the relationship, suggesting some dissonance between desires and actions and speaks to issues of trust.

Those who were engaged in professional work were more likely to socialise with a range of individuals from around the globe, while those who were retired or were operating in the hospitality space were more likely to liaise and socialise with other ELoFTs. In this context, colleagues were seen to have shared values and subsequently created a strong foundation for work relationships that were identified more with the idea of family. Bruce explained his friendships that emerged from these professional relationships, which are indicative of strong network ties within an organisation that spilled over into more personal networks:

> The [Organisation] moved its regional office to Bangkok. We changed our location to be quite close to them, in fact, they used our office and my staff. We actually helped them get established and got to know them in that process. We became good friends with them -they were quite a mixed group. They became our main social group. I still have Facebook and email contact with a lot of those people, because you kind of develop this closeness. The [Organisation] calls itself a family. There's something about the integrity of people who take on those kinds of roles. They are people that you want to know…there is shared value and it is a really firm foundation for a friendship and it can develop very quickly. (Bruce, 56)

Daniel described a similar experience related to working with non-government organisations. His view was consistent with the adage ‘birds of a feather’:

> ... I find myself being interested and attracted to foreigners who've been there for a while and understand stuff. You get NGO people who hang out with NGO people…and then you get AusAID people, who will tend to hang out with other AusAID people...Not with the NGO

> people. Yeah [laughter], it's kind of like they'll hang out with them when they really have to, but, you know…I'm with AusAID... (Daniel, 45)

All participants reported minimal interest in socialising with 'tourists' or short-term travellers, "*Tourists were okay, but oh, people who didn't seem to, well, put something into the culture, I didn't intend to value their time"* (Marty, 43). Jackson elaborated:

> If you go to Bangkok you've got Australians working jobs and living normal lives. If you go to Ko Samui you've got drunk tourists partying with their shirts off just being idiots. I'd be out with a friend and we'd be sitting there watching this happen, watching these tourists party and we think, no wonder Thai people think Westerners are stupid, look at them. Thai people don't see Westerners working jobs, being regular people 48 weeks a year. They just see a few weeks a year they come here and act bananas… (Jackson, 27)

This distancing from those on the 'outside' appeared to be an important vehicle to establish insider status, or perhaps, as Dylan noted, was simply a result of where he lived:

> *[And what proportion of your time is spent with different groups that you have mentioned?]* Locals, um, my de-facto and her granddaughter most of the day. Expats maybe 1 or 2 hours a day. I don't mix with tourists because I live in a Thai area. (Dylan, 56)

5.9.2 Network Features

Participant narratives highlighted a range of salient features relating to creating community including the size, location and quality of relationships with other individuals and groups.

Many participants spoke of the quality of their relationships rather than the quantity. Those who had partners, those who were more interested in local culture or those who were not part of the hospitality industry or beach culture often indicated smaller networks:

> I wouldn't say a huge network. There's probably two or three expats. And at this point in time probably half a dozen Thai, local Thai people. Two guys. My girlfriend. Her friends, she's got quite a few. I'd like to you know be able to interact with them. (Stewart, 52)

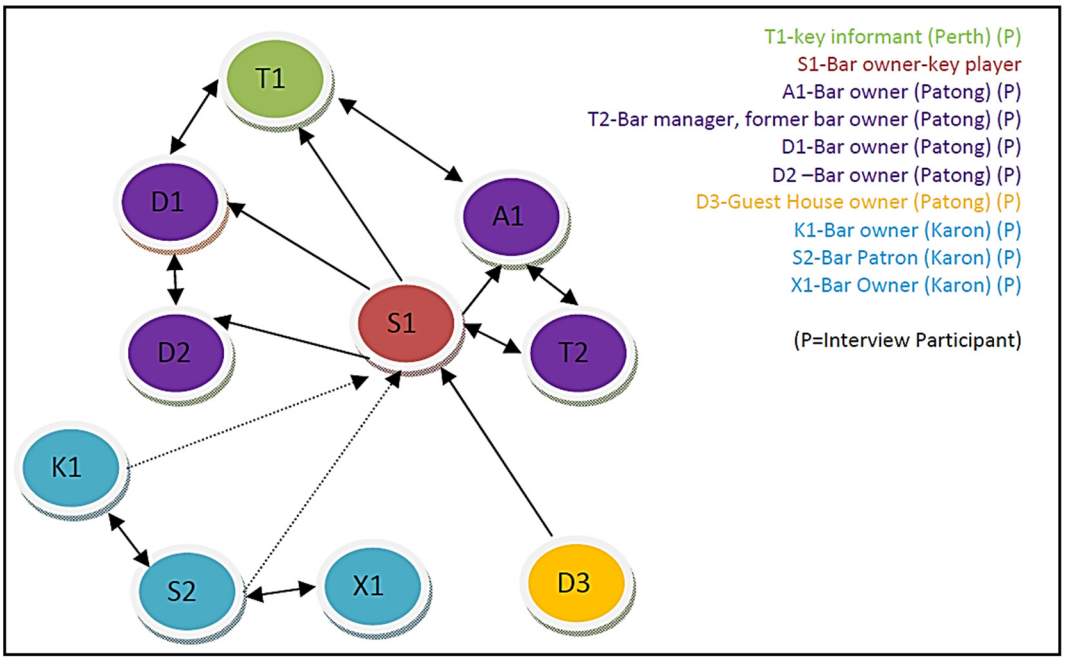
Participants noted the need to find 'your people', reportedly in a smaller community:

> You have to find your friends who are interested in the same thing and have the similar types of values. I found that harder to do that in Bangkok cos it was just a big city whereas Phuket was easy to walk in. When I was first down there, a guy opened up a restaurant bar. I walked in there my second day of work and he was showing the European Cup. On the second or third day that he opened, I was one of his customers. (Marty, 43)

Those participants based in Phuket or Pattaya were more highly networked with other similar ELoFTs, mostly attached to bars and the hospitality sector. Participants based in less dense, less tourist-frequented areas were more connected to partners and family. As an example, of participants interviewed in Phuket, all were connected with one another (see Figure 38). Within this small network there was a significant connection between the ELoFTs. All knew one another, and most had worked with or been in business with one another. Craig (48) suggested this was evidence of the *"Bacon Effect"* (Watts 2004a; Watts 2004b; Togher 2012) or of 'six-degrees of separation' as described by Ivan:

> I'd still say the half dozen guys at your guesthouse sitting at the front. We're on the same team I guess. And it's six degrees of separation so any time you wanna buy something for someone, someone knows someone who can procure that. (Ivan, 55)

Figure 38. Sociogram of small ELoFT network in Phuket



Some participants were more tightly networked than others, with the density of the network decreasing the further the participant was located from Patong Beach (the central hub of Phuket). Those interviewed in Karon and Kata were less connected to this core group (due both to geographic distance and also possibly bar size and time spent in Phuket), though were still aware of the other participants. In this network, all participants articulated connection to a central actor who was highlighted as having a pivotal role in socialisation and supporting new and long-term ELoFTs with evidence of thick trust, reciprocity and strong social ties:

> There's just, there's a lot of Australian expats staying here as well, that haven't got family so, it is a big social circle and we look after each other and, you know… (Derek, 45)

At the centre of this group was a key Australian (S1) living and working in Phuket for around 15-20 years, a bar owner. All participants knew S1 and indicated that he was the *"go to guy"* on arrival in Phuket for advice and also in providing a space to socialise with other ELoFTs. In this small network, friendship groups and networks were substantially with other ELoFTs who linked into their networks.

Participants indicated that while they socialised with other ELoFTs (particularly Australians and the British), there was a perceived cultural divide, *"It's the British and the Germans – never trust the Germans"* and a financial divide where *"big players",* (including S1) those that had money, played golf, owned or operated significant business interests were more likely to *"move together"*. If participants had regular social environments they were most likely to be in Australian owned bars, viewing this as supporting their countrymen.

Many others interviewed, whilst not actively part of these networks, were aware of them and their key group members and engaged with them from time to time. Those participants based in Bangkok or other provinces were less likely to be connected to these networks and instead built their networks with both ELoFTs and locals. These networks appeared primarily based on work connections initially but over time included more local people.

5.9.3 Social spaces

Participant narratives suggested that they were embedded within a number of social spaces that included formalised clubs (e.g. Rotary), less formal sporting or other groups (e.g. running groups, bowls clubs), or other organisations and institutions (e.g. Chambers of Commerce, Thai Australia organisations) which served a range of needs. Place was also used to create enclaves with a range of symbols used to denote connection to country of origin. For example, bars named for country 'Aussie Bar', or having country style activities (football on the TV, Australian style food or beverages) and flags and other paraphernalia that suggest it is somewhere welcoming of its 'own kind'. How participants presented themselves in these social networks also appeared important in sustaining their relationships and ensuring continued access to social networks:

> I think I'm a pretty sociable person, I like talking with people, I like learning from people, and I like learning about the places people come from, I'm always enriching myself by interacting with people, so you know... (Kyle, 52)

Formal structures for connection were described by participants. Participating in groups such as Rotary or sporting clubs or visiting formal expatriate clubs, was said to create a level of formality and familiarity which provided a bridge to the new place with inherent structure, ritual and routine. Marty described the broad social networks of ELoFT teachers and the connection formed through structured activity such as being part of the sailing *"scene"*. He ascribed value to the action-oriented socialising of the sailing community, contrasting it with the bar scene. Common to both settings was drinking and socialising. Marty distinguished his socialising from that of others, as away from the bars and more like Australian dinners in people's homes and in restaurants:

> Because I was a teacher, I met other teachers. I often went out with their social network- they were a bit of a mixed bag, sometimes older, sometimes younger… And the ones that had lived in Phuket for some time. There's a big sailing community. I met a few people through that. The sailing community there's a bit different from the rest because the community has been very well established and lots of people have been living there for a long time. It's different from the bar group. They drink a lot but then they go sailing. People live on boats and come to shore for three or four months and they hang out. A lot of people worked as charter captains, etc. So through that, I met a whole set of different people. But typically, our socialising would not be in bars so much, it would be in restaurants. And because people were more settled, often they have nicer houses as well. So, we go to their house and we make our food and do a bit more like Australia. (Marty, 43)

Stewart (52) described a concrete example of connection to his new home through a bridging network. This connection and participation started in Australia and created social occasions, opportunities to learn about the symbols and rituals of Thailand and a chance to *"get involved"*. For Stewart, and many other participants, this bridge provided a connection to locals rather than only to other ELoFTs:

> I Googled Thai language courses and the Thai-Australia Society came up. And they have been a fantastic resource. Because they're a real hub and there's so many Thai people involved anytime you go there. (Stewart, 52)

Bars and pubs featured prominently throughout narratives as important settings for ELoFT socialisation. They appeared to serve several functions, as a central meeting place for connection and as a bridge between country of origin and destination and a symbol of home. Even the smallest pubs which only seated 10 people, gave *"something to do and it is a meeting place to meet up with other expats".* Narratives indicated that the size of the bar

was not the deciding factor in where to socialise but generally how long the bar and the bar owner had been in a location. Here Marty described his participation in the bar scene:

> *[You mentioned that there was co-mingling between people from different culture backgrounds. How common do you think that was?]* Well, there's English bars, there's German bars, there's French bars, Irish bars, Canadian bars, whatever, there'll be a bar of a nationality that if you wanted to go along and experience that. But you maybe wouldn't go there every night. You might go and try a few other friends' bars cos you met an American and he's got a bar. So you go to his bar at one night. And then you might go to a German's another night. So, most of the time, you go to the one spot. You go to your favourite, but you would get around. And so, you would mix with those other ones. (Marty, 43)

Socialising and socialisation also occurred online or via the use of technology. For many this created bridging capital between networks in country of origin and destination and bonding capital as relationships formed with other likeminded individuals in online communities, *"I consider them a vital part of maintaining contact with others and keeping up with world events"* (Jake, 65). Most participants spoke of the use of social networking sites such as Facebook and other online tools to make the world smaller. Technology was viewed as a way to deepen relationships, as articulated here by Stewart:

> I tell you what has been an interesting experience with this relationship. Over a period of time it sort of evolved and I guess social media has had so much to do with that because we can talk freely daily. But also with the communication her English is not real flash and my Thai's not real good either. But through emoticons and photos there can be so much interchange, which has really helped us to grow. Facebook's great. I wasn't a fan before and I love it now. I remember the days when we'd have to arrange a time to phone and she'd have to be on the end of the phone, or we'd be writing letters and it would be a month before you got something. Whereas now it's instant…it's so much richer. (Stewart, 52)

5.9.4 Activities

Participants engaged in a range of everyday, shared, visible and hidden pursuits. These socialising activities with their communities for some was much more 'social' than their time in Australia. Peter, for example, who was back in Australia whilst waiting to have surgery at the time of interview, noted:

> I go out to friends' places every once in a while. I tend to go out more in Thailand and I have a bit better social life. You have never really had a proper party, unless you've had a Thai party with some of my Thai girlfriends. (Peter, 54)

Declan described the everyday activities that he and others engaged in within their social networks, with a focus on the ritual and symbols of routine and structure:

> Well we have got a pretty structured thing over here. Monday night is stay at home and the wife cooks, Tuesday and Friday nights we go to a local restaurant and meet up with an English couple and chin wag. Typically, Tuesdays and Thursdays I block out to help with my friend's tour company and after that I go up to Bangkok and hit one of the little bars. Saturdays is normally our shopping day so we'll go to the big C and maybe go out for a meal at one of the little restaurants here. Sunday is pretty much like a Monday. (Declan, 58)

Declan's description was representative of observations by Beaverstock (2011) who suggests important features including key social spaces, 'everyday' structured activities, and shared pursuits sustain an expatriate's everyday life. This theme was consistent in the narratives of a number of participants. For some, rest and relaxation took place at home in front of the TV. Others participated in familiar, 'Western' activities, for example watching the football or cricket or observing ANZAC Day. Participants described social activities that provided common interests in sports, and other activities that demonstrated comradery such as golf, bowls. Activities created routine, and suggested enhanced social capital through the creation of both weak and strong ties:

> *[Do you ever have…functions? Is there a time that you get together as a group and visit the other bars together?]* What, in their space? Yeah, like a lot of them, they play golf, I used to. There are golf days. Lawn bowls. I only get one day off a week anyway. I go home and stay home. Or go to X's house for a swim. *[I can't remember if you said you mixed a lot with expats other than Australians...*] Yeah Aussies, English. I've got many friends. (Tom, 44)

Other participants, particularly those working in hospitality, indicated that when they spent time together they visited with each other at their businesses and talked about work:

> I know a lot of friends that work in the bar industry. They come round my place and I go down and see them and we will just sit and eat and talk and get together. (Jackson, 27)

Participants also described a range of visible and more hidden pursuits in which they and others may have taken part. Visible activities were common to most narratives and centred on the activities described above, those that sustained and enhanced everyday life. Such activities were an important ritual in meeting new people, for example participants described the *"barbie"* as a symbol of 'Western' social connection.

A range of less visible or hidden activities were also described or alluded to. This usually related to sex or drug use or other illicit activity. In this context, strong social ties and deep

trust were highlighted as very important due to the nature of the activities and the potential ramifications from participating in such behaviours. In this narrative provided by Daniel, social networks created strong social capital and network sanctioned behaviours, some of which may have been considered deviant, some of which may have been harmful and some of which were illegal:

> There is this network of cafes and bars that people know of. If you want this particular flavour of child or whatever, you go to this café. Everybody else is there for the same reason…it's like this bizarre mateship bonding thing, 'nudge nudge wink wink' we both know what we are after and why we're here. If you ask for a particular flavour, then they'll say, *"Oh, yeah. If you want lady boys, this is a place to go to"*. (Daniel, 45)

5.9.4 Summary

All participants existed in the liminal space. Away from 'ordinary' structures and rules, there emerged a sense of communitas. Here, experiences around the development of networks and community are explored through a range of factors: people, network features, social spaces and activities (see Figure 39).

Figure 39. Key themes emerging relating to creating community

5.10 Summary

ELoFTs formed and re-formed social identities negotiating a complex outsider-insider relationship with their country of destination as they learned the *"rhythms and routines of life"* (Longino Jr, Perzynski et al. 2002, p.32). Five distinct but overlapping categories of ELoFT identity and experiences emerged: professional, authentic, second chance, family and quality of life. While the domains assisted to conceptualise the ELoFT identity, categorisation remained complex:

> There are so many types of expats. It's easy to differentiate according to the quantitative stuff-are they presented by the company? Do they make money? But the qualitative stuff, I would argue, is more important. Are they there because they're escaping the rest of the world… a big fat white fella…I'm going by stereotypes… sitting there having a nice life in Thailand, Indonesia... Or are they genuinely interested in learning from the culture, giving back to the culture. What are you really here for? Is it transferring your life from there? A lot of WA people are like that. They say, *"I've been to Bali many times. I know all about Bali."* They're doing things in Bali they can't do here but can't and they do it in Bali instead - going to the beach, getting drunk, rather than really understanding…I don't feel anything in common with them...I certainly don't see myself as being any better or different. Just my viewpoint is different. I find myself going back to that side of that question, being interested and attracted to foreigners who've been there for a while and understand stuff. (Daniel, 45)

Identity became a critical and defining condition for and result of the development of social networks (explored further in Chapter Seven).

Participant journeys represented pre-migration diversity with a range of subsequent pathways to and motivations for expatriation and travel. Pathways were categorised as self-initiated, assigned, encouraged or opportunistic, while key motivations emerged as security, escape, wanderlust or challenge. These pathways and motivations were linked to different pre-migration circumstances which had subsequent implications for post migration experiences, the trajectory of adjustment and the choices ELoFTs made about their social networks. Motivations and pathways were influencing factors for the development of an ELoFT identity (and to the created Identity categories), experiences of adjustment and support, awareness and practices related to risk and the type of community and networks formed explored further in Chapter Seven.

Place represented an important element of the migration journey, inherent to the (re)construction of ELoFT identities. Meanings associated with SEA were the product of

interactional processes involving individuals, the setting and their social worlds. In SEA, ELoFTs created a new transnational place, full of contiguous spaces for re-invention. The in-between was a place to get life on track, or back on track or to drop out. In remaking a sense of self in a new place, individuals were free to explore other versions of themselves and what was *Other* became normalised. The relationship between identity and place was reciprocal, both shaping and being shaped by each other. Place was commonly constructed as emotional, mythical or commodified. These constructions were influenced by stereotypical representations of country of origin and destination, a male and post-colonial gaze, attitudinal positioning, living in a liminal space, creating an idealised home, and viewing country of destination as a permissive Neverland. Place becomes a critical element of the grounded theory and conceptual model presented in Chapter Seven, in particular as it relates to potential settings for intervention as well as the vehicle which shapes the context for the expression of identity and the practice of risk.

Learning to live successfully in the country of destination or in the liminal space required significant adjustment. This occurred through three key domains: early experiences; participation and embedding; and managing expectations and difference. Participants had perceptions of Thai culture, customs and traditions which required navigating family, religion and spirituality, language, rules and routines, food, relationships and work. Successful embedding required receiving cues about customs, building confidence, mastering language and establishing connections and routines; important components of participant identity formation and socialisation and engagement with and development of social networks. Adjustment was a critical component of the development of ELoFT community and communitas and subsequent social networks, which is described in the grounded theory and explanatory conceptual model presented in Chapter Seven.

Risk was explored as it related to motivation, management, awareness, types and perceptions. ELoFTs generally viewed themselves as experienced with risk. They also viewed themselves as less vulnerable to risk due to a range of past experiences and current practices. Nonetheless ELoFTs described awareness of and experience with a range of risks namely: everyday risks, reward-based risks, karma, personal health, Australian assumptions/ethnocentrism, navigating relationships and hard living. Motivations for risk were: lack of common sense; pleasure; fate; security; connection; and culture. They indicated a number of strategies to mitigate risk: judicious use of healthcare and doing your homework; redefining safer sex; and slowing down and harm reduction. In Chapter Seven risk is contextualised in the explanatory model in influencing adjustment, support and

home, and influenced by journey, identity and place. This information is critical to understand how ELoFTs understand their vulnerability for HIV or other STI transmission in SEA and to determine points in ELoFT social networks where an ELoFT may be more or less vulnerable.

Giving and receiving support were important contributors to the development of ELoFT social networks, often related either to mateship or to getting ahead financially. Support provided was primarily tangible, informational and network support which was critical to promote a sense of community connection and belonging. Participants received support via sources including key people (partners, friends, other ELoFTs, colleagues etc.), online and offline support (books, newsletters, websites, blogs etc.). Support was a critical component of the grounded theory and explanatory conceptual model presented in Chapter Seven. It was an important dimension in learning about new environments and influenced ELoFT experience and speed of, transition and adaptation to their host community and new social networks, reducing social isolation and decreasing the perceived social distance from their country of origin.

Narratives demonstrated the precarious nature of migration. Four key themes related to home emerged: ambivalence about Australia, (im)permanence of home, SEA as a utopian destination and relocation. It was evident that regardless of the perceived permanence of their migration, participants resided in a liminal space with aspects of origin and destination coalescing to form a new sense of home, and for many they continued to have one foot in each location. ELoFTs were 'place-time spanners', located, dislocated and relocated at different times and in different places. Home became a symbol for the ELoFT migration experience meaning safety and security for some, for some it meant escape from repression, and for others still a better way of life. This played an important role in their adjustment or feeling of being 'settled' in their new environment and their ability to connect to the space and others around them. In relation to the grounded theory and conceptual model presented in Chapter Seven, *Home* was an anchoring concept for the migration experience and a context for the transition to ELoFT, a sense of belonging and community and the creation of networks.

Despite its diversity, commonalities existed within the broad ELoFT group. Participants formed enclaves with other ELoFTs by signalling their likeness through a range of symbols such as serving familiar food in their bars, using flags and names that signal that others like them will be welcome. Participants engaged in a range of socialising activities with their

communities. Visible activities were common to most narratives and centred on those activities that sustained and enhanced everyday life. Community was facilitated through key social spaces (formal, bars, online), activities (every day and shared pursuits, visible and hidden pursuits) and people (old ties, new ties). Particular locations, those in beach-based tourist destinations suggested denser connections with most participants articulating connection to a central actor who was highlighted as having a pivotal role in socialisation and supporting new and long-term ELoFTs. This provided evidence of networks with features of thick trust, reciprocity and strong social ties. The community and communitas which emerged in a place viewed as relatively permissive and free from familiar structures became the vehicle through which ELoFTs created their social networks. This is discussed in more detail in Chapter Seven in relation to the activities, people and places which created shared bonds and aims and through which intervention for public health may be possible.

Each of the key concepts were critical to the development of the grounded theory and explanatory conceptual model that is presented in Chapter Seven. The concepts became the properties, conditions, strategies and context through which:

1. ELoFTs developed and sustained their social networks; and
2. how the networks could be used for public health intervention.

The following chapter explores many of these themes and key concepts of SI as they emerged through observation and analysis of interaction in an online forum frequented by ELoFTs.

6. Online Forums

And I've traveled round the world from year to year
And each one found me aimless, one more year the worse for wear
And I've been back to South East Asia/But the answer sure ain't there
But I'm drifting north, to check things out again, yes I am
Well the last plane out of Sydney's almost gone
And only seven flying hours, and I'll be landing in Hong Kong
There ain't nothing like the kisses/ From a jaded Chinese princess
I'm gonna hit some Hong Kong mattress all night long

- Khe Sanh, D. Walker, 1978 -

PRELUDE

In this chapter, findings are presented from the observation and analysis of the online forums. These are presented in the form of the following peer-reviewed publication:

> **Crawford G,** Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research.* 2018; 20(9):e10787. doi:10.2196/10787 (Impact Factor: 4.945)

Chapter content relates to the following objectives:

1. To build a deeper contextual understanding of culture and personal behaviour amongst Australian ELOFTs in Thailand and SEA.
2. To describe the socialisation process and pathways experienced by Australians (potential new ELoFTs) interacting with Australian ELoFTs in Thailand and SEA
3. To investigate the roles of Australian ELoFTs as mentors and potential change agents within ELoFT social networks in Thailand and SEA.

6.1 Data from analysis of online forums

Publication 5: Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveller Networks: Qualitative Study of Peer Interaction in an Online Forum

Citation: Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research.* 2018; 20(9):e10787. doi:10.2196/10787 (Impact Factor: 4.945)

Original Paper

Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum

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Abstract

Background: In high-income countries such as Australia, an increasing proportion of HIV cases have been acquired overseas, including among expatriates and travelers. Australia's national strategies have highlighted the need for public health interventions for priority populations. One approach is to expand efforts to places or spaces where expatriate communities reside. Online settings such as forums used by expatriates and travelers have potential for preventing sexually transmissible infections with those hard to reach through more traditional interventions.

Objective: Our objectives were to (1) identify and describe domains of social interaction and engagement in 1 online forum used by Australian expatriates and travelers living or working in Thailand; and (2) make recommendations to health-promoting organizations and policy makers regarding the role of these forums in public health interventions with mobile populations who may be at risk of acquiring HIV or other sexually transmissible infections.

Methods: We identified forums and users in 2 stages. We identified 13 online forums and analyzed them for inclusion criteria. We searched 1 forum that met the required criteria for users who met inclusion criteria (n=5). Discussion threads, rather than individual posts, were units of analysis. For each user, we collected as transcripts the first 100 posts and 10 most recent posts, including the thread in which they were posted. We analyzed and thematically coded each post (n=550). Transcripts and analyses were reviewed and refined by multiple members of the research team to improve rigor. Themes were not totally emergent but explored against symbolic interactionism concepts of presentation of self, meaning, and socialization.

Results: Key domains were as follows: the forum (characteristics of the space and reasons for use), gaining access (forum hierarchy and rules), identity (presentation of self and role of language), advice, support, and information (sources of information, support provided, influencers, topics of discussion, and receptiveness to advice), and risk (expectations and perceptions). The forum exhibited evidence of unique language, rules and norms, and processes for managing conflict and key influencers. The forum was a substantial source of health information and advice provided to users via confirmation, reassurance, or affirmation of beliefs and experiences. Risk perception and expectations varied. Risk taking, including around sex, appeared to be a key expectation of travel or the experience of being an expatriate or traveler.

Conclusions: Australian expatriate and long-term traveler participation in the online forum formed, influenced, and reinforced knowledge, attitudes, interaction, and identity. Such forums can be used by policy makers and health-promoting organizations to provide supplementary sources of support and information to hard-to-reach mobile populations who may be at risk of acquiring HIV or other sexually transmissible infections. This will complement existing engagement with health professionals and other public health interventions.

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KEYWORDS

HIV; STIs; men; public health; health promotion; online social networks; social support; travel; human migration; emigration and immigration; sexually transmitted diseases; social networking

Introduction

Overview

In high-income countries, including Australia, population mobility has led to changes in transmission patterns of HIV and other sexually transmissible infections (STIs). An increasing proportion of diagnosed cases have been acquired overseas, including among expatriates and travelers [1-5]. Developing interventions to respond to these increases is challenging in part due to geographic barriers to those affected. Online settings can overcome such difficulties. We explored social interaction and engagement in 1 online forum used by Australian expatriates and travelers living or working in Thailand who may be at risk of acquiring HIV or other STIs. We sought to determine the possible uses of such forums for public health intervention, providing new insights for health-promoting organizations and policy makers working in sexual health with mobile populations.

Background

Migration and mobility are inevitably connected with changing environments. Expatriates and travelers may experience a high degree of liminality (described by van Gennep and Turner as transition, a sense of being "being betwixt and between", as reviewed by Thomassen [6]) within and between environments, raising issues of identity and belonging. Research by Brown and colleagues [4] with Australian male expatriates and long-term travelers residing in Southeast Asia suggested that identity and behavior were strongly influenced by local social networks. Support and guidance on how to adapt to the social and cultural norms were gained from peers.

Such findings have implications for the way that countries develop their response for HIV and STI prevention, treatment, and care. Australian frameworks have highlighted the need for public health strategies to target priority populations, including men who travel overseas frequently for work or leisure [7]. One way this may be achieved is to expand intervention efforts into places or spaces where expatriate communities reside [2-4,8], including online settings such as forums used by expatriates and travelers.

Online spaces provide a medium for education and prevention, an approach used effectively with marginalized or vulnerable groups in areas such as youth mental health [9] and public health interventions with gay and other men who have sex with men [10]. Such settings can enhance social capital and community connection and decrease social isolation. This is particularly the case for those who may be difficult to engage or access through more traditional communication methods, or for those who may not identify with general health promotion messages [3,10-13]. These methods may also reduce socioeconomic or geographic barriers caused by stigmatization and afford some level of anonymity to individuals seeking support or information online [10,14-17].

For mobile populations such as expatriates and long-term travelers, connection online may reduce perceived and actual distance between country of origin and destination. Such spaces may reduce some of the liminality experienced or create a "home away from home" [18]. Online communities facilitate peer influence as platforms for individuals to exchange social, emotional, and informational support, share experiences, and seek advice [19,20]. These functions may prove useful in regard to health advice, resettlement, and language, as well as contributing to a sense of belonging [21,22] or a deepening connection to the destination country and others within the peer and social network [18,23].

The Study

There is a lack of literature describing the online information-seeking behaviors of expatriates and other long-term travelers and how advice from their interactions with one another online may influence risk and protective behaviors. This study built on our understanding of Australian expatriate and long-term traveler risk behavior, culture, and experiences [3,4] and the lessons learned from previous successful use of peer influence models with communities and populations at risk for acquiring HIV and other STIs, particularly in Australia [24].

This paper describes an in-depth analysis of social interaction in 1 online forum used by Australian expatriates and travelers in Southeast Asia. We identify the way in which the forum functions as an online community, describing engagement between users; user identity and how the forum mediates this; types of advice and information shared and acceptance of that advice; and perceptions of risk. We make recommendations for policy makers and health-promoting organizations to use these findings to develop, improve, and expand the reach of public health interventions to reduce the transmission and impact of HIV and other STIs with mobile populations who are hard to access.

Methods

Overview

This research was part of a larger qualitative study to determine whether the social networks of Australian male expatriates and travelers in Southeast Asia can support strategies to reduce or prevent the transmission of HIV and other STIs [1]. The focus of this research was to develop greater understanding of Australian expatriate and traveler culture, behavior, and socialization and the potential for members of the target group to act as social influencers around knowledge, attitudes, and behavior. We used conversations from online forums as (1) a source of data and (2) an audit of spaces that expatriates and travelers frequent to assess the online environment for its potentiality for intervention.

Conceptual Framework and Methodology

Symbolic interactionism provided the conceptual framework underpinning this study, as it has useful application to public health [25] and to sexuality and HIV specifically [26]. The symbolic interactionism perspective supports the idea that social interaction is used to construct reality and that individuals interpret and respond to objects and others' actions based on meaning that is created by interaction [27]. Analyzing forum discourses in this way provided insight into how individual attitudes and behaviors were influenced through social interaction. Charon [28] suggested that symbolic interactionism allows for exploration of the development of self and self-identity and how this is influenced through social interactions. We used this point of view when exploring the transition from novice forum user (newbie) to experienced forum user (expert) and to understand how individuals may come to self-identify as an expatriate or long-term traveler.

Research Team

The research and authorship team was composed of 5 members experienced in public health research. Of these, 2 were students at the time of writing. Several members of the research team had experience working in community bloodborne virus organizations, while others had experience working with marginalized or vulnerable groups through qualitative and participatory action research. All members of the mixed-sex team had spent time in Thailand, with 3 of the members collaborating on previous research in Phuket at the commencement of the research project. Members of the team were also experienced in conducting research in the use of online strategies for public health [14,29-31].

Selection Criteria and Forum Search Strategy

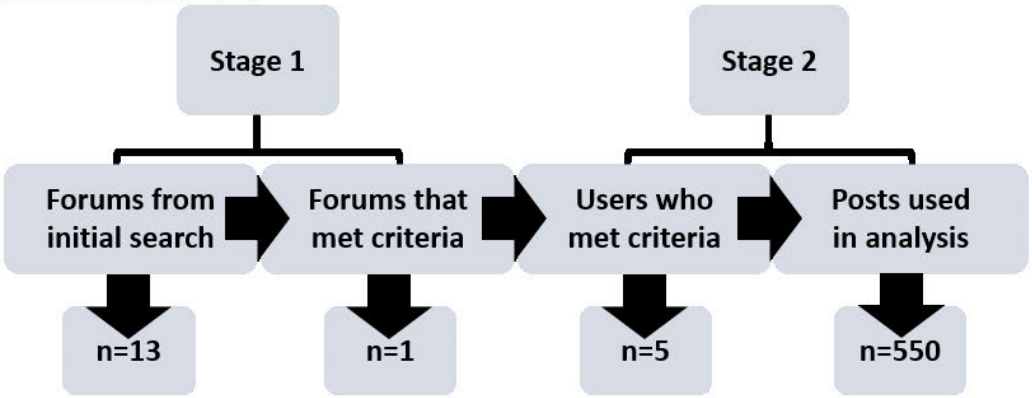
We undertook a comprehensive internet search over a 2-month period to identify forum users for inclusion in this study (Figure 1), described below.

In the first stage, we identified online forums frequented by the target group (Australian male expatriate or long-term traveler to Southeast Asia) through an internet search. At the time of writing, there were at least 10 online forums with thousands of members that Australian male expatriates and long-term travelers were using.

We determined the internet search terms by reviewing commonly used terminology on a variety of forums and a thesaurus search, guided by a review of the literature. Members of the research team provided consensus on search strategy terminology. We entered search terms into Google (Google LLC, Mountain View, CA, USA; Textbox 1) and identified a total of 13 forums.

Search outcomes were checked by 2 members of the research team to ensure consistency. We selected potential forums according to a list of predetermined criteria (Textbox 2). These included whether the forum met the criteria for an online community as operationalized by Herring's 6 dimensions: (1) active participation, (2) shared culture and norms, (3) roles, rituals and hierarchies, (4) a distinct identity, (5) solidarity, and (6) support and conflict resolution [32].

Figure 1. Process of identifying users.



Textbox 1. Google search terms.

(Forum OR blog OR chat room) AND (Expat* OR foreigner OR 'long term traveller*' OR 'permanent tourist' OR 'permanent resident') AND (Thai* OR 'South East Asia' OR South Asia OR Southasia) AND (Australia* OR Aussie OR Oz)

Textbox 2. Forum inclusion criteria.

Posts are accessible to the public.
Users include Australian males who have resided or are residing in Thailand.
Allows identification of the nationality and sex of users.
Allows individual user's post history to be tracked.
Conforms to Herring's definition of an online community [32].

Of the 13 forums, only 1 met the selection criteria and was included in this study. We excluded other forums because (1) we were unable to access a sufficient number of posts, (2) the nationality or sex of users was unclear, or (3) sufficient data were not publicly available.

In the second stage, we searched the identified forum for users who self-identified as Australians, who had resided in or were currently residing in Thailand, and who had created over 100 posts (determined to be a sufficient number to enable the analysis of the socialization processes along the trajectory of forum user newbie to expert [33]). Using these criteria, we identified 5 users for inclusion, and we considered their posts and interaction with other members for data collection.

Ethical Considerations

Ethical challenges related to conducting research within online communities include how, whether, and from whom informed consent is gained; whether anonymity can and should be protected; and sensitivities relating to communities that may discover they are being "researched" [34]. We reduced the risk of altering online discussion based on our presence by not making ourselves known on the forum and not becoming members. This was consistent with other studies where researchers have taken on a remote or objective role and allowed conversations to continue unhampered by the presence of an outsider [33]. Curtin University, Perth, Australia, provided ethical approval for this study. In line with the requirements of the institutional ethical approval and to protect the integrity of the forum and the anonymity of users and their contributions, we have not identified the forum and have deidentified individual users.

Data Collection

Because a forum user's post rarely occurs in isolation, meaning would be lost if the post is not considered within the context of the surrounding discourse and interaction with other users. Consequently, we collected both posts and threads. We took the definitions for threads and posts from Arsal and colleagues: (1) threads are "hierarchically organized postings." and (2) posts describe, for example, "a message written in the online community forum" [22]. For each of the 5 included forum users, we collected their first 100 and 10 most recent posts, along with the thread in which they were posted. This involved using the forum member list to search for the profile of each user and then accessing their posts and threads. We then captured the posts and threads as transcripts of activity.

Analysis

Discussion threads on the forum, rather than individual posts, were the units of analysis. We imported transcripts into NVivo 10 software (QSR International Pty Ltd). Each post was analyzed and coded thematically by a member of the research team, and a sample of transcripts was validated by a second researcher. This process continued until each of the 5 users' posts (n=550) had been coded thematically. Then, 3 research team members reviewed transcripts, compared analyses [3], and developed and refined themes. The remaining team members reviewed samples to improve rigor. Themes were not totally emergent but explored against symbolic interactionism concepts of presentation of self, meaning, and socialization [28], with a focus on interaction within the forum.

Results

The following were the key domains produced from the analysis: *the forum* (characteristics of the space and reasons for use), *gaining access* (forum hierarchy and rules), *identity* (presentation of the self and the role of language), *advice, support, and information* (sources of information, support provided, influencers, topics of discussion, and receptiveness to advice), and *risk* (expectations and perceptions).

The Forum

The forum was well used by Australian male expatriates and long-term travelers. Relatively new at the time of writing, it had over 900 members internationally and in excess of 300,000 posts and 7000 threads. Public information included a member list presenting the member handle and avatar, user join date, number of posts, and last visit to the forum. Data on user numbers at any given time (and status as either member or guest) were also available. It was common for the forum to have several hundred active users at any time, with peak use involving several thousand users (comprising members and guest users). Guest access provided limited viewing access to publicly available spaces within the forum. Member access provided users the ability to post on topics, communicate privately with each other, participate in polls, and upload content.

The forum facilitated a space where those visiting or living in Thailand could seek and provide advice, and establish and maintain online and offline social networks. Forum topics included visas, language, navigating cultural differences, health, sex and relationships, where to go for a night out, and how to avoid being "ripped off." Users demonstrated an interest in building a community of like-minded individuals, which appeared to be an expected and enforced 2-way interaction, as evidenced by a post from a member:

> *Whilst forums can be supportive of different points of view, in my view they ultimately work because membership is primarily comprised of like-minded*

> *individuals that want to pursue similar goals...In (our) case, it is about genuine desire to understand Thai culture, and give it due respect.*

This sense of reciprocity was reinforced by the forum moderator as critical to new users: "part of the forum is the giving and receiving of information, it is maybe how we learn or get to know someone."

Users displayed protectiveness toward and ownership over the forum:

> *We are passionate about the Forum so some people will react to some things said as we are all trying to protect what we have here...if you are just Trolling, this is not the place for it.*

Staying connected to each other, and to Thailand, while in different parts of the world appeared to be the primary reason for using the forum. For example, users who now lived in Australia used the forum to "cure the LOS [Land of Smiles, slang for Thailand] blues." Social ties were developed and enhanced through forum use. As a user commented, "It is great how close everyone has become over a Forum. I cannot wait to continue meeting everyone and sharing my story as it goes on." Seeking connection was exemplified in the posts of 1 user, who suggested the forum provided a way to "kill the loneliness" and meet new people when in Thailand. Quick to extend invitations to new and old users to meet in person, he used extensive knowledge of Thailand, including language and music, to provide advice and establish a connection:

> *You sound interesting. You also sound like you would welcome some tips and tricks over a few drinks...I lived in Bkk [Bangkok] for 11 years, speak the lingo but now spend just two months a year there.*

Several users posted prolifically but tended to avoid sharing personal information and instead offered advice on a variety of topics, such as visas, motorbikes, and relationships. The owner of a pub, who also appeared to know other users offline, used the forum to promote his business, without appearing as though it was advertising. He offered himself as a source of local knowledge, noting "I'll help any visitors as much as possible."

Gaining Access

A hierarchy was evident on the forum, with 3 levels of access ranging from publicly available threads and posts to higher-level, invitation-only spaces, not openly accessible. This hierarchy and structure provided users with the opportunity to become more involved and more deeply connected with the forum and peers.

Level 1 was public; members and nonmembers were free to read posts and contribute posts once they had created an account. It contained general information on life in Thailand, such as relationships, visas, and travel advice. Posts of a sexual nature were not permitted. As the forum moderator described, "P4P is not a focus here so keep it general, if you want prices here is not the place." P4P is a term used to describe pay for pleasure, sexual services provided for money. Private threads in the upper levels containing useful and appropriate advice for the public were generally moved by moderators to level 1.

The second level was accessible once a user had made 30 posts. Users shared more personal information, including photos and details of relationships and sexual behavior. It was described as a place where you could "get down to the nitty gritty." A new user deemed "one of us" would be quickly welcomed and encouraged to post more so that they could access this level. This occurred when a user posted for the first time and was told that "A few more posts and a whole new world will open up on here," "An experienced guy like you...you're [*sic*] input will be welcomed...," and "You are 3 posts off getting to a totally new world."

The third level was by invitation only. One of the users, realizing he did not have access after posting on level 1 over 50 times, asked how to gain access and was told to send a private message to the moderator as "It's a secret handshake not a post count." He then gained access ("I've been admitted to the secret society. Now I'm off to practice that handshake ;)") and was told by another forum user to "enjoy and contribute...some smut 555" (5 in Thai is pronounced *ha*).

An administrator oversaw forum operation along with 2 moderators. Rules guided forum behavior, which were rarely but explicitly spelled out for users:

> *...no personal attacks will be tolerated!! Any personal abuse will be deleted. Repeat offenders will be given a yellow card [sporting reference relating to the use of a yellow card to caution a player about their behavior].*

Interaction demonstrated clear self- and peer moderating. Users reinforced expected behavior regarding contributing and valuing opinions and respecting Thai culture. Users quickly excluded new users who did not meet rules:

> *If you are here to play games...well we are not game players and we will just go quiet. Welcome to the Thai way. We just go quiet.*

Those familiar with the rules quickly resolved miscommunication or disagreements. An example of this was when a user posted a link to discuss with other members but did not contribute his own opinion. Another user challenged him, "May I ask what your problem is? You post a vid, people are responding to it, without any contribution of your side". The first user responded, "You are right it is a discussion and I have not offered an opinion." He attempted to prevent further miscommunication, "I do enjoy your posts, which show a keen understanding of the human condition. I think...wow there are some smart dudes on this forum."

Identity

Users decided on their presentation of self, creating online avatars and identities, and providing data establishing their credibility and belonging. For example, one user described himself as a "no-one in Australia and a VIP in Thailand."

Each of the 5 included users identified as Australian, were proud of their culture, and identified as "Aussies in Thailand." Posting in the forums reinforced this sense of Australian identity in relation to law, food, sport, or society, for example, a posting about Australian-style bars: "Chiang Mai's only genuine big

Aussie pub...Great old fashioned Aussie style hamburgers and more..."

For some users who traveled back and forth between Australia and Thailand, there was a clear delineation between their identity at home and abroad:

> *Thailand is sort of like my "what happens in Thailand stays in Thailand." Two weeks of partying real hard then back to the "real world" as you call it.*

Posters used a combination of Thai and Australian-English slang that appeared unique to the English-speaking expatriate community and, most particularly, Australians. Users explained the meaning of phrases they used when asked, and a specific thread covered basic abbreviations, slang, and the use of ideograms or emojis (this was one source of information for us regarding terminology with which we were unfamiliar). For example, while ATM was used for "at the moment" it was also used to describe "a man who dispenses cash to a TG [Thai girlfriend] or BG [bar girl]." The use of this specific language appeared important in establishing commonality and determining how quickly new members were accepted: "Heh heh you sound sufficiently deviant ☺."

In his first post, a user presented himself as being "one of you," using language demonstrating he had spent extended periods of time in Thailand and knew the language well, ensuring he would have a role to play on the forum as a source of advice. He used language that would be familiar to other users, such as *falang* (Thai for a foreigner of Western descent, also often written as *farang*).

A similar approach was taken by another user introducing himself as an "Aussie pervert who loves motorbikes and football." He was immediately accepted and received welcoming comments, such as "well you tick all the boxes 555...WTTB [welcome to the board]." It is important to note that the use of the word pervert here is culturally specific and used to describe broad sexual interests in a humorous way, but it does not necessarily relate to a technical or formal definition of pervert, particularly where it might relate to illegal sexual activity.

Advice, Support, and Information

Users gave and received a variety of information and advice and provided different levels of support to one another. Posts under the topic heading Trip Reports shared the ins and outs of recent travel, including sexual encounters. Users learned and shared through stories of caution, romance and relationships, sex, mentoring, health risks, and culture, which created commonalities and built rapport.

Discussions were often based on what was reported in the news, with an avatar created specifically to post about news. Users were quick to incorporate statistics, anecdotes, or news from a variety of sources into discussions with varying levels of accuracy and evidence. Demonstrating the power of a cautionary tale in mediating behavior, a user posted in response to a story about a fatal road crash:

> *I love cruisin' around the provinces during my Thai holidays, but have always been aware that the risks are so much higher than in Oz. Hearing of this tragedy only makes me so much more aware. I always intend to travel on during daylight hours but sometimes drive into the night to get to a desired destination. I think I will now take more care in planning my times of travel and be ever mindful to drive defensively.*

Some users acted as influencers, encouraging participation from others (the first 50 users to post were given the title of Founding Member):

> *We, the founding members, can only impart so much knowledge, experiences and advice. The forum needs the input of others, like yourself to cover all the bases needed.*

Key individuals held roles as "sages" (eg, "I was at [X's] 'Table of Wisdom' (555) y/day afternoon...," referring to an individual and their bar and the way in which they "held court" in that space). In this way, they told stories about the support that they had provided for newbies. This established or reinforced their role as a credible expert:

> *Well he was really intrigued, but I could see he was a bit out of his element, so I asked if he wanted to meet up at our hotel that night, and we'd introduce him to [the area]. He was all for it...we had a blast both that night and last night...The funny part was, when we saw him that first night he said "I want you to know, you have successfully mentored me!" "What do you mean?" I said, "Well" he says, "I got a massage today, and the girl giving me the massage was really nice, so I asked her out to dinner, and we're going to see the elephant show as well, and she'll be at the boxing with me tomorrow!*

In relation to romantic or sexual relationships, advice sought and information shared was often explicit and detailed. A new user described his experience:

> *In hindsight...after my sickness I seemed to totally lose all sex drive. It wasn't at all like me...From then on I became more a peaceful observer rather than an active hunter. The more the "sex sell" was offered the further I felt pushed away. I became too aware of the business side of things, the desperation and felt sorry for some of the girls' situations. It was like being at a disco when all the lights are turned on and the music stopped, the vibe dies and certain realities become more apparent...Probably just need to spend more time on the prowl and have a bit more determination? Having a GFE [girlfriend experience] would have been nice, but I didn't have much expectation. As a result I only packed 3 boxes of condoms of which none were used. 555*

In response, another user provided advice and empathy, establishing commonality and solidarity:

> *Mongering [loosely defined in this context as seeking sex] isn't for everyone. It seems like you enjoyed your holiday, but if you ever come back, see about finding a wingman. I think that will make it a lot easier and more enjoyable for you to go out.*

Users appeared generally receptive to and accepting of advice and information provided by others on the forum, often explicitly seeking it. For example, a new user posted:

> *Thanks for the replies gents, and for not ripping me a new one for poor searching of the forum! Managed to get one night with a couple of other like-minded individuals...am very familiar with the P4P scene and frankly love it. What I really want to find out...any BJ [slang for blow job, oral sex] bars or decent massage parlors for a bit of light relief...?*

In response another user posted:

> *I've never found a BJ bar, but there are dozens of massage shops all over...you can casually wander up and down til you find a spot you like the look of. Any more info than that and I'd be spoiling the adventure.*

Risk

Experienced users reinforced a liminal space of adventure and temptation. The level of or willingness for taking risks seemed to be based on active decision making, previous experience, location, advice from others, and the role of luck or fate. For some, risk was considered to be part of the reason for travel (or being an expatriate or long-term traveler), while for others risk was an expected byproduct of the travel. Users discussed and described a range of issues, including untrustworthy airlines, motorbike use, road use, scams, travel insurance, or STIs: "I wonder if travel insurance would cover you if you got HIV or some other STD [sexually transmitted disease] overseas 555."

Expectations were presented around the exotic and erotic, suggesting generally permissive attitudes toward time away. Sex and alcohol and other drug use was normalized as part of the expatriate or traveler experience:

> *Other than the great food, weather and beaches why not top it all off with something you can't do at home? Walk straight into a bar, pick up a chick usually much younger than yourself and go home and have fun all night long? Eat sleep boom boom REPEAT!!!*

Self-control seemed to underpin risk taking or risk management for some (eg, "I had a sober week out of the three last trip...stuck to soda waters but they were still trying to give me shooters as well") with users frequently describing that "temptation is not far away in Thailand..." requiring moderation and discipline:

> *One of the biggest hurdles living in LOS [Land of Smiles]is all the temptation whether it be the girls, the food, the partying it's all got to be done in moderation or health and weight problems creep up on many expats I've known here.*

A sense of frustration toward those perceived as "not following the rules" was exhibited by others. These appeared to be generally accepted and known, and legitimized the identity of expatriates or long-term travelers, differentiating them from other vacationers. Personal responsibility, luck, and karma featured in many descriptions of risk taking:

> *What is it about being on holidays that warps people's minds?? They go off and do things they wouldn't normally do at home. Hire a bike or scooter and take on roads they know nothing off and no knowledge of local driving in one of the most lawless drivers in the world...but hey...I'm on holiday so let's do it!!! Jump off cliffs, hire a jet ski and ride like idiots, hire a prostitute and go bareback...but it's holiday time....FFS [for fuck's sake]!! Then when they come undone it's everyone else's fault.*

Condoms were mentioned with regularity, with discussions relating to frequency of use, use with different partners, and the efficacy of different condom types:

> *Except for one occasion I have never gone bareback and use condoms always. Never had an STI either, maybe more good luck than anything else.*

There appeared to be a range of knowledge and understanding or concern regarding the difference between pregnancy prevention and STI prevention, and interventions to address these issues: "Speaking of condoms...I ALWAYS used them when I had sex with a woman who was not taking the pill. Never had a failure..."

Discussion

Principal Results

Interactions illustrated complex processes of socialization, acculturation, and identity formation and presentation among Australian expatriates and travelers. Key themes emerged regarding advice and support, perceptions, and expectations around risk taking, which have particular resonance relating to prevention of HIV and other STIs. A large number of users were active at any one time, as well as a range of other viewers, who may have included observers, trialists, or those seeking information rather than the reciprocity inherent in greater participation [35].

The forum functioned as an online community providing a space to share common interests and confirmation, reassurance, or affirmation of beliefs and experiences. There was evidence of unique language, norms, and processes for managing conflict [32]. This self- and peer-moderating behavior demonstrated a peer network with clear rules that created and reinforced culture. Users exhibited intense loyalty toward the forum, which, consistent with findings by Hiller and Franz [18], suggests development of a nascent identity rooted in distinctive language, rituals, folkways, and collective network consciousness.

Key influencers emerged, including those with formal roles, such as moderators and longer-serving, high-posting members, who may, as Kavanaugh and colleagues [36] have suggested, be considered bridges in the community, capable of expediting information distribution. We noted layers of complexity, with some users interacting not only in general forums, but also in social spaces outside the view of the public, including offline, other forums, and members-only sections. These interactions appeared to enhance social connectedness, building and augmenting online and offline relationships [37].

The forum provided significant social support, information, and advice about certain health issues, including HIV and other

STIs. This was both directive (practical advice) and nondirective (sharing personal experiences) [38] and in particular focused on informational and emotional support. While many users may have initially joined the forum seeking information, participation continued due to the relationships formed with other members. Risk perception and expectation among users varied. For example, it was clear that, despite sharing stories of risk behaviors, some users did not consider HIV and STIs to be personal risks. Further, much of the information provided about these issues was based on anecdote and word-of-mouth. It appeared that, for many, risk taking, including seeking sexual services or trying something new sexually, was a key expectation of travel or the experience of being an expatriate or traveler.

Comparison With Prior Work

Cultural norms and rules influence the operation of communities and networks [39]. Previous research examining sexual and social networks of men who have sex with men and HIV risk suggested that common norms regarding risk characteristics and behaviors are created [40]. Communities, such as this forum existing predominantly online, gradually develop norms as members interact and debate and agree on what is acceptable [41]. We found sophisticated governance regarding acceptable behaviors and a preestablished network with sustainability and structure. These elements are important to the strength and stability of a peer network, and are important considerations for intervention using a social network or peer approaches such as those used with people who inject drugs [42,43] or men who have sex with men [40].

Members mediated the behavior of new users, and the moderator enforced or reinforced group norms. This generally appears to be the case in online forums, where rules and norms reduce unwanted behavior [44,45]. In this case, it is unclear whether these rules and norms deterred people from joining or inhibited contributions to the community; however, based on the number of users and overall posts, the impact was likely minimal and may have been a way to filter out those less likely to participate "appropriately." Additionally, the forum encouraged registration to access greater levels of privilege and a perceived period of probation in which behavior of new members was observed and supported (or not) [46]. This is consistent with other literature suggesting that the use of reputational and trust metrics can support the management of online communities and prevent or reduce abuse [32].

Studies suggest that key features mediating the success of online communities include trust, honesty, and reciprocity [47-50]. We found that reciprocity was an expectation in this forum, for example, where users read messages in a thread but didn't post and were subsequently criticized as not contributing in the spirit of the forum. A study on influences of consumer behavior in online travel communities concluded that travelers were more likely to follow advice if the online community was trusted and if information provided was perceived to be useful [51]. Kavanaugh [52] has suggested that online networks can build two kinds of trust within groups, defined by Putnam [53] as thin trust (not as personal and established through social relationships that are indirect) and thick trust (triggered by intensive contact among members). The results of this study found evidence of both thick and thin trust with frequent, high-intensity participation by some members, including moderators and founding members, as well as infrequent participation by those seeking information or participating in the lower levels of the forum.

Communities and groups all contain individuals who influence others and who are often explicitly named and rewarded [45,54,55]. On this forum, they were named founding members, gaining access to more private levels after posting frequently, or were given a title of moderator, defined by the forum as "users who are particularly helpful and knowledgeable in the subject of the forum they are moderating." In this way, they could be seen as influencers or opinion leaders. It has been suggested that engagement, positivity, and effective support may be gauges of influence [54,55]. The use of influencers in interventions is an effective vehicle to communicate information in a manner deemed culturally appropriate to peers, who will in turn more readily receive such information or support [56]. This is a model described in the literature in relation to diffusion of innovations relating to HIV prevention or risk within a network [57]. We found that this community demonstrated many similar characteristics. This is consistent with positive outcomes from historical network-level studies indicating the effectiveness of opinion leaders and peers [58,59] in reducing sexual risk taking and in studies exploring the positive impact of peer support for men living with HIV [60,61].

Community connection can play a significant role in reducing stressors connected with migration, providing a social support system, which can reduce psychological distress or culture shock [62]. Our study found a range of advice, information, and support provided and sought. Interaction influenced knowledge and behavior related to health (including risk taking and health protection) and relationships, as well as the migration experience. Our results resonate with those from other research [38,63-65], including in the context of Web- and peer-based interventions examining mental and sexual health promotion targeting men who have sex with men and same sex–attracted young people [29].

Cutrona and Suhr [66] have proposed a system of social support categorization comprising emotional, informational, social network, esteem, and tangible support. Consistent with this categorization, we found evidence of all forms of support categories, particularly informational and emotional support. Previous studies suggested that members in online communities who receive emotional support will remain members longer than those receiving only informational support [67] and, further, that disclosure is more likely to elicit emotional support than question asking. Our study, consistent with others, found that informational support accounted for a large proportion of interaction [65,68] posited to be because users participating in specific topic forums have similar interests or problems [69]. Online support can be empowering for individuals, and sharing stories can affect health behaviors, including self-care and help seeking [63,70,71]. However, as we found to some extent in this study, peer support may also reinforce perceived unhealthy behaviors or norms or may influence others to make more risky decisions [72].

Forums can be a source of health information as well as a conduit for such information [63]. We found that users critically considered the information presented, engaging with and using advice and support, which most resonated with personal experiences [73]. Consistent with other studies, the information provided by other men in the forum (peers) appeared to be well considered, often more highly valued than advice from health professionals or expert news sources [70,73]. While personal narratives may not always be reliable and in fact have iatrogenic effects [70,74], studies suggested that most information presented in forums is actually of relatively good quality [63]. This reinforces that forums are effective platforms for dissemination of health information and that peer information based on personal experience is considered generally trustworthy [73].

"Communification" has been described as connecting an individual to a community involving a process of meaning making through communication of symbols that can arouse strong attachments [75,76]. This forum exhibited features described by Baron and others as particular to online communication with stylistic and technical peculiarities contributing to the creation of a specific and unique language, credited as important in building solidarities [77,78]. This presented through the use of slang, humor, and ideograms unique to forum-using expatriates. We found that users maintained a strong sense of Australian identity despite significant time spent in Thailand, with Australia as a symbolic anchor [18]. Members exhibited a keen sense of place and identity—as "Aussies in Thailand"—with related loyalty to place of origin and new contexts. Thus, while the forum served to sustain old ties and contribute to new identities [18,37], it may also have contributed to homogenizing or reifying cultural differences, which could be counterproductive to migration, reducing social mobility or acculturation or reinforcing social norms that may be deemed unhealthy.

Posts highlighted how users presented self. These findings are consistent with observations by Goffman and others who suggested that, when interacting socially, individuals put on a "front," or create an idealized self, aimed at managing impressions and perceptions [79-81]. Users sought information from others in order to determine how interaction occurred, using that knowledge to portray a version of self that was acceptable to others and that reduced the likelihood of role clashes. As with other research [81], we found that, even when there was connection between online and offline spaces, users spent time creating the identity they sought to present to others by managing the information they shared with other forum users. We found, similar to others [72,82,83], that users took on a range of roles and participative stances, with evidence of protagonists, experts, befrienders, and lurkers [35,46]. Our findings, as in the broader literature [46,54], found that the more charismatic characters helped to draw out others in their participation by providing mentorship and "wisdom."

Strengths and Limitations

To our knowledge, this is the first study to investigate Australian male expatriates' and long-term travelers' social interactions within an online setting, particularly from a public health perspective. The observational nature of this research was a strength. Analysis of publicly available content allowed us to witness real-world interaction unobtrusively. The influence of our presence was removed, allowing individuals to communicate openly in the online environment [16]. However, by remaining invisible, we were unable to pose direct questions or comments that could elicit posts relating to aspects of the broader study, in particular specific knowledge, attitudes, and risk behaviors of users associated with sexual health and STIs.

While we acknowledge that posts from a single forum cannot provide definitive accounts of all aspects of the lives of expatriates and travelers, it was a large and valuable source of naturalistic data [13]. A range of expatriates and travelers were represented with different profiles and demographics (eg, different ages and relationship status; regularity of posts; experience with travel; and social and business intentions), which, while not intentional in sampling, was a useful outcome.

Pragmatic considerations meant that we collected posts in a limited time frame (around 8 weeks). However, analysis of the first 100 posts [33] and last 10 posts, and consideration of the interaction within threads, allowed for exploration of socialization over time and levels of engagement between several users (15 to 20 or more). We encountered difficulty accessing information "behind the wall" in the higher levels of the forum, relying on publicly available information and information in the lowest level of the forum, along with general accounts information located in the higher forum levels. What we did find in the lower level of the forum, however, was a range of information and interaction that was relevant to the study, particularly as this would be the level most accessible to those most in need of information.

The nature of the research meant that, when the meaning or context of posts was unclear, we were unable to seek further clarification. However, the use of language including slang, emojis, and avatar identities provided some further insight into how users presented themselves to others.

Users chose how much personal information to share in forums and how they would present themselves. Additionally, users who posted and responded to personal stories might be different from those who did not. However, the comparative anonymity online and the high degree of trust and credibility that was evident suggest that users shared a significant amount of honest information about themselves, particularly where users were connecting with one another both online and offline.

Implications for Health Policy and Practice

The study provides an important contribution for policy makers and health-promoting organizations in sexual health looking at opportunities, or unsure how, to adapt community and network engagement strategies to this emerging area. Our findings support the limited research insight about these networks and communities and the way they interact or build community. This knowledge is key to identifying and developing or adapting strategies. As an example, mobile populations are named in the Australian national strategy [7] as a priority group, but little clarity is provided for organizations or policy makers in how

or where to respond, nor has there been until recently a solid synthesis of knowledge in this area.

We suggest several considerations from this research for the development of policy and interventions to access this hard-to-reach group that is vulnerable to HIV and other STI transmission. These relate specifically to intervention design, evaluation, and future research.

Intervention Strategies

Participants in the forum provided and received social support, and influenced one another, factors cited as critical in creating peer norms and behaviors, including attitudes about sexual risk behaviors [40]. Findings highlight further opportunities to optimize support in such forums as a public health or primary care strategy. However, it has been noted that interventions must be well connected to the networks in which they are conducted [29]. Thus, it is difficult to determine whether health care professionals and health promotion practitioners would be readily allowed into this forum or others like it in expert roles to share information.

Consequently, while peer influencers and educators can be used for diffusion of messages and information to others in the forum and wider expatriate or traveler community, influence is best done indirectly. Health-promoting organizations could work to influence those who hold key positions within the forum to amplify the visibility of timely and accurate information and advice about HIV and other STIs. The use of opinion leaders working with health professionals is a strategy that has demonstrated utility in peer influence interventions used to respond to HIV, other STIs, and bloodborne viruses among men who have sex with men, sex workers, and people who inject drugs [40,43,84].

Based on our findings, an intervention using these forums can leverage positive norms around risk and relationships and increase the social capital of expatriates and travelers, including disaffected risk takers. Intervention design should provide opportunities to examine risk scenarios and provide specific information and education about the context of unsafe sexual behavior in countries with a high prevalence of HIV and other STIs, as well as promoting social connectedness [8].

Context of Intervention Design

Peer influence methods have been generally most successful and sustainable when driven and undertaken by peers who were part of the community and supported by broader health promotion strategies [24,42]. Peer leaders in these contexts would also engage with the broader stigma, discrimination, and rights-based issues that underpin effective prevention of HIV, other bloodborne viruses, and STIs [24,42,85].

Accordingly, in considering the amenability of such a model, health-promoting organizations and commissioning agencies must pay attention to whether the common attitudes or cultures of such online communities are compatible with an overall health promotion and rights-based approach. This is a challenge highlighted in both historical and contemporary gay community programs where significant work has been undertaken in peer programs to reduce structural and community inequities, including stigma toward people living with HIV, racism, and sexism [86]. In the current context, issues of race and gender-related stigma require further exploration in the design of interventions.

Interventions using forums should be developed in partnership with, or supportive of, local organizations; complement any in situ interventions in expatriate or long-term traveler destinations; and support information provided to expatriates and travelers via social marketing or in primary care. Support for local services may need to be considered for any increased use of health services as a result of better awareness of risks promoted via the forums. It may be that costs to destination countries prove minimal, with anecdotal evidence that expatriates and travelers seek health care in their country of origin for issues such as HIV and other STIs, but they should be factored into intervention design.

Evaluation and Research

Policy makers should commission further research to expand the findings of this study and better understand the way in which expatriate and traveler networks function (both online and offline), specifically the cohesion, density, and homophily of networks [87,88]. A social network analysis within and between forums would complement our findings. We recommended that research and evaluation be undertaken of a formal Web-based outreach intervention. The forum may also be considered as a space to develop, test, implement, or evaluate safer sex messages for an online component of broader campaigns or to promote testing and treatment options, including treatment as prevention.

Interventions require appropriate funding and must be of sufficient duration and dose to see positive outcomes. Policy makers should work with health-promoting organizations and researchers to develop effective indicators of impact and strategies to disseminate findings widely, preventing where possible duplication of interventions and research and allowing positive findings to be adapted or adopted for other contexts, for other health issues, or at scale. The cost effectiveness of such interventions should also be established [8].

Conclusions

Online communities of expatriates and travelers sustain and facilitate social ties; they make geographically distant places more proximal, linking dispersed peoples to their country of origin, as well as to others in the diaspora. Whether explicitly for health or not, such forums influence and affect social connectedness, help seeking, and other health behaviors, both positively and negatively. We conclude that, to access mobile populations vulnerable to acquiring HIV and other STIs but located outside the jurisdiction of specific countries, sexual health policy makers and health-promoting organizations should use such forums to extend the reach of public health interventions. When sensitive and appropriate engagement are used, these forums provide a valuable setting to engage a priority population, provide supplementary sources of support and information, and complement other strategies to prevent or reduce the impact of HIV or other STI transmission in mobile populations.

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Conflicts of Interest

None declared.

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Abbreviations

STI: sexually transmissible infection

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6.2 Summary

Online forums are used by ELoFTs to create community by developing and sustaining relationships on- and offline. Use of forums serve to make geographical distant place more proximal, linking dispersed peoples to their country of origin, as well as to others in the diaspora. In relation to the grounded theory and conceptual model, online forums influenced and affected social connectedness and help-seeking, moderated and facilitated risk, strengthened social capital and social support and (re)created ELoFT identity.

This component of the research is linked to Research Objectives 1,2 and 3. Findings from the analysis of data collected from the online forum were critical to the development of the explanatory conceptual model of the grounded theory that is presented in Chapter Seven. Findings supported understanding of:

1. how ELoFTs developed and sustained their social networks; and
2. how the networks could be used for public health intervention.

In particular, analysis of the online forum provided insights regarding potential places, people and points for intervention in situ in SEA and how online networks created, supported and sustained offline networks. Online forums demonstrated some utility for intervention and as such findings are of particular relevance to Chapter Seven, part two.

The next chapter explores ELoFT Social Networks in SEA and presents the grounded theory and conceptual model in two parts (Chapter Seven).

7. ELoFT Social Networks in SEA: A Grounded Theory and Conceptual Model

"Don't adventures ever have an end? I suppose not. Someone else always has to carry on on the story."

- The Fellowship of the Ring, J.R.R. Tolkien, 1954 -

PRELUDE

In this chapter the grounded theory, incorporating the explanatory conceptual model, is presented in two parts:

7.1 relates to the development of ELoFT social networks in SEA;

7.2 explains the model as it relates to the capacity of the networks to support intervention to reduce the impact/transmission of HIV and other STIs.

This chapter relates to the following objective:

4. To construct a theory and conceptual model explaining the development of social networks amongst Australian ELoFTs, and their capacity to support peer education and social influence interventions to reduce sexual health harms specifically HIV but also other STIs.

Results from Chapters 4 - 6 were used to develop the grounded theory and explanatory conceptual model with reference to the literature.

7.1 Development of social networks amongst ELoFTs in SEA

7.1.1 Overview

ELoFTs formed and re-formed social networks in the transitory, liminal space created by the migration experience and process of adjustment to their new environment. Positioning of ELoFTs within and between SEA and Australia created a transnational identity which negotiated boundaries of space, time, culture and place (both physical and imagined). Bhabha (2004) notes the complex signification of *"cultural translation"* for the transnational ELOFT navigating *"migration, diaspora, displacement, relocation"* (p. 247).

The establishment of ELoFT social networks was based around their identity within the imagined communities of the ELoFT diaspora or 'the West' as well as physical spaces in SEA and Australia (Butcher 2009). In order to make sense of uncertainty and life in the in-between, social networks became important mechanisms to build social capital and support successful embedding. *Identity*, *journey*, *place*, *adjustment*, *risk*, *support and home* were the processes, properties, conditions, strategies and context through which the ELoFT's sense of self was shaped, how social norms were communicated, and how 'ELoFT culture' was built. Networks were developed and sustained through *community and communitas*, important in the development of social capital. The ways in which these variables interacted are represented in Figure 40 and expanded against the interview concepts in Figure 41. Pathways presented are true for all participants interviewed and were supported by findings from observational fieldtrips and analysis of online forum data.

7.1.2 Process

This section describes the process by which ELoFTs formed their social networks. ELoFTs experienced a fracture with their existing (old) reality. This occurred at a point of transition, a transformational event (e.g. divorce, illness, retirement). ELoFTs embarked on a *journey* to something and somewhere different (SEA), for a range of *motivations* and via a number of *pathways* which linked to a range of created *identity categories (e.g. professional, quality of life)*. In the liminal space ELoFTs experienced a sense of dissonance between old and new. Once in their new destination they undertook a process of *adjustment*. They sought to recreate a version of Australia that was comfortable and consistent with their *motivations* for leaving.

Figure 40. Explanatory conceptual model of ELoFT social network development

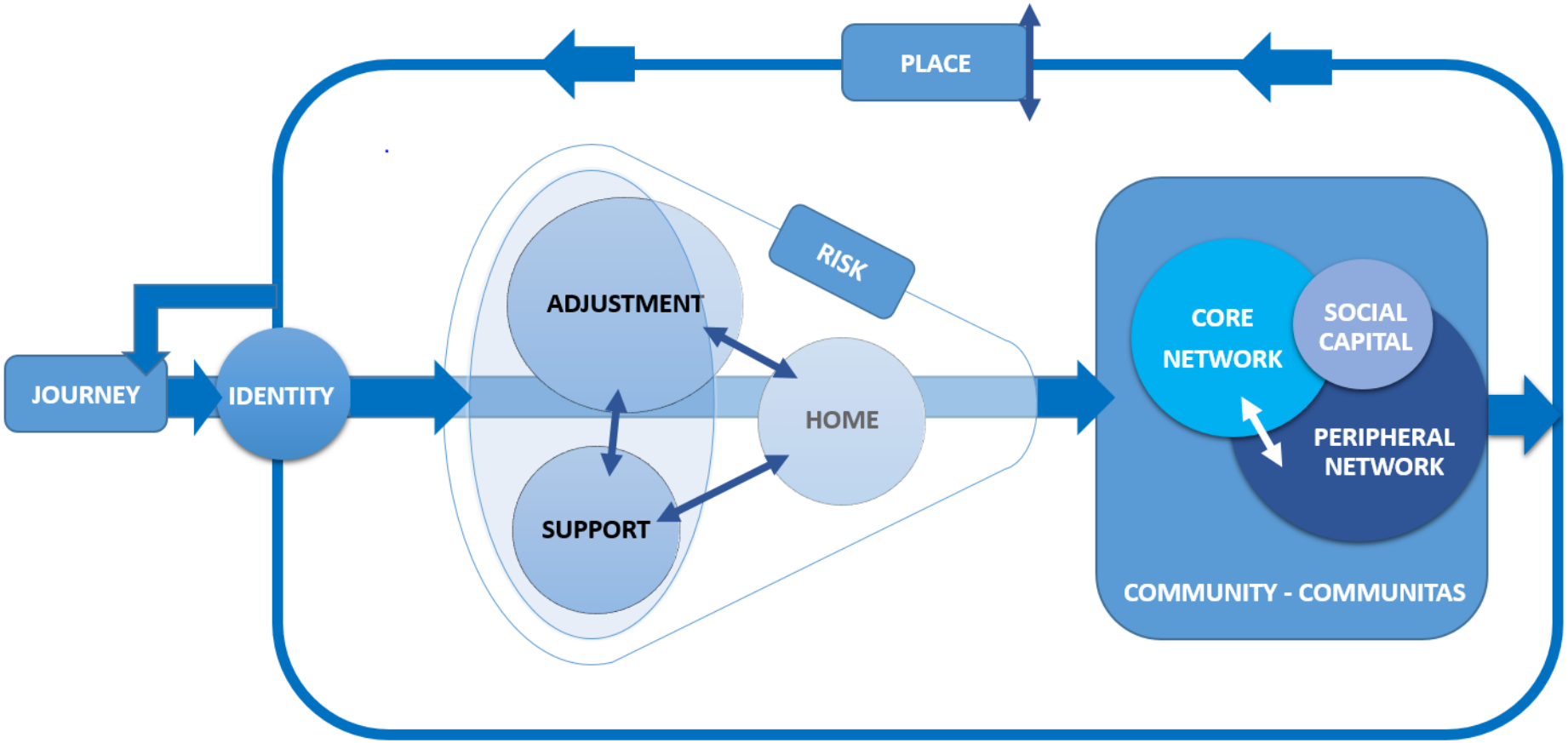
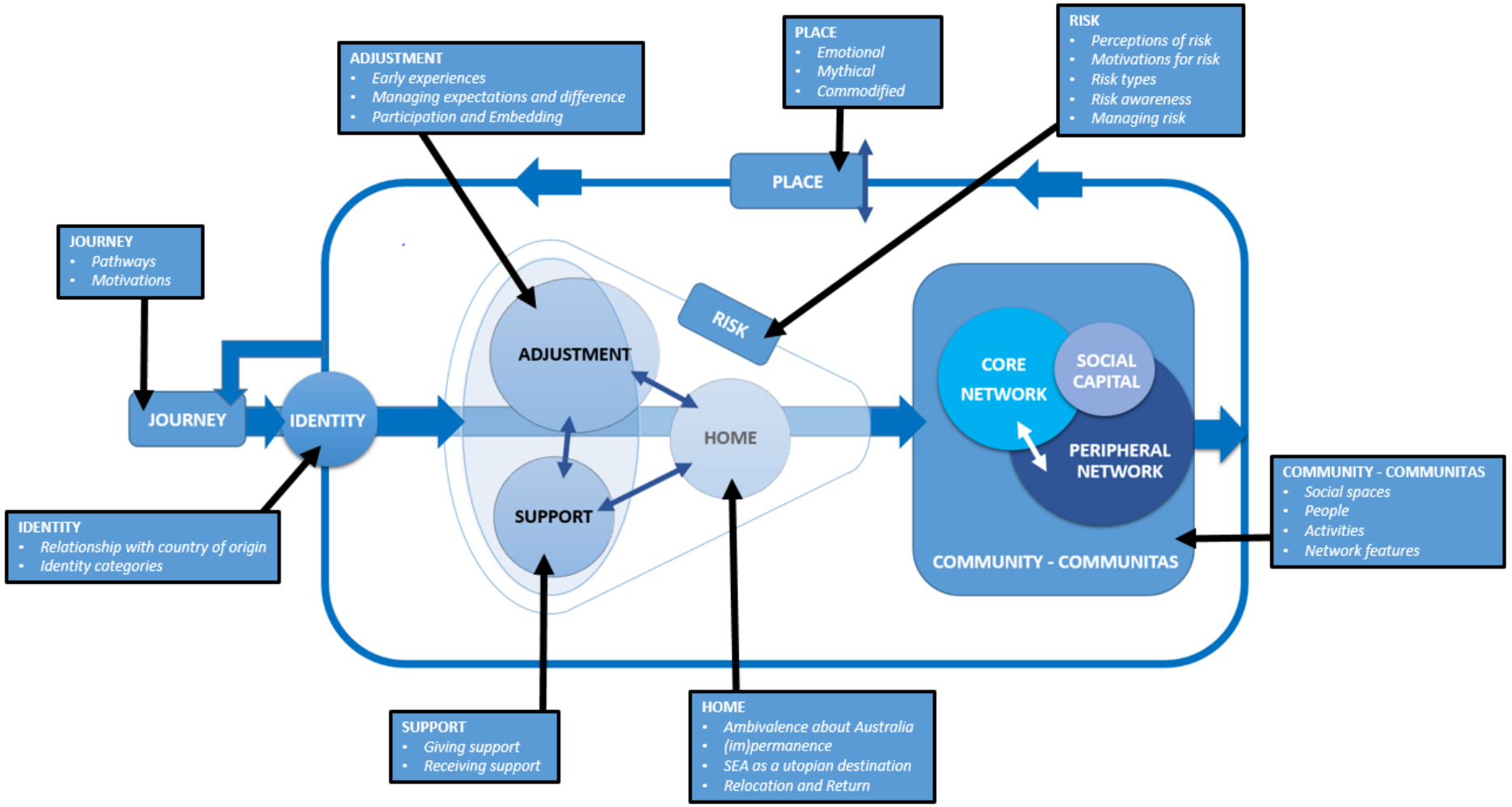


Figure 41. Explanatory conceptual model of ELoFT social network development with expanded concepts



This process of *adjustment*, the speed at which it occurred and its success was influenced by the ELoFT's self-identified and categorised *identity*, level of *support* and experiences of *risk*. As ELoFTs adjusted to their new destination, searching for somewhere to belong, they recreated or made new meanings about *home*. Sense of belonging also influenced *adjustment*. *Place,* both origin and destination, became the context for experience, influenced by and influencing ELoFT *identity*, norms and practices. *Place* was tied to country of origin and destination and the liminal place-the Neverland which facilitated and reinforced practices and understanding of *risk*, particularly during early *adjustment*. *Home* and *place* provided context for, and impacted on, the way meaning was created, the permanence of migration and the ability to adjust.

As ELoFTs searched for meaning and became embedded in their destination they developed a sense of *community* and *communitas* which provided connection in an often transitory environment with limited structure. A sense of belonging and attachment to community and subsequently to networks was influenced by the perceived level of control over pathway, sense of mastery of adjusting to their new location and the level of integration, guidance and *support* that they gave and received. This *community and communitas* provided the catalyst for social networks, both peripheral and core, which built social capital - the goodwill created between individuals and groups (Adler and Kwon 2002), important to the development of ELoFT *identity*, successful emplacement in the country of destination and learning to live transnationally.

ELoFTs created *community and communitas* by developing large networks as they 'prospected' for those who assisted to (re)create *home* and who supported their new world view, who reinforced ideas of *place* and who assisted to reduce dissonance about behaviours, attitudes, and values. As they created *community*, ELoFTs engaged in both purposeful (seeking out others who served a particular function) and ad-hoc (that occurred as part of daily living) interaction. This interaction often manifested as giving and receiving support and engaging with both place and the people in it. Key people (both online and offline) provided validation of the ELoFT experience and positive or negative reinforcement of behaviours and attitudes. As individuals (family, friends, colleagues or acquaintances) provided the ELoFT with information or support, the ELoFT reciprocated both with the original support provider and the ELoFT community more broadly. The greater the reciprocation, the thicker the trust that was created. It appeared that certain individuals were critical in the establishment and preservation of both strong and weak ties, within and between communities, leading to the subsequent formation of several types of networks.

Social networks were composed of a number of actors and assets. Networks suggested both central actors densely connected in a core network as well as a broader, more disparate network through which ELoFTs moved in and out (peripheral network). The core appeared to be a small network of highly trusted like-minded individuals with bonding capital and thick trust, and in the case of this research, represented strong connection between ELoFTs and a 'Western' way of living. As an ELoFT developed their sense of self and belonging, networks were pruned to reduce or remove members who were not concordant with the ELoFT's world view or because they no longer served a purpose; becoming peripheral (but broadly connected).

While there were significant similarities between ELoFTs, they were not totally homogenous group as evidenced by the five created identity categories. Accordingly, the peripheral network served an important function as a drip-feeder to the core network, helping to infuse new ideas based on a broader set of experiences, norms and practices than those present in the core network. It provided access to a variety of individuals who may have been important in furthering a wider range of agendas. Frequent travellers specifically, appeared more often within peripheral networks and served as a bridging function between country of origin and destination. The instrumentality of both the core and peripheral network was the capacity to mediate or reinforce risk, assist with adjustment and influence the likelihood of successful emplacement. The process described above and illustrated in Figure 40 and 41 is articulated in greater detail below in relation to the role of each concept and the relationship between the concepts in the formation of ELoFT social networks.

Identity

The development of ELoFT identity mirrored the development of their networks. The more mature the sense of self as an ELoFT, the more defined the networks became, which in turn influenced and anchored identity. Network development was reciprocal with identity (a means and an end). A transnational identity led to transnational practice creating a range of new bonds and learning opportunities (Butcher 2009). The process of identity formation had no endpoint, it changed as the network changed and as more transition occurred. ELoFTs, including those in country of origin and destination, affected each-others' self-concept. Self-concept, consistent with the perspective of SI (Goffman 1956; Blumer 1969a; Goffman 1972) was constructed and sustained through social interactions in what was for many a relatively homogenous cultural milieus. For these ELoFTs, identity was entwined

with what it means to be an Australian and to be from Australia. Such identities became critical to representations of self and *Other*. Indeed, Guild (2009) argues that expatriates are *"defined by reference to where they came from rather than who they are"* (p. 20). A common theme raised by ELoFTs regardless of their level of desire to "fit-in" locally, was that in relation to identity *"you can't be Thai"*. This assertion was important as it maintained difference creating a unique identity and culture as a farang, an *expat, Westerner* or as an *Australian in Thailand* -not a tourist or a local, but straddling the liminal space between insider and outsider, foreigner and local, Australia and SEA. ELoFT networks reified this difference.

'Becoming' an ELoFT meant taking on the rituals and symbols (Blumer 1969) of expatriation or migration; woven of past, present and future experiences, unravelling a new transnational identity. Participants generally formed one of five constructed identities: *quality of life, authentic, second chance, family* or *professional*. Those who held identities as *quality of life* or *second chance* ELoFTs appeared more likely to have other Australians as part of their core networks and be interested in maintaining a semblance of Australian life. Consequently these identities may be supportive of providing education or support. On the other hand, those whose identity was constructed as *authentic* (e.g. Stewart; keywords: seeker, giver, structure, certainty, helper, culture, spirituality), appeared more likely to embrace local customs (*"I want to live like a Thai*) and their core networks had greater local SEA representation. Whilst there was a level of heterogeneity in the way in which ELoFTs expressed their identity for all participants, it meant 'doing farang', taking on the rituals and symbols of the outsider in SEA, the male Australian (Blumer 1969).

Participants demonstrated a stated intention to not just be, but to belong to networks, the host community and to an ELoFT identity (Levitt and Schiller 2004). All ELoFTs demonstrated ways of being (a range of connections to others from Australia, playing golf, sailing or drinking with other ELoFTs), regardless of whether or not they maintained a strong verbalised connection to Australia. Ways of belonging to this 'Australian' identity were also evident as ELoFTs indicated an enduring connection to Australia and sought to recreate that identity locally which denoted their status as ELoFT and Australian (e.g. watching the Australian Football League Grand Final with other Australians in an Australia-themed bar, serving Australian food, naming bars with Australian names, hanging the Australian flag). As suggested by Levitt and Glick-Schiller (2004), ELoFTs engaged in transnational practices differently over time, enacting diverse ways of being and belonging in particular contexts (Levitt and Glick-Schiller 2004). This was evident in participant

narratives and fluctuated with changes in health, marriage or relationship status, children, retirement or the loss of business. ELoFTs appeared to use their interpretations of local life in SEA to sustain and facilitate their sense of common identity and 'Western' privilege. Ownership of a bar or engagement in various activities (for example drinking, sport) became symbols of both status and democratisation and shaped interaction among both small and large bar owners and participants in different social activities.

ELoFTs learned to 'do expatriation', taking on different roles in their adjustment, in the support that they provided and in the community that they sought to become a part of. They created a version of themselves as ELoFTs as they reflected on the way in which they acted as an Aussie in Thailand. The Aussie in Thailand was the habitual 'I' while the new version as an insider and ELoFT was the 'me' - the purposeful conscious awareness of the environment and the reflection of those around them (Mead 1934a). There was evidence that ELoFTs engaged in performances and roles to protect this valued identity, as it was important to their sense of belonging to their transnational life and to their self-concept (Mead 1934a; Blumer 1969). Roles included: friend, parent, helper, mate, wisdom giver, partner, teacher, mentor, lover, husband, provider, boss and colleague (as described in Chapter 5.1). These roles reinforced the ELoFT identity itself.

How to be an ELoFT, and the likelihood of success as an insider, relied upon positive and negative feedback from those that they came into contact with, demonstrating strong reflected appraisal (Cooley 1902a; Sullivan 1953; Felson 1985). For example, there was tension between how others perceived them in Australia (fat, ugly, old) compared to SEA (where they were viewed as a king). This contrast in how others saw them and how they understand how others saw them was critical in self-identify formation. ELoFTs trialled and assumed roles that developed their sense of self (for example, roles as helpers or wisdom givers) as others reflected back to them their experiences of the roles (for example as described in Chapter 5.7.1 by Peter who assumed a helping role and received respect as a result). Reciprocity was evident as ELoFTs sought to renegotiate roles in the unfamiliar cultural context of SEA. Individuals looked for validation and created networks accordingly. ELoFT social networks and community took on the role of the generalised other in this scenario, providing to the individual a point of reference about ELoFT life. This important role-taking activity, reflective of SI (Mead 1934a; Blumer 1969) became critical in the process of socialisation and connection to others. ELoFTs sought congruity in roles and identity and created their community and networks to minimise any dissonance that may have challenged their core beliefs about themselves or where there were negative reflected

appraisals. For example, it was likely that some of their behaviours and attitudes would be stigmatised in Aussie (such as those described around hidden pursuits or regarding Australian and local women) but not in Thailand. Thus ELoFTs straddled the management of stigma in Australia but the acceptance and even support for that behaviour in Thailand.

Journey: motivations and pathways

Motivation and pathways for migration may be seen as a way to manage situational inconsistency or as a response to negative experiences of reflected appraisal (Mead 1934a; Blumer 1969). ELoFT relationships with SEA and Australia and their evaluation of their position in both places reflected their different motivations, their intentions to stay and their level and type of social integration. The liminal space created a realm for transition and for transformation which was often evident in the migration trajectory. An ELoFT had a 'before' identity created through social interaction in country of origin which involved past experiences and roles. The ELoFT identity was both a result of the 'before' identity, motivations or desires for transition along with their social interaction in country of destination which involved new experiences and roles.

Participants entered their ELoFT journey through one of four pathways: *self-initiated, assigned, encouraged* or *opportunistic*. Those whose experience was assigned, appeared generally less likely to stay in their country of destination over the longer-term (for example Craig, an engineer; keywords: world citizen, family, security, 'expat'). They may also have been less likely to make meaningful local connections. Conversely, those whose pathway was self-initiated or encouraged, appeared more likely to experience a desire for local connection and local integration. For those whose pathways were more circuitous (those who travelled back and forward for example), community served a purpose in determining the extent of permanence of travel and the degree of support to make relocating to the country of destination final. Building community provided a way in which to imagine a future life and self, and provided an opportunity to trial the ELoFT experience. For those whose pathways were more direct (those who migrated for work for example), creation of community and networks aided the process of embedding and adjustment.

The more control, the more purposeful the pathway or more emotional the motivation, the more likely the ELoFT was to successfully embed, particularly with the assistance of social support. The level of friction (how difficult or easy the process and pathway to the country of destination was) may have influenced successful embedding and the type of networks developed. For example, those doing 'lifestyle migration' (Benson and O'Reilly 2016), where

they had a high degree of intentionality and control over their experience, may have experienced their migration as relatively 'frictionless' and may have built networks that were about extending amenability (e.g. Tom; keywords: bachelor, hard man, Aussie in Thailand; who based themselves in high density bar locations and transposed an Australian life to Thailand). Those who experienced a greater level of friction in their journey (e.g. Derek who was seeking escape and second chances in his permanent move to Thailand; keywords: new life, reinvented, the helper) may have been more disposed to creating community which provided a higher degree of social support (which for Derek also facilitated his business interests).

ELoFTs relocated to SEA for a variety of reasons (a relationship breakdown, personal revelation, offer of a better job, see Chapter 5.3), but migration was generally precipitated by a significant life experience. Motives and pathways became patterns of behaviour in coping with a life fracture. ELoFTs consistently described a level of disillusionment with the status quo in their previous life: physically, socially, emotionally or financially. Motivation was often initiated by a level of cognitive dissonance between where they were and where they wanted to be. The Australia that they resided in, for many, no longer reflected their sense of self. This was reflected back by the generalised other creating dissonance between the new identify self and that which there perceive others in Australia might reflect upon them. They no longer received positive reinforcement from their social interactions. Reduced satisfaction and quality of life, absence of meaningful connection, or a desire to engage in behaviours which were not socially sanctioned in Australia were motivating. Motivations were wide-ranging, but were broadly categorised as: *security, escape, wanderlust* or *challenge*. Many of the following themes emerged: running away, dropping out, desire for something new, sick of rules, better life, place to act out fantasy, leap of faith, love or connection.

Those more interested in living a life free from rules (e.g. Stewart or Tom), may have been more motivated to migrate as an ELoFT as it enabled them to reside in the liminal space, creating meaning without structure. If an ELoFT's motivation was about a good life attained through escape (transplanting self into a "*better place"*) they may have been more motivated to remain or become connected to others like them. Those seeking a break with their past life (in order to escape) may have had greater cause to invest emotionally, social and financially in the country of destination. Authentic ELoFTs who were motivated by wanderlust or challenge may have been more socio-culturally interested and subsequently more likely to have been more engaged and integrated with locals and the local

environment (Parey and Waldinger 2011). Those motivated by wanderlust and challenge may have been less financially motivated and more likely to experience a high degree of local amenity and having their needs met.

An ELoFT who was assigned and motivated by security, was often migrating to improve or maintain their financial resources (e.g. Craig). Accordingly, they may have created wide networks as they were most interested in developing relationships and community with those who could further their business interests, assist them to financially benefit or provide advice about how to stretch financial resources. They may have engaged in a range of supportive or supported actions in order to *"get ahead"*. They may have been more interested in seeking out others like themselves and less interested in investing socially in the country of destination.

Place

Representations of SEA (particularly the coastal locations of Pattaya and Phuket) emerged as positive though stereotypical. SEA was viewed as an affable and ineffable Place. There was an emotional charge attached to Place which was framed by participants as *"warm", "friendly"* and *"spiritual*" (see Chapter 5.4.2). These positive representations were appositional to similarly stereotypical but negative representations of the place left behind (Australia) as *"regulated", "expensive"* and "*nanny-state"*. Interaction with other ELoFTs reinforced such representations. ELoFTs presented clear attitudinal positioning (Torkington 2012) with language used to describe place variously as *"a man's world", "place to live like a king", "loose", "primitive", "genuine" and "a fantasy"*. Such language set up a range of binaries. If Thailand was conceived as a man's world, Australia was a woman's world where men were no longer afforded the roles once assigned in the 1960s, a place that was repressive, ordered, fake or affected. These characterisations helped create a cogent representation of place that validated reasons for migration and was a consistently heard and held belief in destination social networks.

In seeking to understand the interaction between the ELoFT and Place and the influence of Place on Identity, I drew on the metaphor of Peter Pan's *Neverland* which was developed through data collected from the observational fieldtrips, interviews and online forum data. Like Neverland, SEA was represented as a permissive imaginary. It was a 'sideways out of time' space that sat between the real and the make-believe, a site of potentialities where revisions of self and of home were possible (Fox 2007). Viewed with a male gaze (Mulvey 1975) and through a colonising lens, place was commodified (*"cheap"*) and objectified

(*"Bangkok is one big brothel"*) transformed into a symbol of wish-fulfilment where services (and pleasure) could be sourced easily, purchased freely and readily consumed. Sexual practices were authorised and visible which were forbidden or invisible elsewhere. Untethered from traditional rules, ELoFTs were free to engage in a range of practices from home or learnt in the new environment. Neverland created ideas of 'them' and 'us' (Hook's Pirates and the Lost Boys) and 'here' (Neverland) and 'there' (England). This was a between space where *"anything goes".* It was a place where boys could be boys, where boys didn't need to grow up and where they could *"act like a king and be treated like a king".*

Place was both feminised (to be dominated) and masculine (to be explored and exploited). Women were noticeably absent in Neverland or acted as nurturers (Wendy) or sometimes as harpies (sirens, Tinkerbell) which is consistent with the way women were described by ELoFTs (*"sweet little girls" or "picky Australian women"*). 'Here' (Neverland/Thailand) and 'there' (England/Australia) were juxtaposed, creating and reinforcing an 'insider' status by embracing the magical 'here' and rejecting the mundane reality of 'there'. ELoFTs (a representation of Peter) took on the identity of Neverland and its make believe, and the identity and characteristics of the imagined ELoFT community. Participants sought to become part of the Lost Boys (an enclave, ELoFT bubble, *"same, same but different"*), developing a communitas that could emerge in the absence of more strict, traditional social structures or mores from home ('there').

Relocation to an unfamiliar place required individuals to seek new structures of affiliation, status and identity. This occurred in part in the everyday social and physical places where ELoFT social networks could develop-bars, restaurants, housing enclaves, at the beach or in clubs. Such places quickly enabled the establishment of new transnational practices while facilitating the continuation of past Australian practices. Consequently, *"there exists a sense of communitas, of homogeneity and comradeship – they possess an area of common living"* (Ryan and Hall 2001, p.4). In bars, fellowship was created for example, over beer, described by Pettigrew (2013) as a *"master symbol in Australian culture"* (p. 1967). In seeking to belong, ELoFTs sought spaces and individuals that created comfort and familiarity where support networks could be established (for example refer to the participation in online networks described in Chapter Six or the role of the bar and pub in creating connection). These became spaces free from constraints but equally where 'Western' privilege or superiority was maintained. The communitas that was constructed in such places assured mateship (over some beers in the pub) and acceptance and created a frontstage for expressing their identity consistent with Goffman's (1956) dramaturgical metaphor. They

were as Cooley's looking glass self (1902b), reimagining themselves in these spaces for the best position to effectively embed within their networks and relationships.

Risk

Risk was integral to an ELoFTs sense of self (Lupton and Tulloch 2002) and was part of the bricolage of the developing ELoFT identity. Migration to SEA created a space in which *"almost anything may happen"* (Turner 1975, p.13). ELoFTs displayed a high degree of uncertainty in their lives as a result of *"living between two worlds".* The liminality created a space-time where risk was enacted - which was in part perhaps a response to managing uncertainty. For ELoFTs, risk was both part of transition to place and motivation for journeying. Risk practices were often rationalised and based on past assumptions that were brought to the country of destination and enacted in the new environment. The liminal environment led to situational disinhibition, tied to a feeling of being a different person during migration, which facilitated a range of risk practices, including the transgression of sexual prohibitions which may have been apparent in the country of origin (Beaulieu and Lévy 2003). This disinhibition led to a general sense of freedom or flexibility in the local environment and a certain level of impunity imbued by distance from country of origin. This was supported by the assertion by some participants that risk was an inevitable part of the migration experience to SEA and therefore simply something to be managed.

ELoFTs highlighted myriad reasons for engaging in risk, demonstrating its multiple meanings. Inherent in the ELoFT discourse were norms around masculinity and sexuality which influenced perspectives and actions on risk. For some, risk-taking was central to their self-concept, for others it sustained and protected a valued identity. For most, it was a by-product of participating in their new life to maximise the likelihood of successful integration into community and networks. Risk motivation focused on positive, social outcomes including: fitting in, social capital, desire for emotional or physical connection, quicker transition and adjustment, coping or achieving reputational and experiential gains. Risk practices reflected situated rationalities (Rhodes 1997; Bloor, Thomas et al. 1998), whereby participants constructed risk rationalities based on their risk perceptions and desired outcomes. The practice of risk was often normalised in the context of the country of destination (as described by Kyle, *"simply going to live in Thailand is very risky"*), which became for some, characterised as habit. For these participants, risk was part of a new cultural practice, a way to connect with others and to fit in. For others, risk was about control-gaining or regaining control-from their previous life, over feelings of unworthiness.

For others still, risk was calculated and often centred on reward-for work or for pleasure. For some, risk practices became an important way to manage perceptions of deviance or a stigmatised lifestyle. Risk practices for some were the same as at home in a more permissive, *"dangerous"* environment, while for others, practices changed considerably. Broadly, themes relating to risk that emerged were those of *connection* (with others, with their new environment, pleasure), *control* (making sense of new environment, rules, at the mercy of others) *leaps of faith* (transition, journey, nativity, relationships, pleasure, reward), *routine* (habit, daily activities, place, fitting in), and *visibility* (past experiences, with their new environment, knowledge).

Risk was integral to developing a deeper connection to place and people (described consistently by Stewart). For those seeking a life free from perceived limits and structure, the rituals and rites of risk in the environment itself facilitated communitas. Different types of risk practice may have led to congregating in supportive social spaces and with supportive individuals. Risk practices created commonalities with others and may have provided an entry into community and networks. Risks and norms were shared with and learned from like-minded others, and in this way served an important binding function in the development of social capital within and between networks. If risk was encouraged or sanctioned by key individuals it was likely to result in the development of strong ties and thick trust. Following (often unspoken) guidelines, modelled within community and networks (including those online, see Chapter Six regarding online rules of engagement) and by influential people and sources, were important risk management strategies. Risk management practices were also operationalised within the social field. They were often based on trust, emotion and past experiences, strategies Zinn (2008) calls 'in-between strategies'.

Adjustment

As Hertz (1988) contends, individuals experience a period of de-socialisation and re-socialisation as they move from country of origin to country of destination. This involves motivation for migration; separation from country of origin; and stages of absorption and re-involvement in the country of destination (Hertz 1988). Factors that influenced ELoFT adjustment were: *early experiences, managing expectations, participation and embedding.* These factors were broadly consistent with domains of adjustment described by Black and Stephens (1989): general (overall adjustment); work; and interaction (social interaction and

communication). Adjustment led to social support which facilitated community and social capital.

Adjustment, for most participants was usually a process of acculturation. The fourfold model (Berry 1980) suggests key acculturation strategies used. These were evident in varying degrees, with most demonstrating some level of *integration* into the local context, adoption of a variety of local norms and customs and some level of *separation*, whereby participants maintained their culture of origin, which was privileged over that of the host country. Few participants described their adjustment as *marginalisation*. A very small number of participants suggested that they felt that they had *assimilated* into the local culture. Strategies to manage the adaptation and acculturation process differed across various domains of their lives, influencing the form and function of community and networks. For example, it was clear that for many participants, certain aspects of local culture, customs, values and norms were acted on and supported publicly, suggesting integration. Privately, there were examples where the individual maintained a certain level of separation from the dominant culture, either through maintenance of Australian identity markers, living in enclaves, or participating in non-sanctioned activities (drug use or purchasing sex). This influenced with whom and how ELoFTs socialised.

When ELoFTs first entered their new environment, they encountered a range of new people and experiences. Early experiences were described as difficult for some (e.g. narratives by Marty and Mark, Chapter 5.5.1). This became easier over time as the individual became more confident, received cues from a wider group of people and met trusted others. Receiving positive reinforcement via verbal encouragement, greater social opportunities, relationship building or job opportunities provided a reflected positive self-image of adjustment and socialisation (Goffman 1972). Cues provided cultural scripts which enabled ELoFTs to effectively navigate the new environment and work towards increasing social connection and becoming an insider. Feedback from trusted individuals may have carried more weight than others, thus ELoFTs created community and networks accordingly. Bourdieu's concept of habitus (Bourdieu 1977) can be used here to examine the way in which ELoFTs navigated their adjustment within a social field. Individual adjustment meant taking on the social expectations and culture of the broader group and community in the country of destination (e.g. Chapter 5.5. Tom describes *"Thai style"* to highlight local expectations). This process reinforced and reproduced social structures, community and networks. The process of adjustment created in the individual a habitus shared collectively with those who are similar, in this case other ELoFTs. These shared

dispositions and learning were important precursors to the development of community and forming strong social ties.

The ability to overcome early obstacles, navigate local environments, establish routine, master language and meaningfully participate in local activities provided a sense of self as capable, acculturated and as fitting-in (see narrative from Bruce, 56). Confidence and ability to cope were important ways to build and rebuild identity. This is something that appeared of importance both to the ELoFT sense of self but also to the way in which they managed their impressions of themselves to others (Goffman 1956; 1972). As ELoFTs gained confidence they acted on and in their environment, developing an ELoFT identity consistent with the view of others. For example, several participants highlighted how they might appear to others in Australia and consequently felt judged. They responded by moving somewhere where the preferred vision of themselves is reflected back to them (*"attractive", "respected")* or where they felt less judged (everyone around them is behaving in the same way as them and they are lauded for it) and where stigma is less likely (Goffman 1956; 1968). Attitudes and behaviour were aligned to reduce cognitive dissonance. Greater levels of political engagement with others facilitated the speed of integration to place and to social networks. This included, for example, committing to organisations and community activity viewed as integral and important to the network (e.g. some language, awareness of role of culture and spirituality, see Chapter 5.5).

Routine, language and spirituality were important markers of identity (Barthes 1977) and provided a means for participation in local life and development of community, both for survival and for integration. Language provided a vehicle to understand cultural practices both within ELoFT social networks as well as the country of destination more broadly. Adjusting to ELoFT networks often meant privileging English and taking on particular forms of local language, often described as slang. This created a specialised and often reviled difference - the 'expat as outsider'- a position which was comfortable for some, and less so for others. Spirituality provided a way to understand and participate in culture. The way in which participants understood spirituality was coloured by previous experience with formalised religion and how *"deep"* their understanding was of Buddhism. For some they took away a more secular set of customs or rituals which they applied to their own lives, while for others it meant full immersion into Thai culture. For most it appeared that spirituality provided a way to reinforce the richness of their migration experience and fitted well with the narrative of a life of enhanced wellbeing (*quality of life*).

Support

Due in part to their liminal state, ELoFTs may have experienced significant barriers in accessing support. The level of support given and received influenced speed of adjustment to and embeddedness in place, sense of belonging and aided the creation of social networks including type of social ties and capital. Social support was a marker of group cohesion and connectedness, and reinforced self-concept. Support frequency and type was dependent in part on level of need, degree of independence or culture shock and pathway and motivation to migration. The feeling of being *"in the same boat"* meant that help and advice may have been frequently given, even to those not part of a core network. Existing networks and connection to country of origin mediated the level of support given and received and the speed of connection to others, social connection and subsequent network development. Social connectedness provided a bridge to build social capital and transition from just being to belonging.

Cutrona and Suhr (1992) have suggested that social support falls into a number of categories which are either action-facilitating or nurturant: informational, emotional, esteem, social network, and tangible. While a variety of examples of social support types emerged across the typology described by Cutrona and Suhr (1992) the greatest focus of support described by ELoFTs was consistent with action-facilitating support (informational, social network and tangible), both given and received. There were examples of suggestion, advice, referral and teaching (e.g. *"transport, safety and general 'dos and don'ts"*). Financial loans, willingness to help and active participation were also highlighted. There were fewer explicit examples given of nurturant support (emotional or esteem). In relation to esteem support, participants provided evidence of validation (see Chapter Six, e.g. *"you have successfully mentored me")*. All forms of network support were evident: access, companions and presence. Examples of emotional support related to encouragement and empathy, though there were no emotional support examples of physical affection or prayer. Increased social support may have facilitated adjustment through emotional support networks in the country of destination. Action-facilitating support played a role in alleviating adjustment stress by addressing specific needs or amplifying feelings of connectedness and acceptance by local communities.

Support was multidirectional, with participants describing both support that they had received and also given *(*e.g. *"I've already got colleagues approaching me"*). Provision of support was both passive (e.g. given when asked but not actively communicated) and active

(e.g. self-initiated or provided freely and often). Provision of support appeared both intrinsically and extrinsically motivated-with themes emerging as *helping as a source of advantage* and *helping for its own sake*. For some, provision of support was calculated, seen as a savvy business practice and was often described as having limits or being conditional, provided to those who were 'worthy'. Others viewed support as altruistic and it appeared linked to their perceptions of self as a "*good guy"* or a *"good mate"*. For others, it seemed a way to establish or re-establish an "Australian" connection. For others, giving and receiving support appeared to be about a sense of *"community", "fitting in",* a way to gain acceptance or develop networks and friendships, build social capital or connectedness. Outcome expectancies influenced the provision and uptake of support and may have reinforced existing group norms and behaviours, including permissive behaviour.

Participants received support directly (from colleagues, family and friends and new acquaintances) and from online sources such as websites, blogs or forums and from books. Generally, participants appeared to assess both online and face to face support in terms of trust and credibility to determine whether it was correct or reasonable. ELoFTs attached substantial credibility to the support of particular sources and individuals. Here there were examples of particular individuals who played a key role in support pathways (e.g. Stickman online blog, or S1 in Phuket). Direct social connections (e.g. family, friends or colleagues) became important avenues for support and the first step in the creation of more specific social networks. Social support from more indirect (e.g. from friends of friends) social connections also contributed to broader social networks. Receiving and giving support both online and offline provided a way to extend the reach of support and strengthen online and offline sociation (e.g. *"through social media I do give a lot advice to other expats. Friends who live locally will occasionally ask me for advice in person,"* Jake). Reciprocity in giving and receiving support ensured that the ELoFT was seen as a more trusted or indispensable individual. This may have sped up integration into networks as it created shared experiences often with positive outcomes (e.g. *"a big social circle and we look after each other…"*). Taking on a support role and building reciprocity, trust and credibility may have earned the ELoFT a certain degree of latitude with regard to any faux pas during initial adjustment.

Home

Rather than being linked only to local culture, ELoFTs were part of a transnational imaginary. This status presented some challenges in forming collective identities and

communities. As suggested by Savage (2005), home and belonging was more than a function of being 'born and bred' in a particular location. It was about *"elective belonging"*, a sense of *"spatial attachment, social position, and forms of connectivity to other places"* (Savage, Bagnall et al. 2004, p.38). Home influenced how and with whom ELoFTs socialised and sought to create community. Home was influenced by: *ambivalence towards Australia; (im)permanence; SEA as a utopian destination* and *ideas about relocation and return.*

Representations often focused on home (both origin and destination), described by Brah (1996) as a *"mythic place of desire in the diasporic imagination"* (p. 194). This conception was important in understanding how ELoFTs thought about their migration journey and the extent to which they decided to be active participants in their country of destination and new networks-both with whom and how they connected. Participants highlighted challenges *"putting down roots"* and used a range of strategies to build connection to place and to people, to integrate into life as an Australian in Thailand, to make a new home whilst in a cycle of perpetual change and to (re)form an identity in their new environment. In doing so, many ELoFTs maintained strong ties to Australia, and belonged to a variety of organisations that spanned borders – social (for example the Australia – Thai Society), political or religious. These loyalties and ties were not seen as antithetical nor incompatible, but rather as part of a *"hybrid and entangled senses of belonging"* (Mejía and Pink 2017, p.87).

Home was more than a location, it was the spaces, people and things that led to feelings of safety and comfort, where ELoFTs could reflexively explore their own identity whilst undertaking new activities in their search for a new life. As suggested by Rapport and Dawson (1998), home is material and immaterial encompassing *"memory and longing, the ideational, the affective and the physical"* (p. 8). For many, home evoked a specific conception of Australia, both in place and time, with a nostalgia or longing akin to the Welsh concept of *hiraeth* or the Portuguese *saudade, "memory of something with a desire for it"* (Rendall, Hubert et al. 2014). For others, it was somewhat akin to the German *heimat*, homeland. Participants demonstrated a strong, if at times uneasy and somewhat conflicted, relationship with home in Australia. For some, there was little in the way of yearning for home (as noted by Ivan *"I don't feel all that connected to Perth anymore, apart from a few people"*), with their experience much more akin to the idea of the *"extended mileaux"* and making a home on the move in *"significant places"* (Dürrschmidt 2013, p.77).

Home was at once the physical security of an abode, the sense of place that ELoFTs made of their varied environments and as well their sense of belonging and identity. For the ELoFTs, their idealised home and home as reality existed together. Rushdie (1992) noted that this in-betweeness may lead ELoFTs to create ideas of home that are *"fictions, not actual cities and villages, but invisible ones, imaginary homelands."* (Ashcroft, Griffiths et al. 2011, p.428). Here the ELoFT's new home was seen as a place of wonder and the old home as a place of repression. High living expenses, restrictive laws and regulations and poor social relationships dominated descriptions of Australia *("the nanny state")*. Country of destination was mythologised as temperate in people and climate, free, loose and ideal for a better life. Yet, despite its perceived 'nanny state' and socialist welfare system, Australia was still an anchor to connect to *"just in case"*. A sense of belonging was creating a place to call home which enabled an idealised view of Australia at its best and sought to escape from Australia at its worst.

Home emerged when ELoFTs were suitably embedded in their new context and had sufficient support to create community. As noted by Toivanen and Kivisto (2014), ideas of home came from *"common experiences and memories…employed to construct collective belonging within the diasporic space"* (p.66). Creation of community was a marker for ELoFT sense of belonging. Those who straddled country of origin and destination appeared to have wider social networks composed of members residing in both countries. Those who had more nostalgic views of Australia sought to recreate an idealised view of home, surrounding themselves with comfortable and familiar people and symbols (e.g. the 'Aussie Bar'). Sense-making of home was influenced by levels of support and experiences of place and risk which became embedded and influenced by ideas of home. Lack of community or lack of trusted social networks and support in country of destination influenced feelings towards home and intention or desire to stay or return to country of origin.

Community – Communitas

ELoFTs established society (Goffman 1956; Blumer 1969) – in the form of *community* - in part through the active cultivation of roles used to test perceptions and take on the perspectives of others. This situational definition served a function to tighten the bonds of fellowship. For some this involved forging a deep relationship with the destination and its people, and discarding old, country of origin relationships and identities. For others, this involved holding firm to the hallmarks of their country of origin. For many, it involved being part of an *"imagined community"* (Anderson 2006) which produced a new sense of locality,

condensing new sets of opportunities and obligations with features of both old and new lives. In creating community, meaning was also being agreed upon through the responses received within a group. The more consensus, the more the meaning of a symbol was clear and the more the group moved towards the establishment of ELoFT community and networks. Meaning for ELoFTs was on the places, rituals and routine which created *communitas*.

As described earlier, the bar for example, became a symbolic environment, a connection to country of origin. ELoFTs used particular symbols, consistent with SI (Blumer 1969) which were recognisable within the network (Brown 1988), to enhance connectedness, for example language, such as the use of *"expat"* or *"farang"*. In part, ELoFTs held particular reputations reinforced in the media and in country of origin and destination based on negative stereotypes about why they were in SEA. Accordingly, the ELoFT identity may have been viewed as synonymous with unsanctioned behaviours or attitudes which leads to negative identity labels and the creation of deviance (Becker 1963; Goffman 1968). This deviance reinforces difference. Even for those ELoFTs who professed to be more integrated into life with locals, the difference remained (as noted by Declan, *"you can never become a Thai citizen, and I wouldn't anyway…"*).

Thus, community was established through both similarity and through difference. The resulting networks that were formed accounted for both the similarities and differences, particularly in the early experiences of migration. Over time, ELoFTs determined their level of interest in cleaving to their original identities or shedding them to more fully integrate into local life (e.g. *"I wanted to sort of become part of Thailand when I was living there")*. ELoFTs formed small core networks of support based on shared experiences and a shared history. They also participated in wider, loosely bounded, interconnected networks, the communitas created by the imagined community which take shape when like–minded people come together in groups that emerge in liminal places where pre-existing social structure is absent (Turner 1969a).

As ELoFTs developed community they also built social capital, both bridging and bonding, critical to the formation of ELoFTs social networks. Shared norms, values, attitudes and beliefs, openness, trust and reciprocity are important facets of social capital (Putnam 2000). Bonding social capital is highly relevant to ELoFT social networks as it denotes close ties between individuals within a social group. It has been suggested that such networks are associated with strong trust and group norms and solidarity (Granovetter 1977; Putnam

2000; Kavanaugh, Carroll et al. 2005; Rademacher and Wang 2014; Aartsen, Veenstra et al. 2017). It appeared that the smaller, tighter network was where social capital was clustered. However bridging capital also served a function as it crossed different groups and allowed network actors to access a wider range of resources and assets available within different groups. These groups may not share mores but may have reciprocity and 'thin trust' based on community norms as opposed to 'thick trust' embedded in strong personal relationships (Putnam 2000). Trust is a critical component of social capital (Nooteboom 2007) and trusted, influential individuals played a key role in facilitating adjustment, creating community and providing support (ELoFTs assessed the trustworthiness of network members e.g. *"Phuket-it is a small place...it's kind of word of mouth in a way because if I trust you and then you tell me that Gemma is trustworthy, I'll trust her,"* and this determined the type of support required and the position particular individuals may have held in either core or peripheral networks.

7.2 Using social networks amongst ELoFTs in SEA for interventions to prevent HIV and other STIs

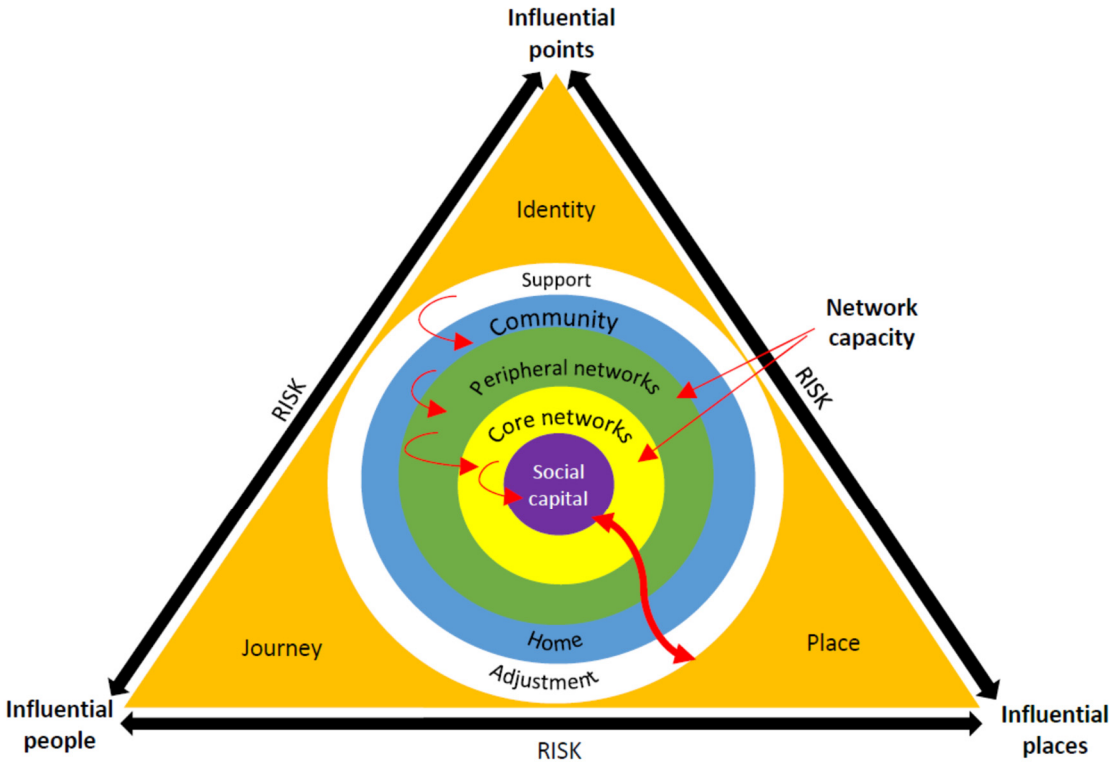
7.2.1 Overview

As suggested by Portes and Bach [ELoFT] migration may be viewed *"as a process of network building, which depends on and, in turn, reinforces social relationships across space."* (Portes and Bach 1985, p.10). ELoFTs developed their social networks as transnational boundary-spanners, as they became peripatetic, so too did their identity and actions. Social networks were the relational ties formed between the ELoFT and others on- and offline, in Australia and in SEA, and included peers, colleagues, family and friends (Johnson, Kristof-Brown et al. 2003; Osman-Gani and Rockstuhl 2008). Networks were formed, both core and peripheral, through interaction between domains of *identity, journey, place, support, adjustment, risk, home* and *community-communitas.*

ELoFTs influenced those around them by adding new voices to the transnational migrant experience which either reinforced or reshaped existing norms. ELoFTs brought with them experiences of home which were subsequently recreated in their new place. They provided sources of support, and guidance to others. They added to, and reinforced particular viewpoints about their new environment and facilitated a 'new normal' with jobs, language, food, risk and sport influencing the existing culture; supporting the move from outsider in their host community to insider in their new imagined community. Through their networks, there was an erasure of difference and the world (past and present) was made smaller.

It was clear that there exists some capacity for the social networks of ELoFTs to be used to influence health outcomes. As suggested by Perkins and colleagues, from a public health perspective it is critical to identify network features and function that might impact on health related knowledge, attitudes and practices (Perkins, Subramanian et al. 2015). Such information can better pinpoint opportunities for programming designed to reduce the impact of HIV or other STIs amongst ELoFTs in SEA. How this could be best achieved appears to be by engaging with *influential people, influential places* and *influential points* (as shown below in Figure 42).

Figure 42. Opportunities for intervention in ELoFT social networks



7.2.2 Process and Opportunities

The greater access that an ELoFT had to a rich, diverse network, the more they may have been able to develop a sense of autonomy, independence and identity that was not based on the knowledge of a few, but the input of many. The network served to facilitate the creation of new knowledge within it which was mediated by adjustment experience, type of expatriation and self-concept and experiences of support. Whilst there exist many components of the network that could be acted on, *influential people, influential points* and *influential places* may act to amplify *social capital* and/or enhance *network capacity*. Interaction and overlap (synergies) exists within and between these domains, and it is likely that the domains are fluid, porous and somewhat malleable.

Social Capital and Network Capacity

ELoFT networks were found to provide flexible, dynamic structures that may replace old, more rigid or hierarchical structures present in country of origin. They provide capacity for intervention because within the network there are shared values, language, past and current experiences and social symbols and levels of capital which may be influenced. Successful embedding as an ELoFT is likely to require significant 'network capital' (Urry 2007). It has been suggested that social capital, the relationships between individuals and

groups within the network, constitutes the social aspects of network capacity (Adger 2003), Social capital bonds together those who share characteristics and creates bridges to those who are more diverse (Dekker and Uslaner 2003; D'Ambrosio, Montresor et al. 2019). As described by Adler and Kwon (2002), *"its effects flow from the information, influence, and solidarity it makes available to the actor"* (p. 23).

In the case of ELoFT networks, interventions may consider how group norms, reciprocity and social sanctions influence social capital. Determining how power dynamics operate within and between networks (e.g. relationships between ELoFTs and between ELoFTs and locals) may have the potential to understand the (re)construction of social inequality and risk. Interventions may capitalise on assets and deficits in relation to control, trust, solidarity and communication (Moody and Paxton 2009; Kim 2012) and also, as suggested by Annan, reputation and cooperation (Annen 2003). Interventions may work to affect low levels of social capital that may contribute to poorer health and wellbeing among ELoFTs, both at the network and individual level (Reeves, Blickem et al. 2014). For example this might mean working with ELoFTs to connect them to formal or informal groups (social, sporting, business etc.).

Strategies to boost levels of [positive] social capital may be effective in reducing social isolation (common for some particularly in the early stages of their migration journey) and improving access to resources (information, support) to increase personal control and reduce health risks (Eriksson 2011). Such strategies may include exerting greater control over the flow of information, norms, social engagement and participation (Reeves, Blickem et al. 2014). This may be particularly effective in online networks or the small networks that are in the beach-based locations which were commonly suggested by participants. The more frequent an ELoFT's participation in sanctioned events and activities and the greater their role in communication within and between networks, the greater their potential power and control (particularly useful for those seeking to promote business interests). ELoFTs with higher levels of social capital in the network may have greater levels of control over their own personal circumstances and experiences within the network, and this may lead to more positive health outcomes (Eriksson 2011).

ELoFT stocks and flows within networks change over time. There may be network attrition as relationship dynamics change or as ELoFTs confront the shifting sands of return migration. Network changes impact the social capital available within the network which may influence network resilience and the health and wellbeing of network members. From

an intervention perspective, stocks and flows of members in and out of ELoFT social networks must be considered in terms of how to limit attrition of social capital and social support. Stocks and flows also affect the composition of social networks, impact on the creation of community and may provide some indications as to whether social networks continue after an ELoFT relocates to their country of origin. Opportunities for intervention may draw on the enduring relationship expressed by most to Australia (e.g. "*Australia is still...If something goes bad or you know, you are always going to go home*") and to existing and ongoing networks of other Australians in country of origin.

Understanding the way in which networks are formed and sustained also means being able to determine where the networks are strongest and weakest and where there is attrition and multiplication within and between networks. Network formation also suggests how attitudes, norms and behaviours are transmitted within and between ELoFT network members and within and between networks. Interventions may seek to influence a range of other network features suggested in the literature: size; density; multiplexity; cohesion; resources (Kim 2012; Rademacher and Wang 2014). Interventions may also seek to influence the way in which ELoFTs negotiate with others in their networks. Interventions may focus on reciprocity and building individual or community capacity to negotiate norms, relationships and environments (this has particular resonance with regard to those in teaching and professional roles, described in Chapter Five). Interventions could also seek to build collective efficacy, shared capability to perform particular risk reducing behaviours (testing, treatment, condoms) or the provision of support.

As suggested by the results of Chapters 4, 5 and 6, ELoFT networks represent an extended hub and spoke model of small, dense core nodes (composed of family, core online networks or location specific networks) with a few, central actors and broader, peripheral networks with a variety of actors (broader Thai and Australian acquaintances, work colleagues). Consistent with the literature, it may well be that the most durable form of ELoFT network is one which contains both strong and weak ties. This would account for the value of the strong ties and homophily of the core network but also for the importance and influence of the weaker ties located in the peripheral networks which represent a more heterogeneous group of wider ranging attitudes and norms (Granovetter 1977; Putnam 2000; Rademacher and Wang 2014).

As not all ELoFTs may be well connected to all aspects of the network, interventions could attempt to reduce the likelihood of nodes (particularly new ELoFTs or those more

vulnerable) being isolated from the network by creating or using bridges (people) and switches (points and places) between non-connected or less connected aspects of the network, amplifying weak ties or dampening strong ties (Kim 2012). If avoiding isolation of nodes can be achieved, a connection may not necessarily be required between every node in the network and this may have utility with relation to intervention resourcing (this can be seen in the way in which the majority of participants had connection to and awareness of S1 but not always to each other - see Chapter 5.9). In this way, the emotional intensity and trust which occur through strong ties can be capitalised upon, but equally weak ties can encourage diversity in the network. This is important, as otherwise ELoFTs may restrict the frequency with which they are confronted by those who hold different values and beliefs (for example socialising only with those who hold similar attitudes towards women or Australia). Consequently amplifying weak ties may be critical in reducing any negative outcomes which could occur in dense networks with strong ties such as the reinforcement of health compromising attitudes or practices or negative norms around gender and race (Putnam 2000).

Weak ties may serve an important function in reducing any social isolation that may be experienced as a consequence of silos within core networks due to their strong ties (Granovetter 1977). Hence, as suggested by Rademacher and Wang, strong and weak ties are required to accomplish required and valued individual (respect, job prospects, personal relationships) and communal ends (greater socialisation, being viewed positively as a community) within and across ELoFT social networks (Rademacher and Wang 2014). Critically, ELoFTs with limited social support or social contacts may be more vulnerable to poor health outcomes (Perkins, Subramanian et al. 2015) and social isolation or conversely it may be those who are highly networked and influenced by social norms who reinforce health harming practices. Thus, it may well be that any homogeneity or heterogeneity of attitudes, beliefs, and practices between ELoFTs and others in their social networks is as a result of their social ties, either strong or weak.

Influential people

ELoFT networks are composed of individuals and groups with a range of relationships across different social fields, yet readily recognisable within the ELoFT community. *Influential people* may be those whom ELoFTs respect, admire, trust or find credible. Or they may be those who have significant power or stakes within the network for example other ELoFTs, locals, those in country of origin and destination or perhaps formal or informal groups or agencies. They may be individuals or groups, tend to be those with

knowledge of ELoFT life, those with broad networks, or, if they are a public figure have attributes consistent with the valued ELoFT life and identity. Influential people may have the ability to influence risk for HIV and other STIs by acting through influential places and at influential points in the network and in the migration journey. This might be to provide information and awareness about HIV, online or at bars, through ELoFT media or formal structures, support individuals to increase social connection to diverse network components or work with sex workers and bar staff who have access to ELoFT networks (see Chapters 5 and 6).

ELoFTs are both influenced by and influence the knowledge, attitudes and practices of those around them. Both core and peripheral components of the network, contain individuals who act as significant others; individuals whose reactions to ELoFT actions shape ELoFT self-concept and reinforce or perhaps enforce elements of the ELoFT identity. Thus, influential people can act as bridges between networks and, consistent with SI (Charon 2001), provide a reflected appraisal for 'appropriate' kinds of actions, norms and behaviours. Consistent with constructs from Social Cognitive Theory (Bandura 1986) and Diffusion of Innovations (Rogers 1983), influential individuals can act as key opinion leaders (S1 was a good example of this), analogous to the network 'pulse' and often (in the case of both on- and offline network components) serve important functions as network moderators or mediators. They may take on a role-modelling function (with multiple suggestions and examples of mentoring) (Bandura 1986), reinforce self-efficacy and can be influential in setting the tone or providing an imprimatur for expected behaviours and practices (advising tourist and travellers what would be viewed as acceptable). It may be that manipulating peer reinforcement particularly from influential individuals might increase the likelihood that others in the network respond to health messages or support (Rogers 1983). The corollary is that these key individuals may also serve as gatekeepers, holding significant power in the flow of members, knowledge and support in and out of the network.

Interventions could seek to create or amplify individual influence by training and supporting some individuals to expand their reach online into different networks or have individuals of influence and those in core networks 'sponsor' or support someone like them towards an insider status. Alternatively an intervention could target individual good will by seeking those interested in helping or already active in providing support or encouraging individual to take on new roles by highlighting tangible or intangible benefits of providing peer support. Most effective might be engagement with those ELoFTs who are well established,

well connected and viewed as helpers. Those participants who *"wanted to give back"*, those who consider it prudent from a business sense (see for example Derek) or those younger or more likely to believe that change is possible (see for example Jackson) may be most useful to a network based intervention. Those ELoFTs who are able to bridge both core and peripheral networks in tourist locations and ELoFT enclaves in Phuket and Pattaya may have the most impact.

Influential people affect structures and capital within the networks. It is likely that power is centralised in the ELoFT network model through active central nodes (either those interested in being helpers, those from formal groups such as Rotary or those who are viewed as influential – e.g. key bar owners). Interventions could seek to diffuse power across network components to account for the impact and benefits of both strong and weak ties and the effect on both proximal and distal actors. Those that are best-placed to do this may be those such as Stewart who was connected to both Australia and Thailand, had experience in a range of sexual and social networks, was actively interested in helping, and understood some of the risks regarding HIV. Acting through and with influential people would include focusing on the different types of relationships between both individuals or between groups that are present in the network. As evidenced by Chapters Five and Six, ELoFTs demonstrated boundary spanning activities between core and peripheral networks (including between SEA and Thailand and between 'Westerners' and locals). This required individuals to access and sustain a range of relationships with *"different groups of insiders and outsiders"* (Osman-Gani and Rockstuhl 2008, p.41) and members of core and peripheral networks, in Australia and in SEA. It appeared that those most likely to take on such roles were those who were most interested in participation in local culture or those with professional backgrounds that required a high degree of reciprocity (those working in educational or favour driving roles). Those with more homopholous networks appeared less likely to take on such roles unless motivated by business interests or some other personal benefit. Acting through individuals who hold boundary spanning roles (between network components but also with links to country of origin and destination) may be an important intervention consideration (this has relevance both on- and offline).

There may be opportunities to use on- and offline relationships (person to person) to capitalise on trust and reciprocity that may be concentrated in influential people and in core networks. Influential people may be successful in assisting to shift obdurate beliefs or norms within networks (for example that HIV is not a risk, around the role of women). They may also successfully influence behavioural change within the network if they are early

adopters of actions (those that engage in testing behaviours, use of PEP, condoms). For example, influential people may be used to impact on cultural and sexual scripts within networks and in the environments and social spaces that the networks operate within. They may create, reinforce or endorse particular social functions, sexual, social or cultural norms which may sanction particular sexual or cultural practices which may then be validated by the broader network. From a Diffusion of Innovations perspective (Rogers 1983), if the innovation is framed as a safer sex culture or about condoms or PrEP, targeting both early adopters but also laggards amongst whom health compromising practices may be sustained or entrenched will be important. Consequently, working on/with sex workers/bar staff who engage with ELoFTs and their social networks is an important consideration.

Influential individuals may be harnessed to smooth out the adjustment and transition process from country of origin to country of destination. Those who have good connections to Australia, including those with Australian networks or those who travel to and from SEA or who are considering migrating would be worth exploring. The network can also play an important function in lieu of formal support, health services and information. If this is the case then it is important that information is credible, that those delivering it have access to support and training and that referral pathways out of the network are clear. Influential people may act as agents of change, holding particular roles in managing the flow of knowledge and information dissemination (Annen 2003). Interventions could focus on training trusted members of networks to act as informal peer outreachers or provide training to tourist police who may be seen as credible and trusted (as suggested through the observational fieldtrips). This may have the effect of providing ways to access networks by those most similar as it is clear that messages may be best received from others like them or from those with a high level of influence.

Influential places

Individuals are acted on by place; this provides context to actions. Thus, place is a clear influencing factor in both individual identity as well as risk practices. Place is important as part of the process of socialisation and enhances a sense of home and belonging. Place is where different components of the network are connected. It is what gives form and life to socialisation and it is where learning about what it means to be an ELoFT is enacted. Thus, an understanding of and engagement with place both broadly (SEA) and specifically (settings) is critical. *Influential places* are physical, virtual or imagined social spaces which are of symbolic importance to the ELoFT and in and through which significant interaction

occurs. They are where individuals connect, communicate and create *community-communitas.* It is the social space in which they give meaning to and create conceptions of *home*. Social spaces are an important facilitator for ELoFTs to create meaningful or purposeful relationships. Influential places provide the context and settings in which influential people and influential points can be reached.

ELoFTs experience a particular *"problem of place"* due to a lack of rules and known social structure, language barriers and because they exist between two worlds. Oldenburg (1999) describes the great good place, *"third places"* which serve an important social function in creating community and could be harnessed from an intervention perspective. Third places include cafes, coffee shops, bars, bookshops and hair salons-those spaces at the *"heart of a community"* (Oldenburg 1999). For ELoFTs these symbolic places can occur both in the physical world such as in bars, and can be replicated in online forums, a *"digital third space"* (Soukup 2006; Stevens, Gilliard-Matthews et al. 2017). These become egalitarian, democratising spaces which can erase status and privilege by comparison to formal clubs or sporting pursuits on one hand, while serving to tighten the bonds of similarity and communitas on the other. Such spaces both physical and digital contributing to individual and community connectedness and engagement, and for ELoFTs, these spaces can create familiar environments in which norms and practices can be reinforced (Soukup 2006). There were multiple examples of engagement with third spaces expressed in Chapters 4, 5, and 6. A place - based intervention working on third places could serve to create opportunities to increase the connection between individuals and groups including bringing together more diverse weak ties.

Based on observations and participant narratives, is likely that harnessing place-based interventions will be less effective in locations where the ELoFT community is less visible or more disparate. For example the tighter networks seen in Phuket and Pattaya may be more effective versus the looser, more geographically dispersed networks in Bangkok. It may be that seeking the components of the network that are most similar or dense will direct interventions to those ELoFT communities that are located in beach locations where networks and communitas are visible and where there may be a greater numbers of influencers (Phuket in particular). Geographically, interventions could work with local networks to develop campaigns or strategies based on setting specific concerns. Use of external network forces such as the tourist police could be reinforced with online support and influencers such as the Stickman site (see Chapter 5.7 and Chapter Six).

ELoFT core networks, which are composed of strong ties appeared to be geographically proximate (particularly in Phuket and Pattaya). Accordingly, it is likely that interventions would be more successful if they incorporated influencers (e.g. S1) in those tightly networked locations. These spaces could be leveraged for intervention by providing opportunities for engagement and connection. Though it may require greater resourcing, strategies such as informational, edu-cafés (analogous to the Cabbages and Condoms concept) could be valuable in providing a base for outreach.

Capitalising on the existence of ELoFT enclaves in country of destination is an important consideration. As seen through observations and reflected in participant narratives, enclaves existed in Phuket and Pattaya amongst *second chance* and *quality of life* ELoFTs and were also common for those migrating through *assigned* pathways. Maintaining contact with place of origin through areas of common living where groups of ELoFTs coalesce may assist ELoFTs to adapt to new environments, place or spaces and develop and maintain their ELoFT identity. Formal and less formal groups and places provided opportunities for ELoFTs to connect with new and with old ties. Place may also be considered for intervention with regard to country of origin. Accessing the networks of those who have returned home, those who have brought Thai partners back to Australia but travel semi-regularly to and from SEA could be valuable. Utilising formal or informal social or business structures such as Thai-Australia Facebook groups or the Australia-Thai Society or the Chambers of Commerce may have traction as they operate across borders and may obviate the need for more intense resourcing in country of destination. This is an approach supported by the narratives of those such as Stewart.

Influential points

The emerging theory suggests that as ELoFTs develop their identity and social networks there are influential points at which they may experience greater vulnerability for the transmission of HIV or other STIs. These may be points along the ELoFT *journey* which represent transition or transformation particularly around identity formation. They may also be the actions taken around *risk* or be where and when *support and adjustment* occur which lead to embeddedness or belonging. These may also be the critical actions or timepoints that provide opportunities for intervention. First, an assets approach could be used to build social support and other positive network functions and create opportunities to mediate more health compromising knowledge, norms and behaviours. This approach was consistent with narratives described by those self-identifying as helpers and mentors.

Alternatively, a deficits approach could work on risk knowledge and practices and actively seek to locate and minimise health-harming, norms and behaviours. In reality it is likely that a combination of approaches would be most effective as has been the case in the broader Australian HIV response (Brown, O'Donnell et al. 2014).

Actively seeking to reduce risk through the network, act on the network to make it less risky, or make it easier to recognise risk points are important considerations. However, strategies must recognise that as evidenced from the results of this study, ELoFTs did not generally see themselves at risk, were not overly concerned about consequences and had a strong desire to be free from rules and from the 'nanny state'. The provision of information about risks, access to condoms, and testing and PrEP would be valuable if provided at influential points where individuals may be developing understanding about how to operate in their new environment, learning about their ELoFT identity, or testing new ELoFT practices. Points may be before or during the migration journey or on return to country of origin or where 'risk' may have occurred. As Zinn (2019) suggests, risk reduction and prevention strategies that focus solely on a perceived lack of awareness or knowledge of risk or only on the biomedical aspects of risk may be less effective. Personal and social capital between ELoFTs varies and accordingly their ability to negotiate and reduce risk may also vary. As suggested by the study findings which suggested that risk practices were often embedded in everyday cultural practices, interventions will need to understand and engage with such conceptions of risk (Tulloch and Lupton 2003; Zinn 2019).

Viewed through the lens of a socio-ecological model of health, interventions might consider different levels of social influence on which to act: intrapersonal, interpersonal level, or community/system level (Rimer 2005). Intrapersonal approaches might influence attitudes, knowledge or perceptions of self-concept. Consideration of motivations and pathways and the ELoFT journey may highlight key points when an individual might be vulnerable or when they might be receptive to intervention. Understanding key points throughout the ELOFT journey may suggest how or why an ELoFT may seek social connection, community and subsequently networks and the types of connections that may be most valuable to them. Further interventions may consider whether those more socially connected are motivated differently and whether there is an opportunity to target these ELoFTs at the beginning of their migration journey. This might include their country of origin networks or information provided via influential people such as those in workplaces, or clinical health service providers with whom they may engage prior to migration or upon return. This may be of particular relevance to work-based ELoFTs, consistent with the *assigned* category.

Intervention may concentrate on education and provision of information to increase awareness and knowledge of issues or encourage uptake of protective practices through the distribution of safer sex hardware or PrEP or improving access to testing services. It may focus on identifying and connecting ELoFTs with relevant resources from the network before, during and after migration to influence an ELoFT's sense of autonomy, control, competence and esteem which may influence decision-making and risk practices.

Interventions at the interpersonal level could use the network to explore relationships between members with a particular focus on *"norms, sanctions, expectations and reciprocity"* (Portes and Bach 1985, p.10). Interventions might focus on strengthening social ties in both core and peripheral networks, building trust, reciprocity and the provision of social support. These relational ties act as conduits for the provision of tangible and intangible resources and support (Adelman 1988; Osman-Gani and Rockstuhl 2008) and provide points for intervention. As indicated by findings from Chapters Five and Six, interventions might also use network peers to provide accurate information or to counter misinformation about HIV and other STIs or particular risk practices. Considerations include ensuring support needs are matched to the relevant situation; delivering the right type of support at the right time (Sterle, Vervoort et al. 2018). Ensuring appropriate, well-timed support may reduce feelings of indebtedness and social isolation and increase the sense of reciprocity and social connectedness (Johnsen, Eriksen et al. 2018; Sterle, Vervoort et al. 2018). Interventions at the interpersonal level may also facilitate transmission of knowledge or skills which could cultivate a range of health supporting practices.

Interventions at a community or structural level may leverage the system in which risk and transmission occurs. Systems based interventions might seek to affect social contexts such as population mobility or globalisation, and social structures such as culture, employment, education and engagement with formal or informal institutions (Berkman, Glass et al. 2000). Interventions may facilitate contagion of relevant phenomena (Scherer and Cho 2003; Christakis and Fowler 2013; Perkins, Subramanian et al. 2015) within the core and peripheral networks, for example encouraging adoption of condom use, testing practices, PrEP or safer sex culture. Encouraging uptake of PrEP or testing may have the added benefit of reducing levels of infection within the network and a positive ripple effect in reducing onward transmission and undiagnosed infection. There was evidence (see Chapter Five) that those in the network had some knowledge of transmission risks (albeit inconsistent and often outdated) and were open to new testing technologies and treatment and many had engaged in testing for STIs.

7.3 Summary

This chapter has detailed the development of a two part grounded theory and conceptual model explaining the development of social networks amongst Australian ELoFTs, and their capacity to support peer education and social influence interventions to reduce sexual health harms including HIV and other STIs.

The theory and model suggest that ELoFTs had large socially patterned networks, core and peripheral, composed of a number of actors and assets. Most ELoFTs indicated a small core network of strong ties, bonding together ELoFTs with similar interests and values. ELoFTs also had a wider peripheral network of weak ties with looser, less frequent connections which provided a bridge to a more diverse group with a wider set of attitudes and experiences. Both aspects of the network were important as they had the potential to amplify or diminish health harming or enhancing knowledge, attitudes or practices within the networks. Networks were sustained through support, trust and reciprocity which built social capital. This goodwill that was created between individuals and groups was important in the development of ELoFT identity, successful emplacement in SEA and learning to live transnationally. The development of social networks demonstrated an individual's migration trajectory from Australian to ELoFT 'newbie' to ELoFT insider in SEA.

The model also indicates that it is apparent that there is capacity for the social networks of ELoFTs to provide opportunity to be used to influence health outcomes and facilitate HIV and other STI prevention efforts. Whilst there were many components of their network which may be acted on, several key features were likely to have traction from a public health perspective: influential people, influential points and influential places. These domains may act to amplify social capital and/or enhance network capacity.

The following chapter concludes the thesis providing a research summary, strengths and limitations of the research and its process, recommendations and final remarks (Chapter Eight).

8. Implications and Conclusions

I've been to cities that never close down,
From New York to Rio and old London town,
But no matter how far or how wide I roam, I still call Australia home.
I'm always traveling, I love being free,
And so I keep leaving the sun and the sea,
But my heart lies waiting over the foam, I still call Australia home.

- I Still Call Australia Home, Peter Allen, 1980 -

PRELUDE

This final chapter concludes the thesis by providing a brief summary of the results with links to the research objectives. It presents the strengths and limitations of the study. Concluding remarks are provided at the end of the chapter.

The chapter explicitly addresses the last research objective:

5. To make recommendations for further research including intervention research targeting ELoFTs

Included recommendations summarise those presented in the published papers along with broader considerations from the findings of the in-depth interviews, fieldwork observations and development of the conceptual model. Recommendations are presented as they relate to policy, practice and research.

The Chapter is divided as follows:

- Research Summary
- Limitations and Strengths of the Research
- Implications and Opportunities
    - *Considerations for cross-cultural stakeholder engagement*
    - *Considerations for Health Promotion and Clinical Practice*
    - *Considerations for Policy*
    - *Considerations for Research*
- Concluding remarks

8.1 Research Summary

Transmission dynamics of HIV and other STIs have changed in Australia and other HICs. For example, an increasing proportion of HIV notifications in jurisdictions such as WA have been acquired overseas, particularly in SEA, amongst older, predominantly heterosexual, Australian-born men. This creates new challenges for those working in the HIV response to develop effective public health interventions to reduce risks for HIV and other STI transmission amongst emerging priority populations.

This research set out to determine whether social network processes of Australian male ELoFTs in Thailand and SEA had the potential to support peer education and social influence interventions to reduce transmission of HIV and other STIs. To realise this aim, the study had five objectives:

- To build a deeper contextual understanding of culture and personal behaviour amongst Australian ELoFTs in Thailand and SEA. This was achieved through Publications 1, 2, 3 and 5 and Chapters 2, 4, 5 and 6.

- To describe the socialisation process and pathways experienced by Australians (potential new ELoFTs) interacting with Australian ELoFTs in Thailand and SEA. This was achieved through Publications 2 and 5 and Chapters 1, 2, 4, 5 and 6.

- To investigate the roles of Australian ELoFTs as mentors and potential change agents within ELoFT social networks in Thailand and SEA. This was achieved through Publications 2 and 5 and Chapters 2, 4, 5 and 6.

- To construct a theory and conceptual model explaining the development of social networks amongst Australian ELoFTs, and their capacity to support peer education and social influence interventions to reduce sexual health harms including HIV and other STIs. This was achieved through Chapters 7.

- To make recommendations for further research including intervention research targeting ELoFTs. This was achieved through Publications 1, 2, 3 and 5 and Chapter 8.

Using SI as its conceptual framework and GT as the methodology, this study conducted in-depth interviews, stakeholder consultation, in-situ observations and analysis of online

forums to examine the experiences, perspectives, practices and networks of Australian male ELoFTs to SEA, particularly Thailand.

The research yielded a number of insights regarding pathways and processes influencing ELoFT socialisation. Data collection and analysis culminated in the development of a grounded theory incorporating a two-part explanatory conceptual model which describes firstly how ELoFTs developed and sustained their social networks and secondly how the networks can be used for public health intervention. A range of knowledge translation activities were undertaken throughout the research including the publication of five peer reviewed journal articles.

Findings suggested that Australian men were motivated to migrate to SEA for a range of reasons and via a number of pathways. Central to their transition to SEA was a desire to belong which influenced the way in which ELoFTs understood and created community. Australians became ELoFTs over time, making a new home in SEA but still anchored to Australia. These transnational bonds articulated a social identity forged from living between two worlds. This transnational identity was re(constructed) through interaction with others and their old and new environments. For most, embedding in local SEA networks was two-fold. It involved an ongoing connection to ELoFT 'Australian-ness' as well as a desire to participate in local activities, culture and language. ELoFTs socialised and were socialised through different types of activity and with different types of people.

To flourish in the liminal space, strong social networks were critical. Development of networks required positive, rewarding experiences, local relationships, support from friends and family, social engagement and cultural connection. The development of ELoFT social networks was predicated on a complex interplay of factors. *Identity, adjustment, support, pathways, motivation, risk, home and place* were the processes and context through which the ELoFTs' sense of self was shaped, how social norms were communicated, and how an 'ELoFT culture' was built. These processes led to the creation of *community* and *communitas* through which ELoFT social networks were established.

Study findings provide some impetus for future work to examine effective mechanisms to engage with expertise in Australia and in Thailand in order to trial a range of safe to fail policy and intervention experiments. Such action will require close cooperation with countries in the region and a focus on strategies which privilege community participation and do not further reify difference. Future considerations for such work are considered later in this Chapter.

8.2 Limitations and Strengths of the Research

The study was conducted with a sample of Australian male ELoFTs. As a woman and a non-ELoFT, this different status presented some challenges as an 'outsider', also found in other such studies (Minkler 2004). Participant narratives may have been influenced by social desirability bias. Some individuals may have provided answers deemed more acceptable rather than responses reflective of their true feelings (Latkin, Mai et al. 2016). Further, there appeared to be some evidence of answers that were deliberately provocative, where participants may have been trying to 'test' me as a young woman. This influenced the way in which participants interacted with me but also the understanding that I brought to the study context and the way in which I understood and analysed the data. This difference was managed by ensuring that I was reflexive throughout the research journey and over time became, through the research process, 'inside' the research topic.

Strategies were used to enhance the rigour and trustworthiness of the study. The consolidated criteria for reporting qualitative research (COREQ) was used for guidance and reporting (Tong, Sainsbury et al. 2007). Multiple data sources enriched researcher insights, developed a more comprehensive understanding of the issue and, where appropriate, allowed consideration of data from multiple theoretical perspectives. Time was spent exploring researcher reflexivity in regular supervision meetings. In stating assumptions and positionality, I sought to make explicit reflexivities and biases brought to the research at its inception. This process enabled me to explore my position with relation to my 'outsider' status and develop strategies to reduce the perceived distance created by being an 'outsider'. The development of a published research protocol (see Publication 4) contributed to research rigor and was an early platform for translation. The protocol provided a blueprint and contract for implementation of the research.

The study only presents the voices of Australian men. Thus, there are a number of silences that need to be noted. The voices of women were noticeably absent. These were the female partners of the participants as well as the Thai and SEA women frequently described in participant narratives. Should the research have considered narratives through a post-colonial or feminist lens, many of the issues discussed would have been considered differently and problematised. I am aware that there are many issues which remained unproblematised such as those relating to gender, power and culture. I consider these issues critical to highlight, but beyond the scope of the current work. They are issues that have and are being considered in other subsequent research that I am conducting with

colleagues (see Appendices I - O). The sample was predominantly composed of Caucasian, heterosexual, Australian-born men. This was not purposeful, though was consistent with the profile of those who had acquired HIV overseas in WA (Department of Health Western Australia 2019). In future work it may be beneficial to further explore the experiences of non-heterosexual men and those of different ethnic backgrounds.

I experienced some challenges in recruiting participants. It was anticipated that a number of the participants could be sourced from mining, oil and gas companies. However, the beginning of the research coincided with a down-turn in Australia's economy and subsequently of employment of men in roles relating to minerals and energy, and those that involved expatriation or fly-in fly-out work to SEA. This may have affected the range of experiences presented by participants. Recruitment relied on voluntary participation which may have attracted a particular type of participant (Salkind 2010), though this was not evident in the demographics of this study which reflected a relatively diverse sample. Recruitment materials did not mention sexual health or HIV prevention, only relationships and networks. This may have been a strength in terms of reducing bias in the sample that was obtained. However it may also be the case that a more explicit recruitment strategy stating the aims of determining public health responses to overseas acquired HIV may have retrieved a different sample. Pragmatic limitations meant that constant comparison of data was not always possible at the time of interview (for example when I was in the field). Consistent with later perspectives on GT, this is not always considered critical (Timonen, Foley et al. 2018).

As an Australian, I acknowledge limited understanding of the context surrounding ELoFT culture in SEA; I did not speak Thai and for pragmatic reasons was only able to spend limited time in the field. Consequently, a number of interviews were conducted in or from Australia. This may have limited the ability to 'get behind the wall' (move toward becoming an 'insider') throughout the research journey. Whilst more time in the field would have been valuable, timelines were hampered by ongoing political unrest which occurred after the first visit, making subsequent visits impossible for some time. I did spend approximately one month over three visits conducting observations and interviews in-situ that deepened my appreciation for the context and country of destination. Limited understanding of local history, culture and language of Thailand meant it was challenging to unpack and locate the experiences of participants in the socio-political context of their destination country. Reading widely and meetings with those who worked in those locations assisted to ameliorate some of these challenges.

In relation to the work conducted with the online forums a number of limitations were highlighted that are summarised here (see Publication 5). Whilst collecting data, I remained invisible on the online forum, unable to pose questions or make comments to users, which reduced the ability for clarification. However, the observational nature of the research allowed me to witness real-world interaction unobtrusively which was a strength. Whilst the research was unable to provide conclusive explanations of all aspects of the lives of ELoFTs through analysis of only one forum, it was a valuable source of naturalistic data. Data were collected over a relatively short-time frame from five users of the Australia forum studied. However, by analysing threads and posts at the beginning and end of the users' participation on the forum, as well as interaction in the threads, I was able to explore socialisation over time and levels of engagement between 15 to 20 or more users. Access was only possible to lower levels of the forum; I may have missed important knowledge that would have been gained from access to higher levels. However, what was found was information and interaction relevant to the study context and points for intervention.

There were a number of limitations relating to the systematic review which were highlighted and are summarised again here (see Publication 3). Only peer-reviewed articles in English were included. The inclusion of papers in other languages or from the grey-literature may have identified additional studies which would have improved the outcomes and reduced any publication bias. The inclusion of both male and female participants in most studies made it difficult to extrapolate findings specifically to male ELoFTs. The heterogeneity and variability of the studies meant that no meta-analysis or synthesis was conducted. To improve the quality of the review an established protocol was developed and registered with the PROSPERO International Prospective Register of Systematic Reviews. The use of seven databases expanded the review's scope as did the inclusion of both qualitative and quantitative studies using a variety of methods. Multiple researchers searched databases and assessed articles enhancing quality. A rapid update prior to thesis publication increased confidence that the findings remained contemporary and relevant.

The research indicated similarities and differences in the experiences of Australian ELoFTs in SEA. There may have been merit in further deconstructing research findings to explore the heterogeneity between expatriates, longer term and frequent travellers. However, the identity categories presented within the thesis and the subsequent research findings suggested significant overlap and fluidity between these categories to support the utility of the broad ELoFT definition. This research has provided an explanatory conceptual model and directions for future policy, practice and research. The use of GT to develop this

conceptual model allowed creative and critical consideration of an emerging public health issue. Using SI as the theoretical lens enabled consideration of how participants developed society, in this case their social networks through their interactions with others and their environments. The findings in relation to the model may prove applicable in understanding impacts for other health issues experienced by ELoFTs.

A background in community-based HIV prevention meant a strong focus on knowledge translation throughout the research journey. Involvement of the affected community and HIV sector stakeholders in two countries enabled the research to be responsive and sensitive to concerns and issues. The research focused on ensuring that the voices of the participants were heard through thick, rich description. In the context of this research, thick, rich description was defined as *"the process of paying attention to contextual detail in observing and interpreting social meaning"* in the collection and analysis of data (Dawson 2010). Geetz (1973) suggests that this means *"setting down the meaning particular social actions have for the actors whose actions they are"* (p.321) and the intellectual effort involved in providing a *"stratified hierarchy of meaningful structures"* (p.312) of cultural significance. This was achieved through the development of fieldnotes and through the action of constant comparison of data and use of memos and engagement with the research team to create a community of practice for the critical consideration of the data.

This was an important consideration and consistent with principles of good practice for working in HIV prevention with a focus on meaningful involvement of priority populations and greater involvement of people living with HIV (UNAIDS 2007; Commonwealth of Australia 2018). To ensure timely dissemination, recommendations from this and related work have been presented to policymakers, practitioners and researchers over the course of the study to ensure that relevant outcomes make their way to myriad end users. It is encouraging that early recommendations such as an advocacy coalition, HIV and mobility forum and more granular surveillance data have been implemented.

The research set out to address a real-world concern for public health in WA; an increase in overseas acquired HIV notifications amongst Australian-born men. The role of ELoFT networks and their potential to impact on health were untested. The study has provided novel ways of thinking and sense making about changes to the HIV epidemic and those at risk (Crawford, Bowser et al. 2013). The chosen methodology has provided new insights into ELoFT behaviour. The study has and will provide policy and practice relevant findings which will contribute to the HIV response with mobile and migrant populations.

8.3 Implications and Opportunities

Study findings have generated implications and opportunities for policy, practice and research. Consistent with the principles outlined in the *HIV and Mobility in Australia: Road Map for Action* (Crawford, Lobo et al. 2014), implications and opportunities incorporate actions which focus on policy and governance; community mobilisation, clinical and public health service design and delivery; and surveillance and research. It is critical that such actions be underpinned by approaches that reduce barriers to testing and treatment, commits ongoing resources for effective strategies and supports methods and that do not demonise or penalise those most vulnerable (Crawford, Lobo et al. 2014). The following are a summary of recommendations and implications presented in Publications 1-5 along with additional considerations from observations, interviews and online forum data. These are presented under the following headings:

- Consideration of Principles for Cross-Cultural Engagement
- Considerations for Health Promotion, Clinical Practice and Policy
- Considerations for Policy
- Considerations for Research

8.3.1 Consideration of Principles for Cross-Cultural Engagement

This study highlighted a number of challenges for cross-country and intercultural research and practice (within and between countries). The extent to which realistic progress can be made outside of Australian borders is difficult to estimate evidenced by competing priorities of in-country organisations, language barriers and time and resourcing challenges. The resources required to implement an in-country intervention may be significant without considerable Australian and Thai investment. Training, staff exchange and continued research may be a better use of future funding. There appeared to be less local health promotion infrastructure than had been previously expected which would prove challenging to embed campaigns or key travel messages. However, there may be the opportunity for a joint travel-based campaign in key spaces including online settings. It is challenging to see clear stakeholder interest from those organisations such as UNAIDS Thailand. Such organisations are grappling with infections on a significantly larger scale. Consequently, it is a ‘hard sell’. Rightly, Australians are not a priority for them. However, the change in transmission dynamics in WA and in other jurisdictions, and increasing recognition that this is an issue for a number of HICs may provide impetus for a shared response in the future.

Partnership

Development of partnerships with relevant stakeholders in country of origin and destination and those working transnationally would be beneficial to ensure strategies complement work already occurring in both locations (Crawford, Lobo et al. 2014). Specifically, more formal partnerships would be valuable with organisations including: the AFAO (which invests in prevention efforts in SEA), DoHWA, DoH, Scarlet Alliance, AIVL, Australian state and territory AIDS Councils, the NAPWHA and key research centres and leveraging existing relationships with organisations in Thailand and the SEA region. A reciprocal relationship similar to the one formed between staff of ACON and Rainbow Sky may be helpful in WA for staff exchange or training and information exchange. As suggested by the study findings, engaging transnational companies employing individuals in SEA may yield health promotion opportunities within the organisation and the community more broadly (Hamer, Ruffing et al. 2008; Dahlgren, Deroo et al. 2009).

Participation

Historically, active participation by affected groups and individuals has been a cornerstone in the Australian HIV response. However, the ELoFT diaspora in SEA is somewhat disparate. In this context it is unclear as to what 'active participation' or indeed 'affected community' means. Consequently community and consumer participation in the development of strategies or in engaging affected /at-risk communities remains a challenge. Within this research there were a number of silences that presented. This included the voices of women, GMSM, sex workers, people who use drugs, people living with HIV and people from SEA more broadly. Exploring experiences through a post-colonial and feminist lens would provide a different perspective to the issues as would further consideration of white, male and 'Western' privilege (Botterill 2017; Stones, Botterill et al. 2019). Interventions must consider issues of cultural security and gender as well as real opportunities for community engagement and participation (Kippax, Stephenson et al. 2013).

Sex worker organisations in SEA and in Australia will be critical in ongoing practice, policy and research involving ELoFT populations (Brown, Ellard et al. 2010). Scarlet Alliance may be instrumental in brokering a more formal relationship on this issue alongside groups such as EMPOWER and SWING in Thailand. Those organisations have a long history of action on HIV and have relationships with sex workers. However, it is unclear as to how positively these organisations are viewed amongst sex workers, and to what extent they have scope to undertake wide-scale outreach activities. Research is required to explore relationships

between bar staff and ELoFTs and determine what impact any public health interventions may have on the safety and health of formal and informal sex workers in the region (Bauer 2007; Brown, Ellard et al. 2012; Rice, Gilbart et al. 2012; Manieri, Svensson et al. 2013). Interventions should intersectional approaches to effect transformation (Kågesten and Chandra-Mouli 2020).

Tailored responses and working upstream

A comprehensive approach to prevention of HIV is required for ELoFT populations. To be effective prevention efforts must be evidence-informed, tailored, and country, context and target group specific (including consideration of ELoFT heterogeneity and homogeneity). Individual and behavioural strategies must be balanced with responses which consider the cultural, political and social determinants of risk (Auerbach, Parkhurst et al. 2011; Kippax 2012; Kippax, Stephenson et al. 2013). An understanding of power, gender and culture in ELoFT cross-cultural relationships in relation to both women and GMSM is crucial (Janoschka and Haas 2013; Botterill 2017), along with a consideration of intersectionality for those who may be at risk. Recognising the complexity of working across borders is vital. In order to effectively work in the transnational space on population mobility and HIV utilising a complex systems approach would be beneficial (Meier, Brugh et al. 2012; Salway and Green 2017; Moore, Evans et al. 2019).

Stigma reduction

Research and practice must avoid stigmatising any particular group so they are not seen as 'the people you get HIV from'. This includes creating or reinforcing stereotypes of those at risk, or sex work or of local communities (Brown, Ellard et al. 2010). Any further research or intervention must be aware of the challenges that may arise if there is heightened awareness of HIV and mobility. This may include, for example, implications for groups (such as formal or informal sex workers) that may have little recourse if employers decided to change the way in which they employ or choose to screen employees, or if sexual or personal relationships are consequently affected. There may be stigma and discrimination of peer leaders within ELoFT social networks. For example anyone who may disclose status or use their status (HIV+ status, or status as a leader) to influence the behaviours of others or the norms within that group.

Awareness of culture and place

Study findings highlight the need to better understand ELOFT context and culture. ELoFTs have a unique culture which recognises their liminal existence and enduring relationship to

country of origin as well as destination which influence their worldviews and experience of adjustment and embedding. Consequently interventions must pay attention to the way in which culture and place shape identity, norms and practice. Risk knowledge, perceptions and practices were also shaped by social and cultural norms (Lupton and Tulloch 2002). Interventions focused only on the negative aspects of risk-taking, or that fails to account for prevailing norms or culture is less likely to be successful. Accordingly, better understanding of the pathways and motivations for travel and migration and recognition of the myriad positive reasons for risk-taking is critical. As noted in Publication 2 by Brown and colleagues (2014), interventions and strategies may have more salience when they appeal to sought-after experiences.

8.3.2 Considerations for Health Promotion, Clinical Practice & Policy

This study has produced considerations for health promotion, clinical practice and policy for those working in the HIV response and with mobile and migrant populations particularly. The following are a summary of recommendations and implications from Publications 1-5 along with additional reflections.

Targeted strategies - media and education

Findings from the systematic review suggested a considerable focus on education (Zuckerman and Steffen 2000; Fenton, Chinouya et al. 2001; Streeton and Zwar 2006; Mercer, Fenton et al. 2007; Croughs, Gompel et al. 2008; Hamer, Ruffing et al. 2008; Zuckerman and Hoet 2008; Combs and Giele 2009; Dahlgren, Deroo et al. 2009; Rice, Gilbart et al. 2012; Matteelli, Schlagenhauf et al. 2013; Whelan, Belderok et al. 2013; Alcedo, Kossuth-Cabrejos et al. 2014; Angelin, Evengard et al. 2014). Accordingly, there may be scope to better deliver health related information to ELoFTs via traditional or new media (Angelin, Evengard et al. 2014) or other appropriate channels to target specific ELoFTs at greater risk (Fenton, Chinouya et al. 2001; Hamer, Ruffing et al. 2008; Bhatta, Simkhada et al. 2009; Alcedo, Kossuth-Cabrejos et al. 2014; Angelin, Evengard et al. 2014). This could include for example, targeting ELoFTs working in countries of high HIV prevalence in SEA for protracted periods through an educational workplace intervention. Information and training could also be delivered in-situ in partnership with, or to support local organisations around health risks, of provision of support for adjustment to country of destination (Fenton, Chinouya et al. 2001; Cabada, Echevarria et al. 2002; Cabada, Montoya et al. 2003; Bauer 2007; Brown, Ellard et al. 2012; Crawford, Lobo et al. 2014).

To be most effective, comprehensive interventions will be critical (Rice, Gilbart et al. 2012; Matteelli, Schlagenhauf et al. 2013; Crawford, Lobo et al. 2014). Interventions which recognise heterogeneity of populations and homophily of core networks may also be more effective (Zuckerman and Steffen 2000; Bauer 2007; Mercer, Fenton et al. 2007; Ansart, Hochedez et al. 2009; Bauer 2012; Brown, Ellard et al. 2012; Whelan, Belderok et al. 2013; Angelin, Evengard et al. 2014; Crawford, Lobo et al. 2014). ELoFTs could be recruited to create an advisory group who could be accessed to provide advice on possible interventions, approaches or resources for their peers (Brown, Ellard et al. 2010).

Using social influence – networks and capital

As suggested by the conceptual model, interventions should capitalise on network features including density, multiplexity, cohesion, social ties, trust and reciprocity to target key individuals, points, actions and places (Kim 2012; Rademacher and Wang 2014). In line with findings around the core and peripheral network, interventions should build on both strong and weak ties, thick and thin trust, and bridging and bonding capital. Findings suggested that peer influence and the provision and receipt of social support were important in exerting social pressure to create norms and attitudes about sexual risk behaviours (Amirkhanian 2014). Consequently interventions should seek to amplify social support which is critical for ELoFT adjustment and may be important in reducing health-harming risk practices, beliefs and knowledge.

Peer influence has been effective when driven by members of the community and supported by broader health promotion strategies (Brown, O'Donnell et al. 2014; Madden and Wodak 2014). This may be a more difficult proposition due to the relatively large ELoFT diaspora and the disparate nature of their transnational networks. However, harnessing core networks may be valuable due to the credibility of key individuals and the high levels of trust and reciprocity that exist within this component of the network. Using opinion leaders has demonstrated utility in peer influence interventions among GMSM, sex workers, and people who inject drugs (Amirkhanian 2014; Fujimoto, Wang et al. 2015; Marshall, Dechman et al. 2015). Further exploration is required to determine who is viewed as most credible. It is likely that resources, information or skills required to reduce HIV transmission risk would not be viewed as meaningful from some sources. Complementing this with interventions that activate the bridging function of the peripheral networks which contains a more diverse set of experiences would be critical.

Settings approaches - the third place

ELoFTs have an enduring and unique relationship with country of origin and destination and with place which influences identity, sense of home and belonging. Exploring opportunities to embed strategies in the third space may be valuable including the potential of bars and other local settings (Crawford, Bowser et al. 2013) as described in Chapter Five. Findings also highlight opportunities to optimise support online particularly given the liminal, transnational status and identity that ELoFTs hold. Online networks and spaces may be used to complement or extend the reach of public health interventions. Harnessing networks via the range of online ELoFT forums may be a powerful way to correct misinformation, provide online communities of support and challenge norms and assumptions around risk practices. Broader social media platforms such as Instagram and Facebook may also provide adjuvant strategies, however may be less directly tailored to those at risk. Reddit or other similar online discussion spaces may also access those with similar attitudes and risk practices. However, as demonstrated by this and other research, individuals delivering strategies must be well connected to the networks in which they are conducted (Hallett, Brown et al. 2007). Accordingly, it may be likely that unless they were peers, clinicians or health promotion practitioners may not readily be accepted into forums or other online communities in expert roles to share information. Health-promotion organisations could instead work to influence those who hold key positions within online networks to amplify the visibility of timely and accurate information and advice, leverage positive norms around risk and relationships and increase the social capital of ELoFTs (Crawford, Maycock et al. 2018).

As reflected in Chapter Six (Publication 5), intervention design must consider whether cultures of online networks are compatible with a health promotion and rights-based approach. This challenge has been highlighted in both historical and contemporary gay community programs where significant work has been undertaken in peer programs to reduce structural and community inequities, including stigma toward people living with HIV, racism, and sexism (Smit, Brady et al. 2012). Additional resources for local services (in country of origin and destination) may be required for any increased use of health services as a result of better awareness of risks (Crawford, Maycock et al. 2018).

Place based interventions would need to overcome the tyranny of distance and associated resourcing implications. Place based action may also be more difficult in areas where there are fewer ELoFT enclaves or less connection back to the ELoFT imaginary or ‘Western’ community. There may be some challenges related to accessing the spaces where power is

consolidated or where health-harming practices may be occurring (backstage). This may be more easily ameliorated online. The potential negative impact of intervention applied only with dense, geographically proximate core networks should be considered. Such interventions may serve to reinforce social inequities, reify difference with locals or reinforce negative norms and may make it more challenging to mobilise the important effects of weaker ties from the geographically more disparate peripheral networks who provide important diversity.

Clinical practice

Results from the systematic review suggest that ELoFTs may have poor knowledge of risks related to HIV and other STIs (Zuckerman and Steffen 2000; Streeton and Zwar 2006; Bauer 2007; Mercer, Fenton et al. 2007; Zuckerman and Hoet 2008; Brown, Ellard et al. 2012). Barriers should be identified and addressed which prevent clinicians from raising concerns with patients or which prevent routine testing (Zuckerman and Steffen 2000; Cabada, Montoya et al. 2003; Zuckerman and Hoet 2008; Bhatta, Simkhada et al. 2009; Rice, Gilbart et al. 2012). Clinicians require guidelines regarding pre-post travel as well as information and advice (including carrying and using condoms) that is tailored to the context of travel and which includes the provision of more regular sexual health testing with ELoFTs on return to countries of origin. (Zuckerman and Steffen 2000; Fenton, Chinouya et al. 2001; Cabada, Echevarria et al. 2002; Streeton and Zwar 2006; Hamer, Ruffing et al. 2008; Croughs, Gompel et al. 2008; Zuckerman and Hoet 2008; Dahlgren, Deroo et al. 2009; Rice, Gilbart et al. 2012; Alcedo, Kossuth-Cabrejos et al. 2014; Boggild, Geduld et al. 2014). Opportunities should be explored to increase vaccine coverage for hepatitis B amongst ELoFTs (Streeton and Zwar 2006; Bauer 2012; Rice, Gilbart et al. 2012; Manieri, Svensson et al. 2013; Angelin, Evengard et al. 2014). Fieldwork indicated opportunities for Australian clinicians to work more closely with local pharmacies and clinics in SEA to discuss consistency of advice and practices around testing and treating those who may be at risk as well as explore options for HIV rapid testing, and HIV self-testing.

Policy, funding, monitoring and evaluation

Interventions require appropriate funding and must be of sufficient duration and dose to see positive outcomes. Policymakers should work with health promotion practitioners and researchers to develop key indicators to evaluate programs (Fenton, Chinouya et al. 2001; Cabada, Montoya et al. 2003; Bauer 2007; Hamer, Ruffing et al. 2008; Bhatta, Simkhada et al. 2009; Dahlgren, Deroo et al. 2009; Brown, Ellard et al. 2012; Crawford, Lobo et al. 2014).

Cost effectiveness should also be established (Crawford, Lobo et al. 2014). Regular, embedded monitoring and evaluation is needed alongside more standardised jurisdictional surveillance for sub populations which would assist to tailor strategies and provide a rationale for government resourcing (Cabada, Montoya et al. 2003; Wilson and Halperin 2008; Collins 2009; Crawford, Lobo et al. 2014). Universal access to HIV testing and treatment is required for all Australian residents, including temporary visa holders.[18] Additionally, PrEP should be made widely available to those who may be vulnerable in line with national recommendations (Commonwealth of Australia 2018b; Community of Practice for Action on HIV and Mobility 2018). Any cost implications of increased testing and treatment will be an important consideration.

8.3.4 Considerations for Research

Findings from this study suggest a number of avenues for future research. Opportunities include improved study designs for work with ELoFTs, enhanced surveillance, intervention studies and social network analysis. Nationally it is recognised that subsequent research may focus on broader issues of HIV and mobility (e.g. within culturally and linguistically diverse communities) in line with changes in WA epidemiology; this is not within the scope of the current research area. The following are a summary of recommendations and implications from Publications 1-5 along with additional considerations.

Methodological improvements

In relation to other research, findings from the systematic review found few studies that specifically examined perspectives of ELoFTs, few which focused on GMSM and few which focused on men travelling to destinations of high HIV prevalence. Accordingly, further research that has an explicit focus on the experiences of ELoFTs including GMSM would be valuable, particularly examining practices in countries of high HIV prevalence. Other key issues included a lack of target group segmentation (e.g. capturing data on country of origin and destination, travel duration, risk practices, frequency of stay or familiarity with the destination); problematic to tailor future interventions (Yokota 2006; Brown, Ellard et al. 2012; Brown, Ellard et al. 2014).

Methodological improvements will better inform the design and delivery of interventions. The review indicated a number of limitations related to study design and type. Most review studies were quantitative and cross-sectional with reliance on self-reported behaviour and

[18] People living with HIV without a Medicare card cannot formally access subsidised antiretroviral treatment.

knowledge. Valid, standardised measures are needed to supplement self-report data to make comparisons across studies and clear conclusions about current trends. Findings from the analysis of online forum data would have benefitted from analysis of a greater number of posts and threads to look at perspectives over a longer length of time. Replicating this piece of work would be helpful to determine whether the forum contains a greater number of Australian ELoFTs whose perspectives would be valuable or whether other forums have emerged that may prove useful for intervention or research.

As mentioned previously, more harmonisation in the way in which data are recorded about country of birth and place of acquisition would be valuable in national and jurisdictional surveillance efforts. A cross-sectional behavioural study of WA men exploring travel and risk practices including those relating to sexual health would provide further context for the design of interventions. A second follow-up with Australian men who acquired HIV overseas to explore issues highlighted in this study would be helpful.

Settings, place and culture

Historically, many HICs have viewed LMICs through a colonial lens, positioning countries in SEA as permissive, sources of infection or as *"pleasure peripheries"* (Bandyopadhyay 2013, p.2) (Yokota 2006; Collins 2009; Brown, Ellard et al. 2012; Brown, Ellard et al. 2014). Research could explore the diversity of ELoFT perspectives, particularly in relation to constructions of risk in origin and destination countries (Cabada, Montoya et al. 2003; Ward and Plourde 2006; Bauer 2007; Brown, Ellard et al. 2012). An examination of the drivers which enable people to migrate will provide important intervention context (Organisation for Economic Co-Operation and Development 2009). Better understanding is required of the experiences and practices of the men and women working in bars and the potential role they may play within ELoFT networks. Transformational opportunities to involve and support women and which consider the range of factors and influences on their health outcomes were highlighted as critical which has been highlighted as central to gender equity (Kågesten and Chandra-Mouli 2020). Stakeholders suggested that sex workers, sex worker organisations and women who work in bars should be at the centre of projects, have the opportunity to actively contribute to projects (including being part of decision making processes) and to directly benefit (economically or socially) from projects. Projects should focus on power and culture as well as education and importantly, be supportive to and understand the needs of Thai sex workers including social, economic and cultural needs.

Results revealed the influence of place on health and impact of people on place. Further observational work would be valuable to better understand opportunities for settings-based interventions. There was strong evidence of enclaves and micro-cultures which required further examination. It has been suggested that *"Static identity markers do not capture embeddedness in transnational social fields"* (Somerville 2008, p.31), which was supported by this research. Accordingly, further work is needed to understand the range of individuals who become ELoFTs and their collective and individual identities both before, during and after the migration experience including the expression of identities, and the meanings ELoFTs attach to those identities. Future research and interventions could consider the wealth of literature in geography, tourism and place which is of great relevance to public health and mobility. Further, it would be beneficial to engage with those working in geographies, tourism, and in place-based research who have observed and documented experiences of ELoFTs, specifically expatriates and travellers, for some time albeit not in relation to public health issues (see for example work by Benson (2016)).

Testing and treatment as prevention

Participants demonstrated an engagement with and interest in treatment and prevention. This should be capitalised on, particularly in relation to PrEP. Such research might explore ELoFT acceptability of treatment as prevention, for ELoFTs who may be at risk of HIV in SEA countries of high HIV prevalence. The review and the study findings suggested a need to examine barriers and facilitators to pre and post travel consultation and testing (Cabada, Echevarria et al. 2002; Streeton and Zwar 2006; Zuckerman and Hoet 2008; Angelin, Evengard et al. 2014; Boggild, Geduld et al. 2014).

Networks and social influence

Further research could expand findings to a social network analysis for deeper understanding of the way in which ELoFT networks function (both online and offline), including cohesion, density, and homophily and relationships between social ties (Wright 2000; Veinot, Caldwell et al. 2016). This may assist to understand the network processes which may act on ELoFT health-related attitudes, behaviours, and outcomes (Perkins, Subramanian and Christakis 2015). Consideration of actor-network theory in any applied research interventions may assist to understand how ideas circulate through ELoFT networks (Salazar 2012). The theory may be used to show how everyday ELoFT practices in country of origin and destination are transmitted throughout the network leading to social change and the channels by which actor-networks are formed and sustained (Duim 2005;

Latour 2005). Research to identify key assets and actors who may act as opinion leaders would be helpful in recognising and capitalising on the influence of others on the knowledge and practices of the individual and between the individual and the environment (Brown, Ellard et al. 2010). Further exploring constructs from behavioural and social theories such as Diffusion of Innovations (Rogers 1983), Social Cognitive Theory (Bandura 1986), Theory of Reasoned Action (Fishbein and Ajzen 2009) or Social Impact Theory (Latané and Wolf 1981) would be of interest.

It would be valuable to explore the role, type, timing, level and quality of social support in ELoFT networks. Further exploring the contingent nature of support is recommended. Examining mechanisms to enhance social capital and the links between these and health and risk knowledge, beliefs, norms and practices would be helpful. This includes the positive and negative aspects of social networks that may be health enhancing or harming as well as and existing levels of self-rated health, perceived support and social isolation/exclusion. Examining the role of minority influence or the potentially negative impact of bonding capital and strong ties which may further social control and exclusion may be valuable (Uphoff, Pickett et al. 2013). Further research should consider socio-economic status, education and age as moderating pathways within the network and subsequent impact on health (Aartsen, Veenstra et al. 2017). Critically, moving upstream to scrutinise broader sociocultural contexts in which ELoFT networks are situated and which shape the structure of networks may yield important insights (Berkman, Glass et al. 2000).

Online Intervention

An applied research project could explore an online outreach intervention. As per the findings of Publication 5, an online forum may provide health promotion agencies a space to trial safer sex messages, provide peer support or information or as part of a broader campaign to promote testing and treatment, including PrEP (Crawford, Maycock et al. 2018). Utilising peers (including PLHIV ELoFTs) in the online space (e.g. through social media) may provide avenues for informal, incidental outreach, opportunities to correct misinformation or to exert subtle pressure on negative stereotypes or norms (Crawford, Maycock et al. 2018). Such interventions must be carefully facilitated so as not to render influencers vulnerable nor consolidate power where it may be potentially health harming. It is recommended that a composite body of knowledge is developed with a coordinated national approach or with other jurisdictions experiencing similar challenges to develop such a project.

8.4 Concluding remarks

Australia is making great gains towards achieving its HIV targets. But approximately 1000 new HIV infections are still recorded each year. There is no panacea. Driving down new notifications will require a range of actions. This means embracing new testing mechanisms, better access to combination prevention, wider coverage of treatment as prevention, policy mechanisms to increase health service and treatment access and more interventions targeted where those most vulnerable live, work and play.

This research has contributed new insights about a group at risk for HIV acquisition. Findings from this study shed light on potential transmission dynamics amongst Australian men who acquire HIV in SEA. The explanatory conceptual model emphasises the pathways and motivations that underpin migration amongst Australian ELoFTs to SEA. In order to 'live liminal', social networks were important social survival strategies. Networks both core and peripheral were developed and sustained through community and communitas. Identity, adjustment, support, pathways, motivation, risk, home and place were the processes and contexts through which the ELoFT's sense of self was shaped, how social norms were communicated, and how an 'ELoFT culture' was built. Networks were composed of multiplex social ties of varying strengths and were illustrative of key social capital features; influential in affecting group norms and attitudes. There is some role for networks to be used to influence health outcomes including HIV risk, best achieved by engaging with influential people, influential places and influential points that act to amplify social capital and/or enhance network capacity.

The 2018 Lancet Commission on Migration and Health argued that migration is a critical and contemporary global health priority (Abubakar, Aldridge et al. 2018). The Commission Chair, Professor Abubakar noted, *"How the world addresses human mobility will determine public health and social cohesion for decades ahead"* (UCL Lancet Commission on Migration and Health 2018). In the context of population mobility, a reduction in HIV notifications will require greater consideration of the connection between local and global, and the complexity of behaviours, settings, norms and contexts for risk and for prevention of HIV. This study has yielded strong, evidence informed recommendations for intervention and policy design to reduce risk of HIV and other STI transmission amongst mobile populations.

An end to new HIV infections is within our grasp. It is the fervent hope of this researcher to have made some small contribution to this vision, and to be part of the public health community when it becomes a reality.

We shall not cease from exploration, and the end of all of our exploring will be to arrive where we started and know the place for the first time.

- Little Giddings, T.S. Eliot, 1942 -

Appendices

Appendix A: Copyright permissions

Crawford G, Lobo R, Brown G and Maycock B. The Influence of Population Mobility on Changing Patterns of HIV Acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia*. 2016: 27(2):153-154. doi:10.1071/he15042

Brown G, Ellard J, Mooney-Somers J, Prestage G, Crawford G and Langdon T. 'Living a Life Less Ordinary': Exploring the Experiences of Australian Men Who Have Acquired HIV Overseas. *Sexual Health*. 2014; 11(6): 547-555. doi:10.1071/sh13155

Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249

Crawford G, Bowser NJ, Brown GE and Maycock BR. Exploring the Potential of Expatriate Social Networks to Reduce HIV and STI Transmission: A Protocol for a Qualitative Study. *BMJ Open*. 2013; 3(2): e002581.doi:10.1136/bmjopen-2013-002581

Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

Appendix B: Co-author contributions

The International Committee of Medical Journal Editors recommends that authorship is based on the following four criteria:

1. Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
2. Drafting the work or revising it critically for important intellectual content; AND
3. Final approval of the version to be published; AND
4. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

See: http://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html.

The following works included co-authors.

1. Crawford G, Lobo R, Brown G and Maycock B. The Influence of Population Mobility on Changing Patterns of HIV Acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia*. 2016: 27(2):153-154. doi:10.1071/he15042
2. Brown G, Ellard J, Mooney-Somers J, Prestage G, Crawford G and Langdon T. 'Living a Life Less Ordinary': Exploring the Experiences of Australian Men Who Have Acquired HIV Overseas. *Sexual Health*. 2014; 11(6): 547-555. doi:10.1071/sh13155
3. Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249
4. Crawford G, Bowser NJ, Brown GE and Maycock BR. Exploring the Potential of Expatriate Social Networks to Reduce HIV and STI Transmission: A Protocol for a Qualitative Study. *BMJ Open*. 2013; 3(2): e002581.doi:10.1136/bmjopen-2013-002581
5. Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

The following works included authorship contributions as part of manuscript publication.

Crawford G, Lobo R, Brown G and Maycock B. The Influence of Population Mobility on Changing Patterns of HIV Acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia*. 2016: 27(2):153-154. doi:10.1071/he15042

Author contributions: GC was responsible for coordinating the contribution of all authors to this paper. All authors made significant contributions to the development and conceptualisation of the protocol. GC and RL were responsible for drafting this paper. GB and BM were responsible for editing and guidance on the paper. All authors were responsible for critically revising the paper. All authors approved the final version of this paper for submission.

Brown G, Ellard J, Mooney-Somers J, Prestage G, Crawford G and Langdon T. 'Living a Life Less Ordinary': Exploring the Experiences of Australian Men Who Have Acquired HIV Overseas. *Sexual Health*. 2014; 11(6): 547-555. doi:10.1071/sh13155

Author contributions: GB was responsible for coordinating the contribution of all authors to this paper. GB was responsible for the conceptualisation of the paper. GB and GC were responsible for drafting this paper. JE, JMS, GP and TL were responsible for editing and guidance on the paper. All authors were responsible for critically revising the paper. All authors approved the final version of this paper for submission. GC was responsible for manuscript submission, liaison with the journal, responding to reviewer comments and readying the manuscript for final publication.

Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review. *International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249

Author contributions: GC was responsible for coordinating the contribution of all authors to the paper and conceptualised the study. GC, RL, BM and GB designed the study protocol. GC, CM and HS undertook database searching and data extraction. GC, RL, CM and HS completed the quality appraisal. GC, CM and HS drafted the paper. RL, BM and GB were responsible for editing and providing guidance. All authors read and approved the final version for submission.

Crawford G, Bowser NJ, Brown GE and Maycock BR. Exploring the Potential of Expatriate Social Networks to Reduce HIV and STI Transmission: A Protocol for a Qualitative Study. *BMJ Open*. 2013; 3(2): e002581.doi:10.1136/bmjopen-2013-002581

Author contributions: GC was responsible for coordinating the contribution of all authors to this paper. All authors made significant contributions to the development and conceptualisation of the protocol. GC and NB were responsible for drafting this paper. GB and BM were responsible for editing and guidance on the paper. All authors were responsible for critically revising the paper. All authors approved the final version of this paper for submission.

Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

Author contributions: GC was responsible for coordinating the contribution of all authors to the paper and conceptualised the study. All authors supported the design of the study protocol. GC and RT undertook data collection and analyses and drafted the paper. RL, BM, and GB were responsible for providing critical revision and guidance. All authors read and approved the final version for submission.

Main Co-authors

Professor Bruce Maycock

I, Professor Bruce Maycock contributed as a supervisor of this PhD. I had an ongoing, close relationship with the research, including contributing to the project proposal, discussing structure of publications, reading drafts and making suggestions for improvements to the publications entitled:

1. Crawford G, Lobo R, Brown G and Maycock B. The Influence of Population Mobility on Changing Patterns of HIV Acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia*. 2016: 27(2):153-154. doi:10.1071/he15042
2. Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249
3. Crawford G, Bowser NJ, Brown GE and Maycock BR. Exploring the Potential of Expatriate Social Networks to Reduce HIV and STI Transmission: A Protocol for a Qualitative Study. *BMJ Open*. 2013; 3(2): e002581.doi:10.1136/bmjopen-2013-002581
4. Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

All co-authors, including the candidate met the guidelines for authorship.

Professor Bruce Maycock – 19/07/2019

Associate Professor Graham Brown

I, Associate Professor Graham Brown contributed as a supervisor of this PhD. I had an ongoing, close relationship with the research, including contributing to the project proposal, discussing structure of publications, reading drafts and making suggestions for improvements to the publications entitled:

1. Crawford G, Lobo R, Brown G and Maycock B. The Influence of Population Mobility on Changing Patterns of HIV Acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia*. 2016: 27(2):153-154. doi:10.1071/he15042
2. Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249
3. Crawford G, Bowser NJ, Brown GE and Maycock BR. Exploring the Potential of Expatriate Social Networks to Reduce HIV and STI Transmission: A Protocol for a Qualitative Study. *BMJ Open*. 2013; 3(2): e002581.doi:10.1136/bmjopen-2013-002581
4. Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

I led the conceptualisation and drafting of the paper for which the candidate is the corresponding author. The candidate was responsible for drafting the manuscript, coordinating all contributions from authors and liaison with the journal, responding to reviewer comments and readying the manuscript for final publication.

1. Brown G, Ellard J, Mooney-Somers J, Prestage G, Crawford G and Langdon T. 'Living a Life Less Ordinary': Exploring the Experiences of Australian Men Who Have Acquired HIV Overseas. *Sexual Health*. 2014; 11(6): 547-555. doi:10.1071/sh13155

All co-authors, including the candidate met the guidelines for authorship. For paper 5, I sign on their behalf.

Dr Graham Brown – 05/08/2019

Dr Roanna Lobo

I, Dr Roanna Lobo contributed as a supervisor of this PhD. I had an ongoing, close relationship with the research, including discussing structure of publications, reading drafts and making suggestions for improvements to the publications entitled:

1. Crawford G, Lobo R, Brown G and Maycock B. The Influence of Population Mobility on Changing Patterns of HIV Acquisition: Lessons for and from Australia. *Health Promotion Journal of Australia*. 2016: 27(2):153-154. doi:10.1071/he15042
2. Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249
3. Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

All co-authors, including the candidate met the guidelines for authorship.

Dr Roanna Lobo – 05/08/2019

Other co-authors

Nicole Bowser

I, Nicole Bowser contributed as a research assistant to this project:

1. Crawford G, Bowser NJ, Brown GE and Maycock BR. Exploring the Potential of Expatriate Social Networks to Reduce HIV and STI Transmission: A Protocol for a Qualitative Study. *BMJ Open*. 2013; 3(2): e002581.doi:10.1136/bmjopen-2013-002581

I was involved in drafting this paper and making revisions to the paper. I approved the final version of this paper for submission. All co-authors, including the candidate met the guidelines for authorship.

Nicole Bowser – 01/05/2019

Rochelle Tobin

I, Rochelle Tobin contributed as a research assistant to this project:

1. Crawford G, Maycock B, Tobin R, Brown G and Lobo R. Prevention of HIV and Other Sexually Transmissible Infections in Expatriates and Traveler Networks: Qualitative Study of Peer Interaction in an Online Forum. *Journal of Medical Internet Research*. 2018; 20(9): e10787.doi:10.2196/10787

I was involved in the design of the study protocol. I supported data collection, analyses and made contributions to the manuscript. I read and approved the final version for submission. All co-authors, including the candidate met the guidelines for authorship.

Rochelle Tobin – 25/04/2019

Chloe Macri

I, Chloe Macri contributed as a research assistant to this review:

1. Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249

I supported data collection, extraction and quality appraisal and contributed to the draft manuscript. I read and approved the final version for submission. All co-authors, including the candidate met the guidelines for authorship.

Chloe Macri – 06/12/2018

Hannah Smith

Hannah Smith contributed as a research assistant to this review:

1. Crawford G, Lobo R, Brown G, Macri C, Smith H and Maycock B. HIV, Other Blood-Borne Viruses and Sexually Transmitted Infections Amongst Expatriates and Travellers to Low- and Middle-Income Countries: A Systematic Review*. International Journal of Environmental Research and Public Health.* 2016; 13(12): 1249. doi:10.3390/ijerph13121249

HS supported data collection, extraction and quality appraisal and contributed to the draft manuscript. HS read and approved the final version for submission. All co-authors, including the candidate met the guidelines for authorship.

UNCONTACTABLE

Appendix C: Rapid update of systematic review (2016-2019): data extraction table

Author/Purpose	Origin/Destination	Study Details	Sample/Response	Reported Outcomes
(Beauté, Cowan et al. 2017) *To estimate risk for gonorrhoea among travellers from Nordic countries using surveillance and tourism data*	**Origin:** Denmark, Finland, Norway, Sweden **Destination:** Africa, North and South America, Asia, Europe, Oceania	**Design/Methods:** Retrospective review of epidemiological data **Participants/Recruitment:** Gonorrhoea surveillance data 2008−2013 from Denmark, Finland, Norway and Sweden and EU tourism denominator data.	**Sample:** N/A **Response rate:** N/A	• Socio-demographics • Country of residence and destination • Sexuality • Location and year of gonorrhoeal infection
(Brown, Prestage et al. 2018) *To compare recently acquired HIV infections amongst gay men occurring in Australia to those that occurred overseas.*	**Origin:** Australia **Destination:** North and South America, Europe, UK, Asia, Oceania, Africa	**Design/Methods:** retrospective data analysis **Participants/Recruitment:** Male; GMSM; 16 yrs or older; living in Australia; diagnosed with HIV within previous two years. Data drawn from online HIV Seroconversion Study	**Sample:** n = 446 **Response rate:** N/A	• Description and location of high risk event leading to infection • Reason for travel • HIV testing history • Sexual and drug use behaviour • Beliefs about HIV risk • Sources of support and community contact • Mental well-being
(Dahl and Wallensten 2017) *To identify countries associated with notifiable or self-reported travel-associated infections for Swedish international travellers*	**Origin:** Sweden **Destination:** Europe, Asia, Oceania, North America, South America	**Design/Methods:** Retrospective ecological study. **Participants/Recruitment:** Males and Females; Swedish; <75 years; travelling abroad for at least one day 2009–2013; recruited via a commercial travel database of international travel by Swedish residents.	**Sample:** n = 18,507 **Response rate:** N/A	• Length of travel and destination • Self-reported and notifiable infections including: chlamydia, gonorrhoea and hepatitis B

Author/Purpose	Origin/Destination	Study Details	Sample/Response	Reported Outcomes
(Lewis and De Wildt 2016) *To measure unprotected sex by backpackers travelling in Thailand and identify predictors of unsafe sexual behaviour.*	**Origin:** UK, North America, Europe, Oceania, Other **Destination:** Thailand	**Design/Methods:** cross-sectional survey **Participants/Recruitment:** Males and females; single; from a range of high –income countries; aged 17 to 63 yrs. Intercept interviews using a pen and paper questionnaire at tourist locations (n= 2013).	**Sample:** n = 1238 **Response rate:** N/R	• Socio-demographics • Travel details • Sexual behaviour during travel • Number and gender of new partners • Consistency of condom use with new partners
(Peach, Lemoh et al. 2018) *To describe characteristics of new HIV diagnoses in Victoria amongst migrants and those born in Australia attributable to non MSM transmission*	**Origin:** Australia **Destination:** Europe, North America, Southeast Asia, sub-Saharan Africa, Other	**Design/Methods:** Retrospective analysis of Victorian public health surveillance data **Participants/Recruitment:** New HIV diagnoses; males and females; residing in Australia; 18 yrs or older; reporting heterosexual sex or IDU as likely route of exposure. Data came from the Public Health Event Surveillance System from 1996 to 2014.	**Sample:** N/A **Response rate:** N/A	• Socio-demographics • Place of exposure • Estimated date of infection • Place of HIV acquisition Advanced infection • Newly acquired infection
(Tanton, Johnson et al. 2016) *To examine prevalence of, and factors associated with new sexual partner(s) while overseas*	**Origin:** UK **Destination:** Europe, UK, Oceania, America, Caribbean, Asia, Middle-East, sub-Saharan Africa	**Design/Method:** Stratified national probability survey; face-to-face computer-assisted interviews. **Participants/Recruitment:** Male and female; 16–74 yrs; travellers; British residents reporting ≥1 sexual partner(s) outside UK for the first time in past 5yrs	**Sample:** n = 12 530 **Response rate:** 57.7%	• Socio-demographics • Sexual attraction, experience and behaviours • Overseas travel • Number and demographics of overseas sexual partners

Appendix D: Sample Advertising Materials

Flyer – made available in hard copy and online

About the NEXUS project

We are conducting research into the relationships and social networks that exist amongst Australian expatriates within South-East Asia (particularly Thailand).

Research team

Ms Gemma Crawford
Dr Graham Brown
Professor Bruce Maycock

Organisation

Western Australian Centre for Health Promotion Research,
Curtin University of Technology, Western Australia

Your role

If you agree to participate in the research, you will be asked a series of questions through an interview. This will take between 1-2 hours of your time, and the information will be digitally recorded. Information throughout this process will be kept confidential.

Information gathered through the study may be published, however your anonymity will be maintained throughout the research and you will not be identified in any way. All participants do so voluntarily and may withdraw from interviews at any time. It is not envisaged that sensitive information will be collected and there are no known negative consequences for participants. Further information or support can be provided to you on completion should you require it.

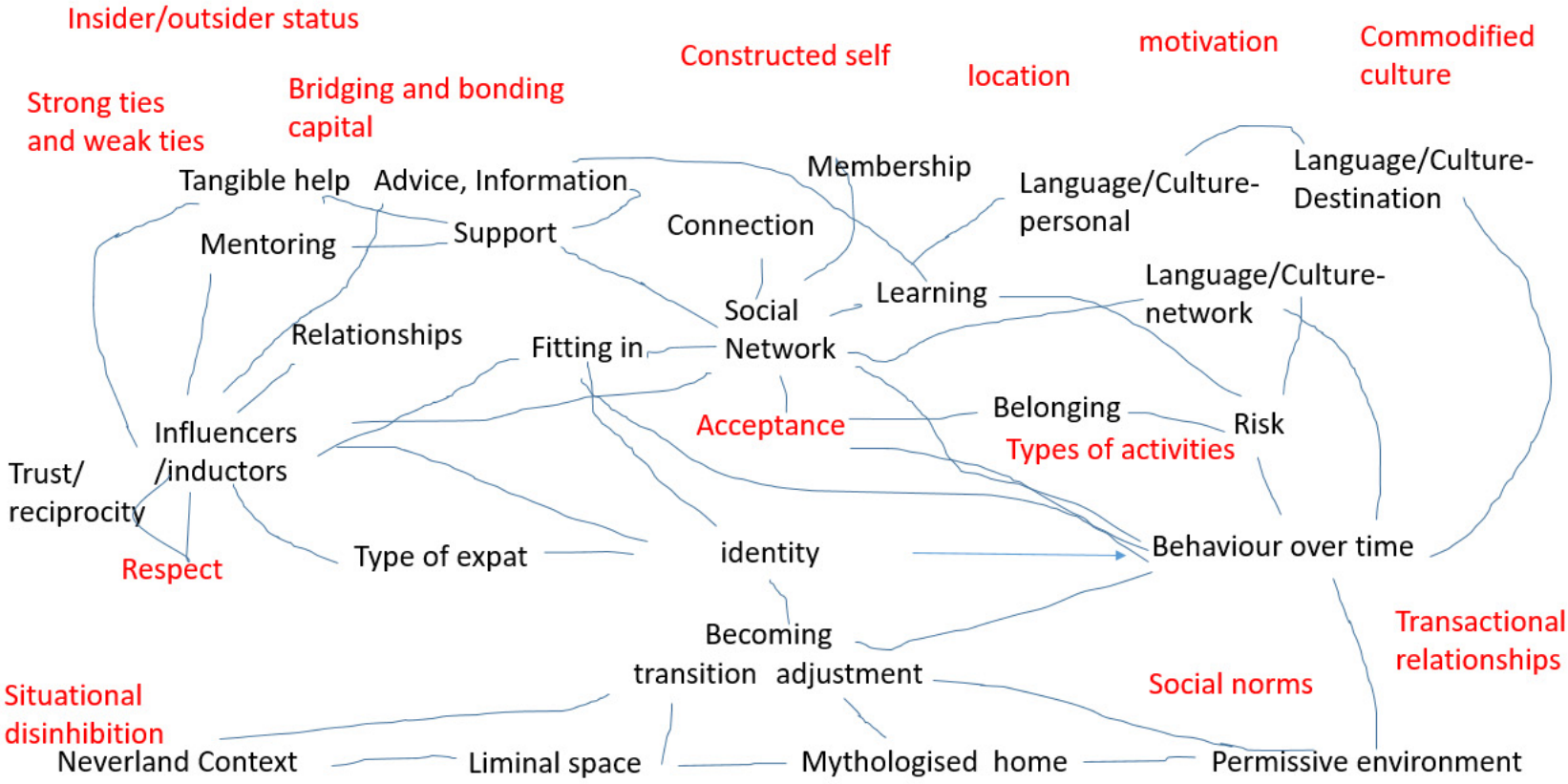
Ethics approval

This study has been approved by the Curtin Human Research Ethics Committee (Approval Number: SPH-13-2012). If needed, verification of approval can be obtained either by writing to the:

Human Research Ethics Committee
c/-Office of Research and Development
Curtin University of Technology
GPO Box U1987, Perth WA 6845

or by telephoning +61 8 9266 2745.

Appendix E: Example diagrams to develop conceptual model



Concept map showing codes rudimentary relationships

Identity in Place – Expatriate + Traveller

Type of expat/Role (seeker status-respect, reward, risk freedom, desire, spiritual connection) (seeker, cynic, angry man, lonely man, expert, giver, joker (quality of life, authentic, second go, family, professional), insider/outsider

Self concept (emotional and cognitive aspects-as a man, as an Australian, as a lover, partner, retiree, business man, helper), ideas of masculinity, pride (role identities) (shame or sense of shame at not being good enough at home)

Portrayal/Reflected appraisal (how I represent myself to others in my new environment/How others see me) (acting like a real aussie bloke)

Social norms and expectations (too many rules at home, Thailand is just one big brothel

Past, present, future experiences (relationship and business breakdown)(life of luxury, friends, partner, perpetual holiday)

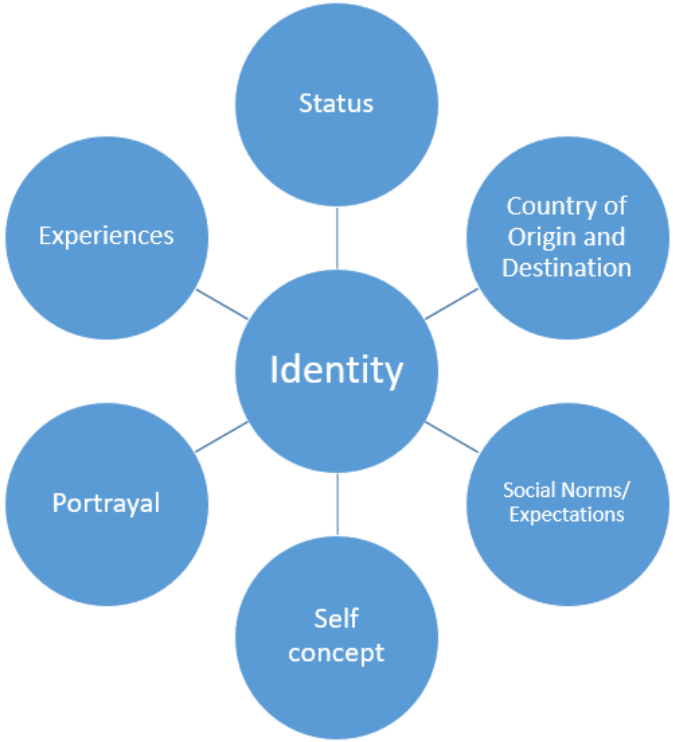
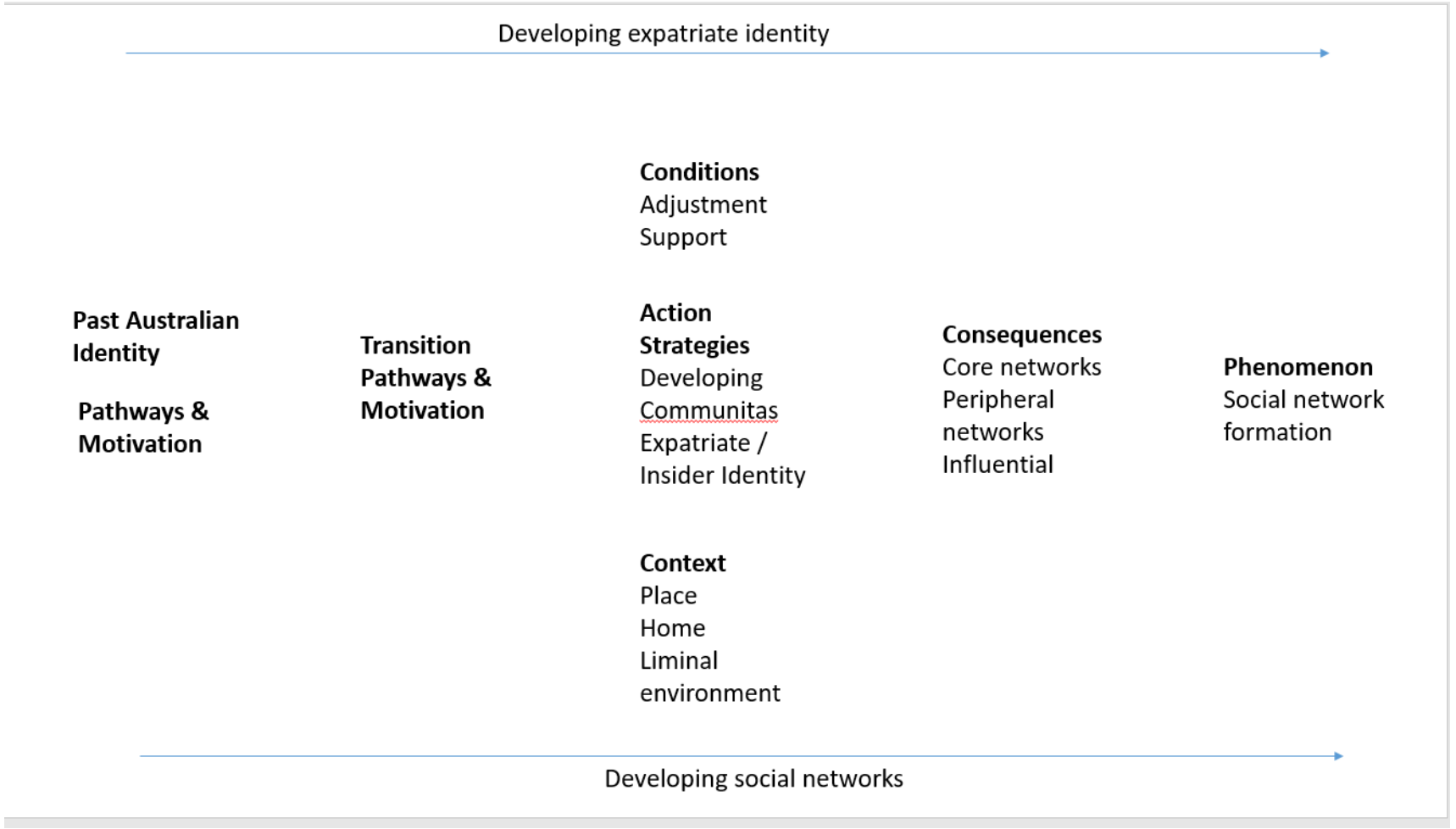


Diagram to unpack themes

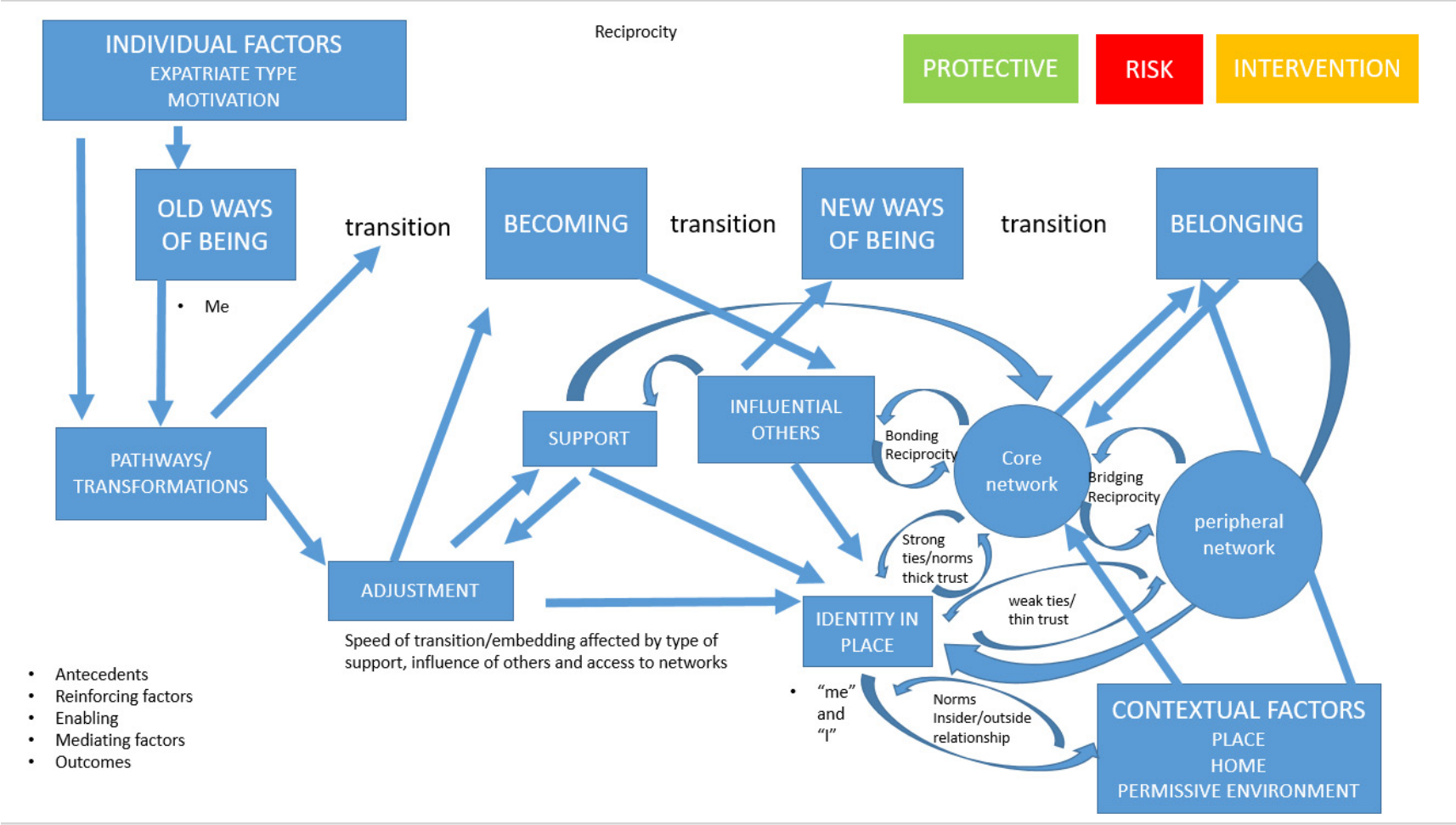
Opportunity	Acceptance	Belonging- New identity/reality/new ties, culture, membership, support giving	home
	Dissonance, reinforcement	Transition/transformation	risk
Opportunity	Connection-adjustment	Becoming - New behaviours, projected self, culture, relationships, trialing, networks, support, mentorship	Liminal space
	Dissonance, reinforcement	Transition/transformation	risk
Opportunity	event	Beginning - Old identity/reality/behaviours/ ties	home

Context-mythologised 'home', permissive destination, desire for authenticity, to fit in, to drop out, free from control.

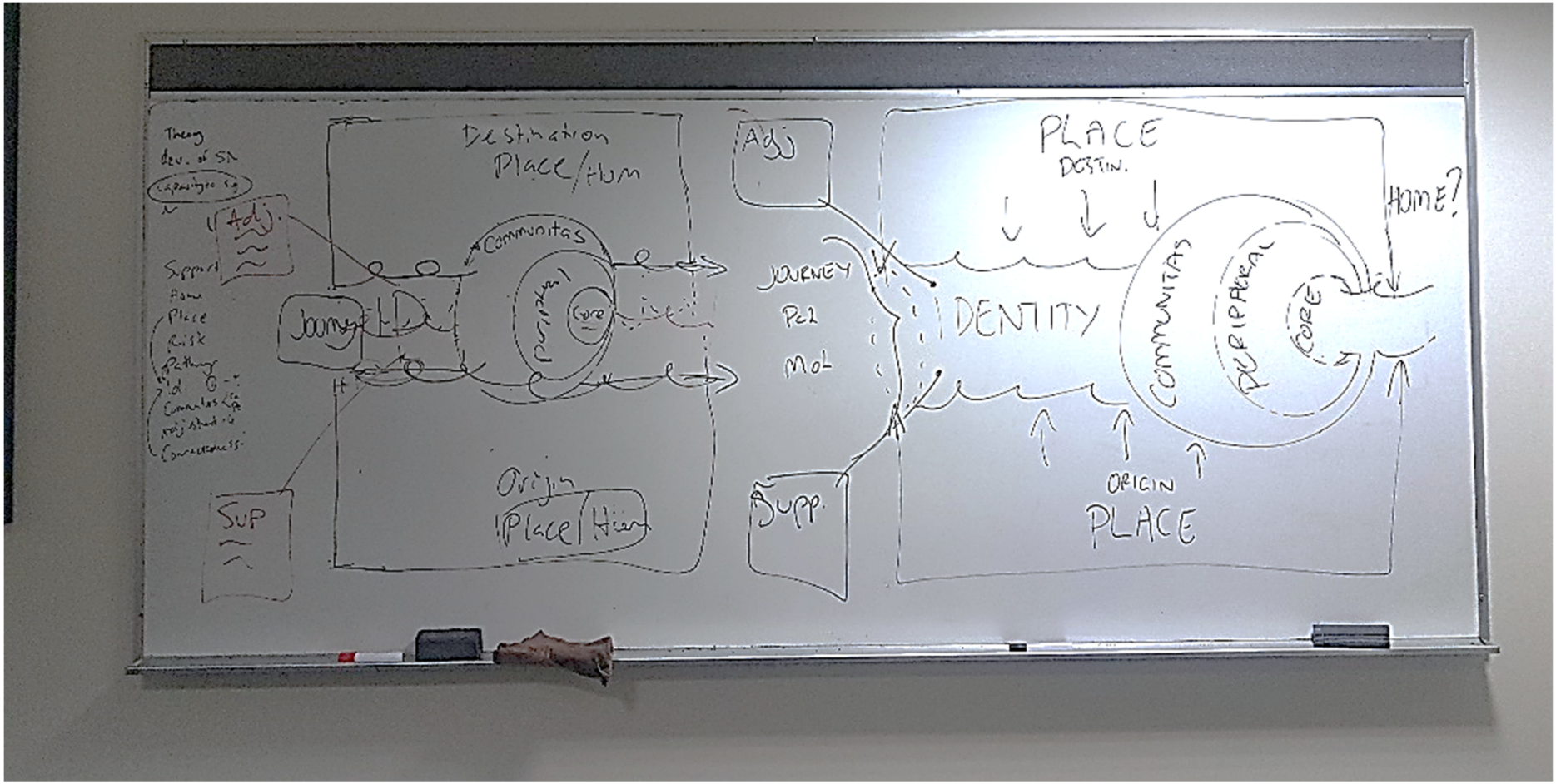
Linear brainstorm with process



Early grounded theory linear, text based diagram

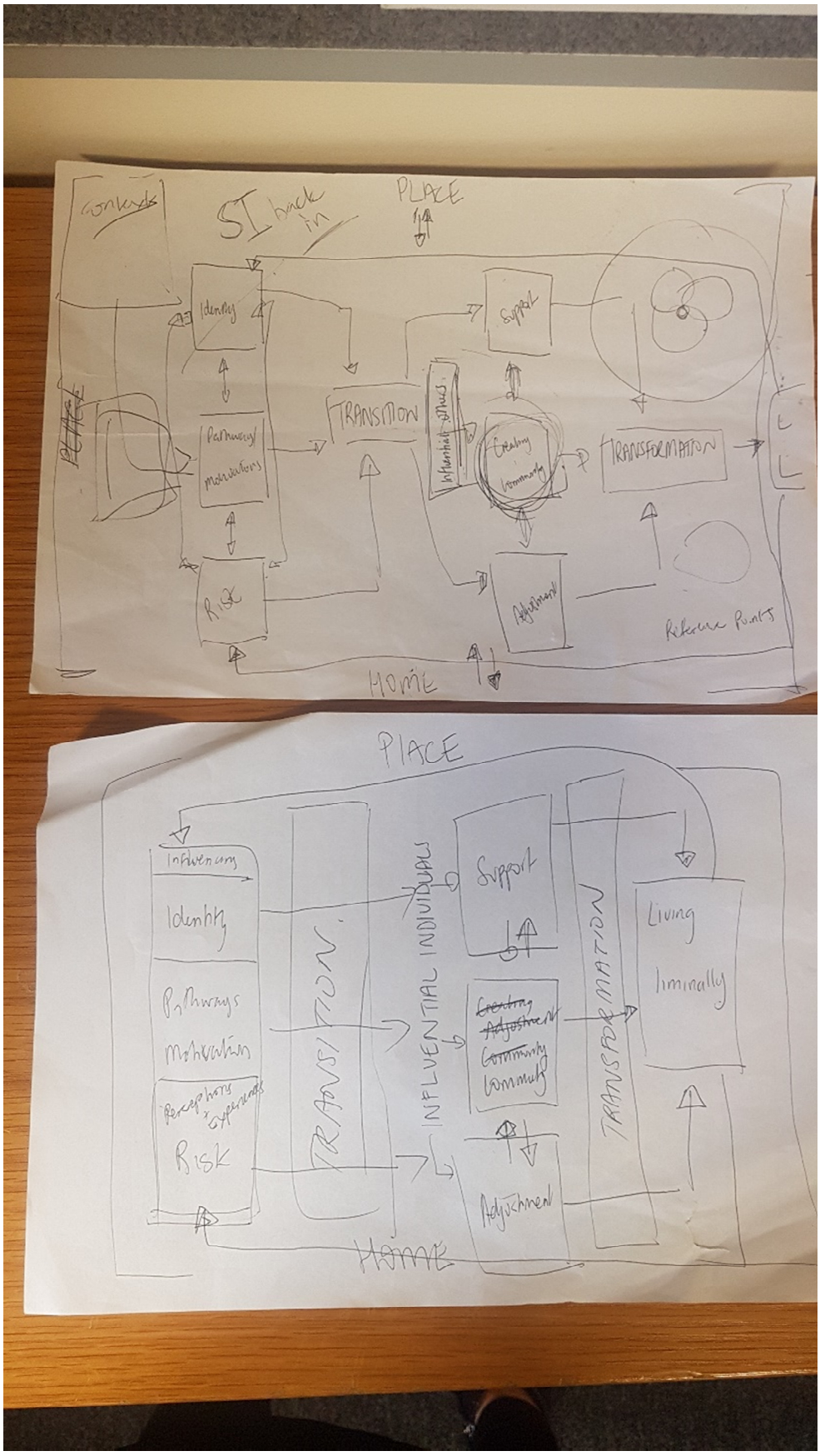


Attempts to show relationships and temporal factors



A whiteboard attempt to create a visual diagram of the conceptual model

Hand drawn attempts to draw the conceptual model showing connections and context



Hand drawn attempts to draw the conceptual model showing connections and context

Appendix F: Ethical Approval

Curtin University

Memorandum

School of Public Health
Telephone: 9266 7819
Facsimile: 9266 2958
l.thompson@curtin.edu.au

To	Ms Gemma Crawford
From	Mrs Leslie Thompson, Ethics Coordinator
Subject	Protocol Approval – SPH – 13 - 2012
Date	April 24th, 2012
Copy	

Thank you for your "Form C Application for Approval of Research with Low Risk (Ethical Requirements)" for the project titled: The NEXUS Project: "Investigating Australian male expatriate and long term traveller social networks in Thailand to determine their potential to influence HIV and other STI risk behaviour". On behalf of the Human Research Ethics Committee, I am authorised to inform you that the project is approved.

Approval of this project is for a period of twelve months, April 24th, 2012 to April 23rd, 2013.

The approval number for your project is SPH – 13 – 2012. *Please quote this number in any future correspondence*. If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately.

Thank you

Mrs Leslie Thompson

Ethics Coordinator

School of Public Health

Curtin University

Appendix G: Participant Consent Form

CONSENT FORM

My name is: _____

I hereby consent to participate in the Expatriate and Long Term Traveller Networks Study.

1. I am 18 years or older.

2. I acknowledge that I have read/been read the participant information sheet and understand its contents. I have been provided the opportunity to ask any questions that I have relating to the project. The research project, as far as it affects me has been explained to my full satisfaction and I therefore freely give my consent to participate in this project.

3. I understand that if I choose to participate in this study that I will be asked to participate in an interview. This will encompass questions about my experiences of being an Australian expatriate/living away from my primary place of residence for significant periods of time and the way that I engage in social networks whilst overseas.

4. I understand that the information that I provide will be kept confidential within specific limitations. These limitations concern disclosure of harm to others or abuse of children.

5. I understand that data will be stored in a locked cabinet at Curtin University of Technology in Perth, Western Australia. Data entered on the computed will be password protected and available only to the researchers.

6. I have been informed that while the information collected through this study may be published in a report or journal, I will not be identifiable in any way in the publications.

7. I am aware that I am free to withdraw from the study at any time, without explanation or penalty and should I decide to withdraw, then all material and information that has been collected from/about me will be destroyed.

8. I give consent to have this interview audio recorded.

9. I give consent to provide you my contact details and am aware that by doing so I may be further contacted for follow-up information.

My address is: _____

My email is: _____

Appendix H: Participant Information Sheet

Information Sheet | NEXUS Project

Introduction

You have been invited to take part in this research study. Before you make your decision, it is important for you to understand why the research is being done and what it would involve. Please read the following information and if there is anything that is not clear, please ask us to clarify.

Research Details

Researchers: Gemma Crawford, Professor Bruce Maycock, Dr Roanna Lobo, Dr Graham Brown
Organisation: WA Centre for Health Promotion Research, Curtin University, Western Australia

Overview

Research has indicated that a strong expatriate culture and networks exists outside of the Australian environment. There is however, a lack of information regarding the local relationships formed by expatriates and travellers, information shared in these relationships and the effects that these social networks have on their health. We are conducting research into the relationships and social networks that exist amongst Australian expatriates and long term travellers within Southeast Asia (particularly Thailand) to determine how we can develop programs that seek to reduce the impact of behaviour that may result in health harms. Interviews are being carried out with:

1. Men in Western Australia and in Thailand or Southeast Asia who are 18 years or older, and who are Australian expatriates or long term travellers to South East Asia.
2. Key stakeholders in Australia and Thailand or Southeast Asia who will assist to inform the direction of the research.

If you meet these criteria, we would like to interview you to find out more about your relationships with and knowledge about other Australians living and travelling in Southeast Asia.

Your role

If you agree to participate in the research, you will be asked a series of questions through an interview. This will take between 1-2 hours of your time, and the information will be digitally recorded. Information collected throughout this process will be kept confidential. Information gathered through the study may be published, however your anonymity will be maintained throughout the research and you will not be identified in any way.

All participants do so voluntarily without reward and may withdraw from interviews at any time. It is not envisaged that sensitive information will be collected and there are no known negative consequences for participants. Information collected and stored on audio files, written notes or computer files will be carefully secured at all times by the researcher.

Data will only be accessed by the researcher and by supervised administrative staff involved in the transcribing of audio recordings. All information will be destroyed after five years. Further information or support can be provided to you on completion should you require it.

Research Queries

Should you have any questions regarding this research, please do not hesitate to contact:

Gemma Crawford - WA Centre for Health Promotion Research | School of Public Health
Faculty of Health Sciences | Curtin University |Ph: (08) 9266 4851|Email: g.crawford@curtin.edu.au

This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number SPH-13-2012). The Committee comprises members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Appendix I: Conference Presentations

1. **Crawford G.** Travelers: the potential for HIV/sexual health peer and network interventions among Australian travellers and expatriates in high prevalence countries. Mobility/Migration Symposium. Australasian Sexual Health and HIV&AIDS Conference. Perth *(Symposium invited speaker)*
2. Gray C, **Crawford G,** Lobo R, Brown G. 2019. HIV and Mobility in Australia: Creating a Coalition for Action. Australasian Sexual Health and HIV&AIDS Conference. Perth *(Poster)*
3. Gray C, **Crawford G,** Lobo R**.** 2018. *HIV and Mobility in Australia: Creating a Coalition and a Road Map for Action.* 1st World Congress on Migration, Ethnicity, Race and Health 2018. Edinburgh (*Presentation*)
4. Gray C, **Crawford G,** Lobo R**.** 2017. *Using online communities of practice to facilitate collaborative work in HIV and mobility*. 15th World Congress on Public Health. Melbourne. *(Presentation)*
5. **Crawford G**, Lobo R, Gray C, Brown G. 2016. *HIV and Mobility in Australia: Road Map for Action Update*. SiREN Symposium. Perth *(Presentation)*
6. **Crawford G.** 2016. *Making the healthy choice the easy choice: not that easy: HIV and Mobility in Western Australia*. WA Health Translation Networks Public Health and Health Promotion Workshop. Perth, Australia *(Invited Presentation)*
7. Gray C, Brown, **Crawford G**, Lobo R. 2016. *HIV & Mobility in Australia.* AFAO HIV & Mobility Forum. Sydney (*Invited speaker)*
8. Lobo R, Brown, **Crawford G,** Gray C. 2015. *HIV and Mobility in Australia: Launch of the Interim Report Card.* Australasian HIV and AIDS Conference. Brisbane (*Oral session and posters)*
9. **Brown G,** Crawford G, Lobo R. 2015. *HIV and Mobility in Australia: A Roadmap for Action*. Inaugural International Conference on Migration Social Disadvantage and Health. Melbourne *(Presentation)*
10. **Crawford G,** Lobo R, Brown G, Maycock B, Tobin R, McCausland K. 2014. *Rites & Responsibilities: exploring digital discourse of Australian expats/travellers*. PHAA 43rd Annual Conference: The future of public health: big challenges, big opportunities. Perth *(Presentation)*
11. **Crawford G,** Langdon P, Lobo R. 2014. '*Fast & Cheap': travel, HIV and public health responses.* PHAA 43rd Annual Conference: The future of public health: big challenges, big opportunities. Perth *(Poster)*

12. Langdon P, Lobo R, **Crawford G**. 2014. *Beyond border control? HIV, migration and public health policy*. PHAA 43rd Annual Conference: The future of public health: big challenges, big opportunities*.* Perth *(Poster)*
13. **Crawford G**, Lobo R, Brown G, Maycock B, Tobin R. 2014. *Risk, Rites and Responsibilities: Digital discourse among Australian expats and travellers in South East Asia.* SiREN Symposium. Perth *(Presentation)*
14. **Crawford G**, Lobo R, Brown G, Maycock B, McCausland K. 2014. *Australian Travellers, Relationships & Risk: exploring the nexus*. HIV & Mobility Satellite. Perth *(Presentation)*
15. Langdon P, Lobo R, **Crawford G,** Brown G. 2014. *HIV & Mobility Discussion Paper*. HIV & Mobility Satellite. Perth *(Presentation)*
16. Langdon P, Lobo R, **Crawford G**. 2014. *Globalisation, Mobility and HIV: Implications for HIV prevention and care in WA*. SiREN Symposium. Perth *(Presentation)*
17. **Crawford G,** Langdon T. 2009. *Responding to Increases in Overseas Acquired HIV Diagnoses in WA.* Go West: Australian Health Promotion Association 18th National Conference. Perth *(Presentation)*

Appendix J: Related Publications

1. Gray C, **Crawford G,** Lobo R and Maycock B. Co-designing an intervention to increase HIV testing uptake with women from Indonesia at-risk of HIV: protocol for a participatory action research study. *Methods and Protocols.* 2019; 23; 2(2): pii: E41.
2. Ghimire S, Hallett J, Gray C, Lobo R and **Crawford, G.** What works? Prevention and control of sexually transmitted infections and blood borne viruses in migrants from sub-Saharan Africa and South East Asia living in high-income countries: A systematic review. *International Journal of Environmental Research and Public Health*. 2019; 16(7): 1287.
3. Gray C, Lobo R, Narciso L, Oudih E, Gunaratnam P, Thorpe R and **Crawford G**. Why I can't, won't or don't test for HIV: Insights from Australian migrants born in sub-Saharan Africa and South East Asia. *International Journal of Environmental Research and Public Health.* 2019; 16(6): 1034.
4. Gray C, **Crawford G,** Reid A and Lobo R. HIV knowledge and use of health services among people from South-East Asia and sub-Saharan Africa living in Western Australia. *Health Promotion Journal of Australia.* 2018; 29(3):278-281.
5. Agu J, Lobo R, **Crawford G** and Chigwada B. Migrant Sexual Health Help-Seeking and Experiences of Stigmatization and Discrimination in Perth, Western Australia: Exploring Barriers and Enablers. *International Journal of Environmental Research and Public Health.* 2016; 13(5).
6. Rade DA, **Crawford G**, Lobo R, Gray C and Brown G. Sexual Health Help-Seeking Behavior among Migrants from Sub-Saharan Africa and South East Asia living in High Income Countries: A Systematic Review. *International Journal of Environmental Research and Public Health.* 2018; 15(7).

Appendix K: Related Grants

1. **Crawford G,** Lobo R. Exploring Overseas Acquired HIV amongst Australian born men in WA. (2019-2021) Department of Health WA ($130,000) *under review*
2. Gray C, **Crawford G,** Lobo R. Establishing a Multicultural Community Advisory Committee to address HIV in priority communities in Western Australia (2020) Gilead Sciences Research Fellowship ($60,000) *under review*
3. **G Crawford,** R Lobo. Community of Practice for Action on HIV and Mobility (2017). WA Health ($11,000)
4. C Gray, **G Crawford**, R Lobo, R Guy, G Brown. Barriers and facilitators to HIV testing among sub-Saharan Africa and Southeast Asia populations (2017-2018). Gilead Sciences Research Fellowship ($40,000)
5. C Gray, R Lobo**, G Crawford.** To investigate barriers and enablers to HIV testing for people from two priority CaLD populations in Perth, WA (2017). Healthway & Australian Health Promotion Association ($42,000)
6. R Lobo, **G Crawford**, J Hallett, P.J.M Tilley, J Jancey. SiREN 2020 (2016-2020). WA Health ($783,750)
7. **G Crawford**, R Lobo, G Brown. Establishing a Community of Practice for Action on HIV & Mobility (2015). WA Health ($14,920)
8. R Lobo, M Doherty, **G Crawford**, J Hallett, J Comfort, J Jancey, P. J. M Tilley. Sexual Health and Blood-borne Virus Research & Evaluation Network (2012-2015). WA Health ($432,307)
9. R Lobo, **G Crawford**, G Brown. HIV and mobility project (2013-2014). ARCSHS, La Trobe ($23,000)
10. G Brown, **G Crawford.** HIV and Social Networks Project (2011). WA Health ($24,000)

Appendix L: Related Conference Presentations

1. **Crawford G,** Gray C, Lobo R, Ghimire S, Rade DA, Brown G, Hallett J. 2019. What are the barriers to help-seeking and how do we respond to HIV and other STIs among migrants from Sub-Saharan Africa and Southeast Asia living in high income countries: findings from two linked systematic reviews. Australasian Sexual Health and HIV&AIDS Conference. Perth *(Poster)*
2. Gray C, **Crawford G,** Leowalu S, Nausita K, Santi R, Septarini BS, Wardhani E, Yuniar P, Lobo R, Maycock B. 2019. Srikandi: Pathways to HIV testing for women from Indonesia living in Western Australia. Australasian Sexual Health and HIV&AIDS Conference. Perth *(Poster)*
3. Gray C, **Crawford G,** Leowalu S, Nausita K, Santi R, Septarini BS, Wardhani E, Yuniar P, Lobo R, Maycock B. 2019. Srikandi: A participatory action research project with women from Indonesia to increase HIV testing. Australasian Sexual Health and HIV&AIDS Conference. Perth *(Presentation)*
4. Hosny A, Gray C, **Crawford, G.** 2018. Barriers and enablers to HIV testing among women from South East Asia living in WA. SiREN Symposium. Perth *(Presentation)*
5. Gray C, Reid A, **Crawford G,** Lobo R. 2017. A survey of HIV knowledge and use of health services. 15th World Congress on Public Health. Melbourne *(Presentation)*
6. Doherty M, Lobo R, **Crawford G,** Tilley PJM, Hallett J, Jancey J. 2015. Partnerships that effectively inform prevention and management of sexually transmitted infections (STIs) and blood-borne viruses (BBVs): a case study from Western Australia. 22nd Congress of the World Association for Sexual Health, Singapore *(Presentation) (Published proceeding)*
7. Gray C, **Crawford G,** Lobo R, Narciso L, Oudih E, Gunaratnam P, Thorpe R. 2018. Barriers and enablers to HIV testing among people born in sub-Saharan Africa and South East Asia living in Australia. 1st World Congress on Migration, Ethnicity, Race and Health. Edinburgh *(Poster) (Published proceeding)*
8. Gray C, Reid A, **Crawford G,** Lobo R. 2018. HIV knowledge and use of health services among people born in sub-Saharan Africa and South East Asia living in Perth, Western Australia. 1st World Congress on Migration, Ethnicity, Race and Health. Edinburgh *(Poster) (Published proceeding)*
9. Gray C, Shearer J, **Crawford, G,** Lobo R, Narciso L, Oudih E, Gunaratnam P, Thorpe R. 2018. GPs experiences of testing people born in sub-Saharan Africa and South East Asia for HIV in Australia. 1st World Congress on Migration, Ethnicity, Race and Health. Edinburgh *(Poster)(Published proceeding)*
10. Gray C, Shearer J, **Crawford G,** Lobo R, Narciso L, Oudih E, Gunaratnam P, Thorpe R. 2017. GPs experiences of testing people born in sub-Saharan Africa and South East Asia for HIV. Australasian HIV/AIDS Conference. Canberra *(Poster)*

11. Hosny H, Gray C, **Crawford G.** 2017. Barriers and enablers to HIV testing among women from South East Asia living in WA. Australasian HIV/AIDS Conference. Canberra *(Poster)*
12. Gray C, Sande V, **Crawford G**, Lobo R, Narciso L, Oudih E, Gunaratnam P, Thorpe R. 2017. Barriers to HIV testing for people born in sub-Saharan Africa and South East Asia: Preliminary findings. Australasian HIV/AIDS Conference. Canberra *(Presentation)*
13. Rade D, **Crawford G,** Lobo R. 2016. Migrant sexual health help-seeking in high-income countries: A systematic review. SiREN Symposium. Perth *(Presentation)*
14. Agu J, Lobo R, **Crawford G,** Chigwada B. 2016. Migrant sexual health help-seeking and experiences of stigmatization and discrimination in Perth, Western Australia: exploring barriers and enablers. SiREN Symposium. Perth *(Presentation)*
15. Gray C, Reid A, **Crawford G,** Lobo R. 2016. A survey of HIV knowledge and use of health services among people from CaLD populations in WA. SiREN Symposium. Perth *(Presentation)*
16. Agu J, Lobo R, **Crawford G,** Chigwada B. 2016. Migrant sexual health help-seeking and experiences of stigmatization and discrimination in Perth, Western Australia: exploring barriers and enablers. National Health Promotion Conference. Perth *(Presentation)*

Appendix M: Related Media

1. Lobo R, Gray C and **Crawford G**. 2019. People on the move: implications for meeting Australia's 95:95:95 targets by 2022. *HIV Australia.* Available from: https://www.afao.org.au/article/people-on-the-move-implications-for-meeting-australias-959595-targets-by-2022/

2. Mobility drives new HIV epidemic (March 2017) https://healthsciences.curtin.edu.au/faculty-news/pvc-message-march-2017/feature-hiv-research/ http://healthsciences.curtin.edu.au/wp-content/uploads/sites/6/2017/03/2017-health-at-curtin-public-health.pdf

3. **Crawford G**, Brown G and Lobo R. HIV and Mobility: Road Map for Action. *HIV Australia.* 2015; 13(1). Available from: https://www.afao.org.au/article/hiv-mobility-australia-road-map-action/

4. Partnerships key to preventing HIV transmission overseas (24 February 2015) https://medicalxpress.com/news/2015-02-partnerships-key-hiv-transmission-overseas.html

5. HIV and Mobile Populations: exploring the complexities (10 October 2014) http://afaotalks.blogspot.com.au/2014/10/hiv-and-mobile-populations-wa.html

Appendix N: Related Supervision

1. Georgia Thorpe (2019-2020) Master of Public Health

   Supervisors: Maycock B, **Crawford G,** Gray C.

   Health literacy measure for culturally and linguistically diverse populations

2. Corie Gray (2018 -) Doctor of Philosophy

   Supervisors: Maycock B, Lobo R, **Crawford G**.

   Co-designing an intervention to increase HIV testing uptake with women from Indonesia at-risk of HIV: protocol for a participatory action research study

3. Victoria Sande (2018) Master of Public Health

   Supervisors: **Crawford G,** Lobo R, Reid A**.**

   A survey tool to measure BBV & STI knowledge, attitudes & behaviours amongst migrants from Southeast & Northeast Asia & sub-Saharan Africa living in Australia.

4. Sajana Ghimire (2018) Master of Public Health

   Supervisors: Hallett J, **Crawford G**.

   What works? Prevention & control of STIs & BBVs in migrants from sub-Saharan Africa & Southeast Asia living in high-income countries: A systematic review

5. Helen Goodwin (2017) Master of Health Promotion

   Supervisors: **Crawford G**.

   HIV and Population Mobility in Australia: 2017 updates

6. Amira Hosney (2017) Master of Public Health

   Supervisors: **Crawford G,** Gray C.

   Barriers and enablers to HIV testing among adult women in Southeast Asia

7. Corie Gray (2016) Public Health Honours

   Supervisors: Lobo R, **Crawford G,** Reid A.

   A survey of HIV knowledge and use of health services among people from culturally and linguistically diverse populations in WA.

8. Josephine Agu (2015) Master of Public Health

   Supervisors: Lobo R, **Crawford G,** Chigwada B.

   Migrant sexual health help-seeking and experiences of stigmatisation and discrimination in Perth, Western Australia: exploring barriers and enablers.

9. Rade D (2015) Master of Public Health

   Supervisors: **Crawford G,** Lobo R.

   Migrant Sexual Health Help-seeking in High Income Countries: A Systematic Review.

Appendix O: Related Technical and Other Reports

1. Community of Practice for Action on HIV and Mobility. 2018a. *HIV and Mobility in Australia: Priority Actions*. Perth, WA: Collaboration for Evidence, Research and Impact in Public Health, Curtin University
2. Collaboration for Evidence Research and Impact in Public Health. 2018b. 'I want to test but I'm afraid': Barriers to HIV testing among people born in South East Asia and sub-Saharan Africa: Final report. Perth, Australia: Curtin University.
3. Gray, C., **Crawford, G**., Lobo, R., Shearer, J., Gunaratnam, P., & Thorpe, R. 2017. *Barriers to HIV testing among people born in sub-Saharan Africa and South East Asia: Preliminary findings*. Perth, Australia: Curtin University.
4. Community of Practice for Action on HIV and Mobility. 2016. *HIV and Mobility in Australia: Interim Report Card 2*. Perth, Australia: Curtin University.
5. Community of Practice for Action on HIV and Mobility. 2015. *HIV and Mobility in Australia: Road Map for Action – Interim Report Card*. Perth, Australia: Curtin University.
6. **Crawford, G.**, Lobo, R., Brown, G., & Langdon, P. 2014. *HIV & Mobility in Australia: Road Map for Action*. Perth Australia: Western Australian Centre for Health Promotion Research, Australian Research Centre in Sex, Health & Society.

Appendix P: Service, Awards and Other Outcomes

- IUHPE AHPA Registered Health Promotion Practitioner, 1st Registered Practitioner in Australia (2018)
- Healthway, Health Advisory Committee (2013-2018)
- Course Coordinator - Graduate Certificate, Diploma and Master of Public Health; Graduate Certificate and Diploma of Health Promotion (2013-)
- Alcohol Advertising Review Board, McCusker Centre for Action on Alcohol and Youth/PHAIWA (2013-)
- AHPA, National President and Board Chair (2013-)
- Sexual Health & BBV Applied Research & Evaluation Network, Management Group Member (2010-)
- National Sexual Health Congress, Scientific Committee Member (2017)
- Primary Health Care Research Conference Best Poster Award (2016)
- AHPA (WA), Emerging Leader Award (2015)
- Mental Health First Aid, Master Trainer Award (2015)
- 3rd National Population Health Congress, Organising Committee Member (2014-2015)
- Curtin Student Guild Excellence in Teaching Award (Undergraduate Lecturer/Tutor) (Nomination) (2014)
- AHPA (WA), Treasurer, Co-President, President (2005-2014)
- Curtin Local Drug Action Group, Member (2012-2014)
- Health Promotion & Sexology, School of Public Health, Curtin University, Bright Spark Award (2013)
- Faculty of Health Sciences, Curtin University, Excellence in Teaching (Early Career) Award (2013)
- AHPA IUHPE International Conference Scholarship (2013)
- AHPA (WA), Strategic Advisory Group Member (2013 -)

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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