



PROGRAM AND ABSTRACTS

# evolving **k**nowledge & **p**ractice

11th Social Research Conference on HIV, Hepatitis C and Related Diseases

National Centre in HIV Social Research  
University of New South Wales  
Sydney, Australia

8–9 April 2010





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## Organisers and sponsors

### Conference organising committee

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# Welcome

It is my pleasure to welcome you to the 11th Social Research Conference on HIV, hepatitis and related diseases, for the first time in my role as director of the National Centre in HIV Social Research. This year's conference has again attracted more registered delegates than before, attesting to the important role the conference plays as a national platform that facilitates networking and knowledge sharing between social and behavioural researchers, policy makers, health professionals and community organisations. The number of presentations also continues to grow and in some instances the time for presentations has been reduced to accommodate the large number of high quality contributions within an already packed two-day program.

This year's conference theme, evolving knowledge and practice, draws attention to the continually changing nature of the epidemics in which we work and encourages reflection and debate on advances in treatment and changing community understandings and how these intersect with appropriate and effective prevention, care and support. Effective responses to evolving epidemics require optimal policy and legal environments and an exciting addition to the conference program this year is the panel discussion in the closing session. In this new session a panel of eminent thinkers with backgrounds in law, policy and advocacy will highlight what they consider to be major challenges, both domestically and in the region. The closing session will offer ample opportunity for audience engagement and I encourage you to participate and contribute to shaping what may well prove to become an agenda for the future.

The 11th Social Research Conference also marks the 20th anniversary of the National Centre in HIV Social Research. In the past 20 years the Centre's research programs have contributed a unique voice to both national and international responses and I look forward to contributing to this tradition of cutting-edge research. Some of the key thinking that shaped and shapes the 'voice' of the Centre will be presented and discussed in a unique plenary session with a panel of past staff members who will share their current work and perspectives.

The conference organising committee did a fantastic job in bringing us together around an engaging program that is made possible thanks to your participation, presentations and contributions to debates, for which I would like to thank you. I hope you will enjoy an inspiring conference.



Professor John de Wit

Director



## General information

### Venue

The 11th Social Research Conference on HIV, Hepatitis C and Related Diseases will be held in the Mathews Theatres of The University of New South Wales. Access to Mathews Theatres is via **High Street** (Gate 9).

### Public transport to UNSW

Public transport to the university is by bus. The entrance closest to the conference is in **High Street** (Gate 9).

From Sydney city to the **Anzac Parade entrance** of UNSW take a No. 394, 396, 397 or 399 from Circular Quay or Taylor Square, a 30-minute journey. From Railway Square or Cleveland Street take a No. 393 or 395.

There are special university buses to the **High Street entrance** of UNSW. From Eddy Avenue, Central Station take a No. 891 (mornings) and 895 (evenings) from Anzac Parade to Central, a 30-minute journey. Special university buses can also be taken from Sydney city; No. 890 (mornings) to High Street and 892 (evenings) from Anzac Parade to Sydney city.

From the airport, take bus No. 400 or 410 to the **High Street entrance** (Gate 9), a 20- to 30-minute journey costing \$5.20. A taxi to or from the airport takes about 20 minutes and costs \$35 to \$40

The Nos. 890, 891, 892 and 895 buses are 'pre-pay only'. Bus tickets can be bought at newsagents and from shops displaying the Sydney Transport logo.

For public transport information, phone 131 500, or go to [www.131500.com.au](http://www.131500.com.au)

### Parking

As parking facilities in and near the campus are extremely limited driving to the conference is not recommended.

However, casual day-parking is available on the top floor (level 5) of the multistorey car park inside Gate 14, off Barker Street (turn right after coming through Gate 14) (map reference M17). Look for the 'All Day Pay & Display' bays. You will need coins for parking meters to the value of \$6 (first 5 hours) and \$2 (each hour thereafter). If you have left your car on a lower floor in the area designated for cars with UNSW stickers, please move it, as heavy police fines apply.

### Food and drink

Lunch and morning and afternoon teas are included in the registration fee. They will be served on Thursday and Friday in **Mathews Pavilions** located adjacent to the Mathews building (map reference E24).

If you have special dietary requirements and have requested special meals, please approach the staff at the registration desk at the beginning of each break.

There is also food to suit most tastes available in the food court located on the lower ground floor of the Mathews building many of which open early for breakfast. The café **Biblio** is located at the entrance to the food court near the Library and provides a quick coffee option.



## Disabled access

The Mathews building is accessible to wheelchair users (ramp access to all floors except Mathews lecture theatre C). All conference activities take place on the ground, first and second floors of this building. If you have concerns about access, please contact the conference organisers.

## Health and medical needs

The University Health Service is on the ground floor of the Quadrangle Building (map reference E17). Doctors are available for consultation Monday to Friday from 8.30am to 5pm. The Health Service is available to all students, staff and visitors to the campus. Telephone 9385 5425 for an appointment.

Within the University Health Service, there is a Dental Surgery available to all students, staff and visitors to the campus. Telephone 9313 6228 for an appointment.

There is a pharmacy on campus in the Quadrangle Building (map reference E15): telephone 9385 7617.

## Help points

There are several Help Points on campus. They are marked by a big yellow dot. If you need a security officer, press the button on the unit. This will connect you with UNSW Security.

## Internet access

There are no internet cafés on campus and no general internet access. However, if you do need emergency internet access, please see staff at the conference registration desk.

## Printing/Photocopying

For small numbers of photocopies, you are welcome to use the copier at NCHSR (see staff at the conference desk for assistance).

Photocopying, laser printing, transparency copying, binding and scanning are available at PrintPostPlus (P3) located on the lower ground floor of the Mathews building (map reference F23) (phone 9385 7726). Opening hours are 8.30 am to 5.30 pm daily.

## Mobile phones and pagers

As a courtesy to all delegates and speakers, please switch off your mobile phone or pager (or set it to 'silent') during all sessions.

## Personal mail

The conference organisers do not accept responsibility for personal mail. Please have all mail sent to your accommodation address.



## Name badges

For security purposes all attendees must wear their name badge at all times when on the UNSW campus. Entrance to all sessions will be limited to badge-holders only. If you misplace your badge please advise the staff at the NCHSR front desk.

## Registration desk

The registration desk will be open from 8.30 am to 1.30 pm on both days. Outside these times please direct all enquiries to staff at the NCHSR front desk.

## Smoking

Smoking is not permitted within any UNSW building. Please go outside to smoke and place your butts in the bins supplied.

## Speaker preparation

All speakers must pre-load their presentations on the laptop computer in the relevant room. This should be done at the beginning of the day or at the very latest during the break before your session.

Video presentations should be given to the conference organisers at least a day before your presentation is scheduled.

## Bookshop

The UNSW Bookshop is on the lower ground floor of the west wing of the Quadrangle Building (map reference E14). There will also be a bookstall at the conference located in the Mathews Pavilions outside Mathews Theatres.

## Post office

The campus post office is located at the back of the Library, behind the Commonwealth Bank (map reference F22).

## Banking

On campus there are a Commonwealth Bank (map reference F22) and an ANZ Bank (in the Quadrangle Building, next to the UNSW Bookshop) (map reference E14).



# The program at a glance

Thursday 8 April					
8.00–9.00	Registration (foyer of Mathews Theatres)				
9.00–9.30	Conference welcome <b>Carla Treloar</b> Welcome to country <b>Allen Madden</b>				
9.30–10.30	<b>1</b> Opening plenary <b>Alan Petersen</b>				
10.30–11.00	Morning tea				
11.00–12.30	<b>2A</b> Symposium <b>Rapid HIV testing: its about time!</b>	<b>2B</b> Proffered papers <b>Understanding hepatitis C</b>	<b>2C</b> Proffered papers <b>HIV and heterosexuality</b>	<b>2D</b> Proffered papers <b>Health and sexuality in cultural context</b>	
12.30–1.30	Lunch				
1.30–3.00	<b>3A</b> Proffered papers <b>BBV issues for CALD communities</b>	<b>3B</b> Proffered papers <b>Decisions about treatment for hepatitis C</b>	<b>3C</b> Proffered papers <b>Evaluating health promotion</b>	<b>3D</b> Proffered papers <b>Redesigning service models for people who inject drugs</b>	<b>3E</b> Proffered papers <b>Sex and risk: men who have sex with men</b>
3.00–3.30	Afternoon tea				
3.30–5.30	<b>4</b> Plenary: <b>The NCHSR 20 year alumni plenary: evolving knowledge and practice</b>				

Friday 9 April					
8.00–9.00	Registration (for delegates only attending day 2 of the conference)				
9.00–10.30	<b>5A</b> Proffered papers <b>Drugs, injection and risk</b>	<b>5B</b> Proffered papers <b>Practices of research</b>	<b>5C</b> Proffered papers <b>Queer(y)ing sex and drugs</b>	<b>5D</b> Proffered papers <b>Reinvigorating prevention</b>	
10.30–11.00	Morning tea				
11.00–12.30	<b>6A</b> Proffered papers <b>Advancing health and research with indigenous communities</b>	<b>6B</b> Proffered papers <b>Health promotion in hepatitis C</b>	<b>6C</b> Symposium <b>HIV-related stigma: experiences and implications for policy and practice</b>	<b>6D</b> Proffered papers <b>Biomedicalisation: the interface of research, practice and policy</b>	
12.30–1.30	Lunch				
1.30–3.30	<b>7A</b> Proffered papers <b>Peer education and self- determination</b>	<b>7B</b> Proffered papers <b>Treatment for viral hepatitis</b>	<b>7C</b> Proffered papers <b>Media and technology in research and health promotion</b>	<b>7D</b> Proffered papers <b>Depression, stigma, isolation</b>	
3.30–4.00	Afternoon tea				
4.00–5.00	<b>8</b> Closing plenary <b>John de Wit</b>				
5.00–5.30	Closing remarks				
5.30–7.00	Cocktail party				



# Breakdown of sessions

Session	First author/ Presenter	Title of presentation
<b>THURSDAY 8 APRIL</b>		
<b>1</b>	<b>Chair: Carla Treloar</b>	<b>Welcome and opening plenary</b>
9.00–10.30 Mathews Theatre B	9.05	Allen Madden
	9.10	John de Wit
	9.15	James Donald
	9.20	Richard Henry
	9.25	Mark Butler
	9.30	Alan Petersen
		<b>Opening plenary</b> Communicating health risk in a context of uncertainty: what can we learn from the experiences of emergent technologies?
<b>2A</b>	10.30	Morning tea
	<b>Chair: Geoff Honnor</b>	<b>Rapid HIV testing: its about time! (Symposium)</b>
11.00–12.30 Mathews Theatre C	11.00	Iryna Zablotska
	11.10	David Wilson
	11.25	Martin Holt
	11.35	Chris Bourne, Warwick Allan
	11.45	Yves Calmette
	11.55	Phillip Keen
	12.05	Discussion
<b>2B</b>	<b>Chair: Carla Treloar</b>	<b>Understanding hepatitis C (Proffered papers)</b>
11.00–12.30 Mathews Room 102	11.00	Rachel Deacon
	11.20	Emily Lenton
	11.40	Kate Seear
	12.00	Peter Higgs
	12.20	Discussion
<b>2C</b>	<b>Chair: Christy Newman</b>	<b>HIV and heterosexuality (Proffered papers)</b>
11.00–12.30 Mathews Room 107	11.00	Jessica Elkaim
	11.20	Asha Persson
	11.40	Nandini Ray
	12.00	Graham Brown
	12.20	Discussion
<b>2D</b>	<b>Chair: Evelyn Lee</b>	<b>Health and sexuality in cultural context (Proffered papers)</b>
11.00–12.30 Mathews Room 104	11.00	Verity Slee
	11.20	Barbara Nattabi
	11.40	Kare Moen
	12.00	Lisa Wojciechowski
	12.20	Discussion
	12.30	Lunch



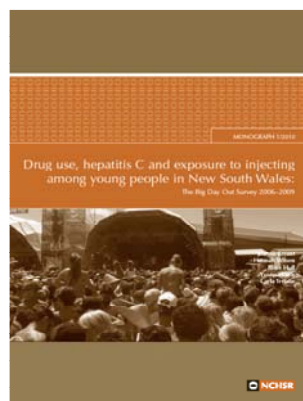
Session	First author/ Presenter	Title of presentation
<b>3A</b>	<b>Chair: Henrike Korner</b>	<b>BBV issues for CALD communities (Proffered papers)</b>
1.30–3.00 Mathews Room 104	1.30	Tadgh McMahon
	1.50	Solomon Wong
	2.10	Marina Suarez
	2.30	Robyn Horwitz
	2.50	Discussion
<b>3B</b>	<b>Chair: Max Hopwood</b>	<b>Decisions about treatment for hepatitis C (Proffered papers)</b>
1.30–3.00 Mathews Theatre B	1.30	Peter Hull
	1.50	Jake Rance
	2.10	Heidi Coupland
	2.30	Sione Crawford
	2.50	Discussion
<b>3C</b>	<b>Chair: Graham Brown</b>	<b>Evaluating health promotion (Proffered papers)</b>
1.30–3.00 Mathews Room 107	1.30	Kathy Triffitt
	1.50	Alisa Pedrana
	2.10	Michelle Horner, Kate Weston
	2.30	Robert Lake
	2.50	Discussion
<b>3D</b>	<b>Chair: Hannah Wilson</b>	<b>Redesigning service models for people who inject drugs (Proffered papers)</b>
1.30–3.00 Mathews Theatre C	1.30	Kate DeMaere
	1.50	Robert Kemp
	2.10	Charles Henderson
	2.30	Jo Holden, Jason Prior
	2.50	Discussion
<b>3E</b>	<b>Chair: John de Wit</b>	<b>Sex and risk: men who have sex with men (Proffered papers)</b>
1.30–3.00 Mathews Room 102	1.30	Ian Down
	1.50	Garrett Prestage
	2.10	Iryna Zablotska
	2.30	Paul Andrews
	2.50	Discussion
3.00 Afternoon tea		
<b>4</b>	<b>Chair: Susan Kippax</b>	<b>The NCHSR 20 year alumni plenary: evolving knowledge and practice</b>
3.30–5.30 Mathews Theatre B	3.30	Suzanne Fraser
	4.00	Kane Race
	4.30	Helen Keane
	5.00	Niamh Stephenson



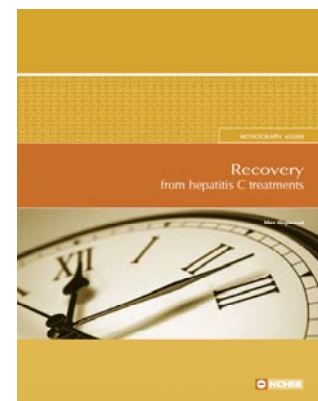
Session	First author/ Presenter		Title of presentation
<b>FRIDAY 9 APRIL</b>			
<b>5A</b>	<b>Chair: Loren Brener</b>		<b>Drugs, injection and risk (Proffered papers)</b>
9.00–10.30 Mathews Room 107	9.00	Amanda Roxburgh	Patterns of drug use and sexual risk among a sample of gay, lesbian and bisexual regular methamphetamine users
	9.20	Hannah Wilson	Sharing of injecting equipment and the perception of HCV risk among injecting drug users who attain injecting equipment from pharmacies in Western Australia
	9.40	Rebecca Gray	Intimate Injectors: towards a systemic awareness of drug injecting practice within intimate relationships
	10.00	Joanne Bryant	Needle sharing in regular heterosexual relationships: serodiscordance and the gendered character of injecting
	10.20	Discussion	
<b>5B</b>	<b>Chair: Peter Hull</b>		<b>Practices of research (Proffered papers)</b>
9.00–10.30 Mathews Room 104	9.00	Gary Gahan	Capacity building with front-line health workers in qualitative research: impact in a sensitive area
	9.20	Dermot Ryan	Off road: undertaking the Gay Community Periodic Survey in regional New South Wales
	9.40	Iryna Zablotska	Pilot study of respondent driven sampling among gay men in Sydney: lessons learned
	10.00	Discussion	
<b>5C</b>	<b>Chair: Kane Race</b>		<b>Queer(y)ing sex and drugs (Proffered papers)</b>
9.00–10.30 Mathews Room 102	9.00	David McInnes	Responsibility, risk and negotiation in the discourse of gay men's group sex
	9.20	Jack Bradley	The balance of risk and reward
	9.40	Angela Matheson	Hep C transmission prevention and knowledge among gay, lesbian and bisexual regular methamphetamine users
	10.00	Toby Lea	Young men and women's experiences with the lesbian/gay/queer scene In Sydney
	10.20	Discussion	
<b>5D</b>	<b>Chair: Jeanne Ellard</b>		<b>Reinvigorating prevention (Proffered papers)</b>
9.00–10.30 Mathews Theatre C	9.00	Althea Mackenzie, Kay Bazley	The less it's seen the better it works: novel approaches to health promotion
	9.20	Yves Calmette	One size does not fit all anymore
	9.40	Ben Tart	We're not beyond the basics: getting the balance right from HIV to syphilis and condoms
	10.00	Garrett Prestage	Enlightened self-interest or 'cultures of care'?
	10.20	Discussion	
	10.30	Morning tea	
<b>6A</b>	<b>Chair: Clair Jackson</b>		<b>Advancing health and research with indigenous communities (Proffered papers)</b>
11.00–12.30 Mathews Room 104	11.00	Meggan Grose, Michael Blakeney- Campbell	Issues for Aboriginal and Torres Strait Islander People Living with HIV: a social justice perspective
	11.20	Monique McEwan	A secondary analysis of Pharmacy Needle and Syringe Survey data to describe injecting drug use among Aboriginal people in New South Wales
	11.40	Sallie Cairnduff	Evolving hepatitis C prevention projects for young Aboriginal people
	12.00	Loren Brener, Veronica Saunders	The Aboriginal Cancer Care Project: an evolving partnership process
	12.20	Discussion	



Session	First author/ Presenter	Title of presentation
<b>6B</b>	<b>Chair: Joanne Bryant</b>	<b>Health promotion in hepatitis C (Proffered papers)</b>
11.00–12.30 Mathews Room 102	11.00	Paul Harvey Hepatitis C and men's health promotion: the where, why and wherefore
	11.20	William Jang One shoe fits all: a train-the-trainer program that aims to empower those living with hepatitis C in South Island New Zealand
	11.40	Sophie Bannar-Martin Breaking down barriers: an evolving partnership
	12.00	Louisa Walsh Hep C—take control: a chronic disease self-management intervention for people with hepatitis C
	12.20	Discussion
<b>6C</b>	<b>Chair: Dean Murphy</b>	<b>HIV-related stigma: experiences and implications for policy and practice (Symposium)</b>
11.00–12.30 Mathews Theatre C	11.00	Jude Byrne “Why don't they like us?” General population views on injecting drug users
	11.15	Daniel Reeders Developing shared language around stigma reduction
	11.3	Simon Donohoe Formative research for a national HIV stigma and discrimination campaign
	11.45	David Menadue Stigma and discrimination towards HIV-positive people in diverse communities in Australia
	12.15	John de Wit HIV-related stigma in gay and other men who have sex with men: mostly a matter of a serostatus-based sexual divide
	12.15	Discussion
<b>6D</b>	<b>Chair: Rebecca Gray</b>	<b>Biomedicalisation: the interface of research, practice and policy (Proffered papers)</b>
11.00–12.30 Mathews Room 107	11.00	Martin Holt Maintaining HIV social research in the era of biomedicalisation: the strategies of social and political researchers
	11.20	Bridget Haire Standards of care in HIV biomedical prevention trials in the developing world: a comparison
	11.40	Mary Poynten Attitudes towards biomedical HIV prevention technologies among a cohort of HIV-negative gay men in Sydney, Australia
	12.00	Pol McCann A love–hate relationship: the impact of differing attitudes towards condoms for gay men in Australia
	12.20	Discussion
12.30	Lunch	<b>Performance by acoustic duo</b> , Ngaratya (together, in company), Alicia and Emily Johnson <b>Report launches</b> <i>Drug use, hepatitis C and exposure to injecting among young people in New South Wales: The Big Day Out Survey 2006–2009</i> by Joanne Bryant, Hannah Wilson, Peter Hull, Yvonna Lavis and Carla Treloar <i>Recovery from hepatitis C treatments</i> by Max Hopwood <b>Encore performance</b>



Launch by Professor John de Wit, Director, National Centre in HIV Social Research, Sydney



Launch by Stuart Loveday, Executive Officer, Hepatitis NSW, Sydney



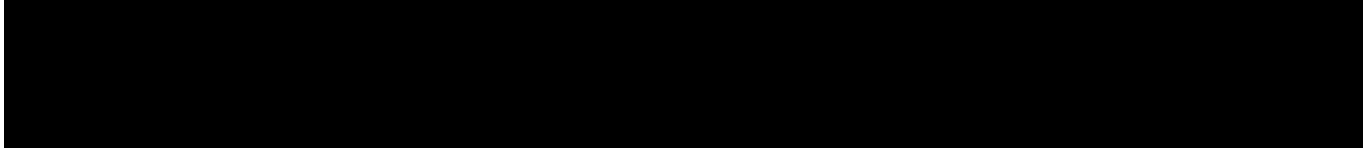
Session	First author/ Presenter	Title of presentation
<b>7A</b>	<b>Chair: Jake Rance</b>	<b>Peer education and self-determination (Proffered papers)</b>
1.30–3.30 Mathews Room 107	1.30	Jamee Newland How social networks of people who inject drugs influence hepatitis C discussions in New South Wales
	1.50	Jeffrey Wegener Idealism and realism in equality driven community development. Reflections on the theory and practice of peer education with drug users. A project workers perspective.
	2.10	Carla Treloar Authentic and self-determined peer education: creating an evidence base and challenges for funders and researchers
	2.30	Jamee Newland Peer distribution: a harm reduction practice that is necessary and illegal
	2.50	Annie Madden It's all smoke screens and mirrors: self-determination, representation and identity from the drug user's perspective
	3.10	Discussion
<b>7B</b>	<b>Chair: Robyn Horwitz</b>	<b>Treatment for viral hepatitis (Proffered papers)</b>
1.30–3.30 Mathews Room 102	1.30	Marlize Mouton More than a liver: the role of the social work practitioner in hepatitis C treatment centres
	1.50	Christine Janssen What happens when treatment fails? An investigation into the development of better practice models to prepare patients for relapse post HCV therapy
	2.10	Max Hopwood Interferon-based hepatitis C treatments: contested notions of treatment success.
	2.30	Nicola Hodge The INSURE Project – 'Investigation into necessary support: uncovering real-life examples'
	2.50	Suzanne Polis Patient experiences of adherence to hepatitis B anti viral medications
	3.10	Discussion
<b>7C</b>	<b>Chair: Philippe Adam</b>	<b>Media and technology in research and health promotion (Proffered papers)</b>
1.30–3.30 Mathews Room 104	1.30	Sonam Paljor Determinants of a culturally inclusive website: recommendations on developing a friendly culturally and linguistically diverse website
	1.50	Paul Byron Young people, heterosex and condom agency
	2.10	Barry Adam hivstigma.com: an innovative web-based stigma-reduction intervention for gay and bisexual men
	2.30	Iryna Zablotska Gay Community Periodic Survey and online survey of gay men (E-male) in Australia: comparison of sexual practices
	2.50	Yves Calmette Gen Y: an urgent need to re-think health promotion strategies
	3.10	Discussion
<b>7D</b>	<b>Chair: Martin Holt</b>	<b>Depression, stigma, isolation (Proffered papers)</b>
1.30–3.30 Mathews Theatre C	1.30	Henrike Körner Gay men's discourses of depression: the medical, the social and the personal
	1.50	Christy Newman 'I definitely wouldn't talk to random doctors like that': the role of the general practitioner in the lives of Australian gay men with depression
	2.10	Rebecca Gray Shame, stigma and covert moralism: barriers to counselling clients in alcohol and other drug settings
	2.30	Kath Albury CHINWAG: stigma, identity, and counterpublic health promotion
	2.50	Grenville Rose Attitudes towards heavy co-occurring drug/alcohol use and mental illness amongst people with severe mental illness, and their carers
	3.10	Discussion
	3.30	Afternoon tea <b>Report launch</b> <i>Status of sexual and reproductive health rights of young people in Pakistan: findings and recommendations</i> , by World Population Foundation Pakistan, to be launched by Professor John de Wit.
<b>8</b>	<b>Chair: John de Wit</b>	<b>Closing session</b>
4.00–5.30 Mathews Theatre B	4.00	Michael Kidd <b>Closing plenary</b> evolving knowledge and practice: inter-relationships with policy and the law
	5.15	John de Wit <b>Closing remarks</b>
	5.30	Cocktail party



evolving knowledge and practice



# Biographies of keynote speakers



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### Dr Suzanne Fraser

Suzanne Fraser is a senior lecturer in the Centre for Women's Studies and Gender Research at Monash University. She has published widely in health, blood-borne viruses and drug use, and has been the recipient of a range of highly competitive grants. Between 2002 and 2007 Suzanne conducted research at the National Centre in HIV Social Research (UNSW) and remains a visiting fellow with the Centre. Suzanne is in residence at the Centre during the first half of 2010, and will be drawing on the wealth of expertise in hepatitis C and illicit drug use there to support her current projects. These projects focus on the politics of disease, the body and health in relation to hepatitis C, injecting drug use and addiction. For example, she is currently chief investigator on a groundbreaking ARC-funded study entitled 'Under construction: The social and cultural politics of hepatitis C in Australia' (with Carla Treloar and David Moore). Suzanne is author of *Substance and substitution: Methadone subjects in liberal societies*, Palgrave 2008 (with Kylie Valentine) and *Cosmetic surgery, gender and culture*, Palgrave 2003.

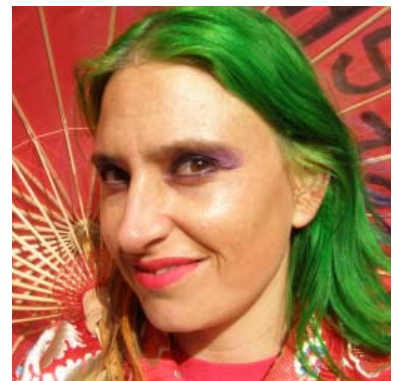


Session 4, Thursday 3.30pm, p.7

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### Ms Elena Jeffreys

Elena Jeffreys is a sex worker and the President of Scarlet Alliance, the Australian Sex Workers Association, the peak body for sex workers and sex worker organisations. Elena has worked in sex-worker community development and HIV prevention services in Australia and the Asia Pacific. She is a member of the Commonwealth Attorney-General's Roundtable on People Trafficking and writes extensively on the topic of migrant sex work and sex trafficking. As well as peer education for street-based sex workers, who used drugs in Northbridge (2001–2003), Fortitude Valley (2004) and Kings Cross (2005–2006), her community development work has also taken her to Thailand (2004), Hong Kong (2004), Canada (2005), Papua New Guinea (2005), and Mongolia (2007–2008), working with emerging communities of sex workers and representing Scarlet Alliance. Most recently she has presented on HIV and Criminalisation at the Bali 2009 ICAAP International AIDS Conference, facilitating the pre-conference sex-worker-only meetings and running training sessions for sex workers on participating in and conducting sex-worker peer-led research.



Session 8, Friday 4.00pm, p.10

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### Dr Helen Keane

Helen Keane's research examines the social and cultural aspects of medicine and health, with a particular focus on drugs and drug use. Her main current project is on ADHD, medicalisation and childhood but she has also recently published on concepts of addiction in pain medicine and the medical and popular understandings of intoxication. She was a UNSW Vice Chancellor's postdoctoral fellow at the National Centre for HIV Social Research from 2000 to 2002. During this time she completed her book *What's Wrong with Addiction?* (Melbourne University Press 2002) and carried out research on anabolic steroid use and ideals of health. She is a Senior Lecturer in the School of Humanities at the Australian National University.



Session 4, Thursday, 4.30pm, p.7





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## The Hon Michael Kirby, AC CMG



Session 8, Friday 4.00pm, p.10

When he retired from the High Court of Australia on 2 February 2009, Michael Kirby was Australia's longest serving judge. He was first appointed in 1975 as a Deputy President of the Australian Conciliation & Arbitration Commission. Soon after, he was seconded as inaugural Chairman of the Australian Law Reform Commission (1975–84). Later, he was appointed a judge of the Federal Court of Australia, President of the New South Wales Court of Appeal and, concurrently, the Court of Appeal of Solomon Islands. His appointment to the High Court of Australia came in 1996 and he served thirteen years. In later years, he was Acting Chief Justice of Australia twice.

In addition to his judicial duties, Michael Kirby has served on three university governing bodies being elected Chancellor of Macquarie University in Sydney (1984–93). He also served on national and international bodies; among the latter have been service as President of the International Commission of Jurists, Geneva (1995–8); as UN Special Representative on Human Rights in Cambodia (1993–6); as a member of the UNESCO International Bioethics Committee (1995–2005); as a member of the High Commissioner for Human Rights' Judicial Reference Group (2007–) and as a member of the UNAIDS Reference Group on Human Rights(2004–).

Since his judicial retirement, Michael Kirby has been elected President of the Institute of Arbitrators & Mediators Australia and also serves as Editor-in-Chief of *The Laws of Australia*. He has been appointed Honorary Visiting Professor by eight Australian universities, and he participates regularly in many local and international conferences and meetings.

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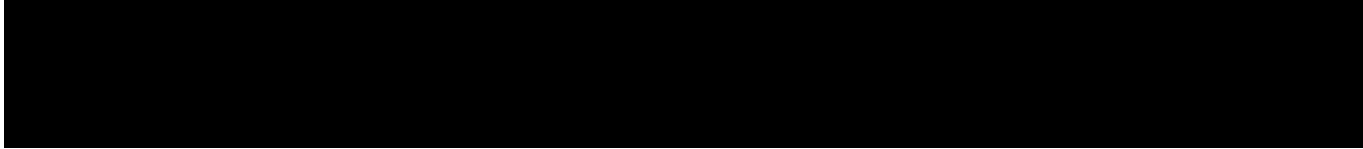
## Annie Madden



Session 8, Friday 4.00pm, p.10

Annie Madden is currently the Executive Officer of the Australian Injecting & Illicit Drug Users League (AIVL) which is the national peak organisation representing people who use illicit drugs and consumers of drug treatment services in Australia.

She has been working in the areas of illicit drug use, blood-borne viruses, peer education and drug user representation for 20 years. She is currently undertaking a postgraduate law degree with a focus on human rights law.



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### **Annmaree O’Keeffe, AM**

Annmaree O’Keeffe has extensive experience in international relations and development as a diplomat, aid worker, journalist and analyst. She was Australia’s first Ambassador on HIV/AIDS responsible for advocating improved leadership throughout Asia-Pacific in responding to the epidemic. Until late last year, she was one of Aus AID’s deputy directors general responsible for the PNG and the Pacific programs and is now a research fellow at the Lowy Institute as well as a strategic adviser to the Inuit Circumpolar Council in Ottawa, Canada.

She has been Australia’s ambassador to Nepal, the senior aid officer based in Port Moresby responsible for Australia’s aid program to Papua New Guinea, and has worked as a journalist and international editor for the International Committee of the Red Cross. She was made a member in the Order of Australia in 2007 in recognition of her services to international relations particularly in the area of HIV/AIDS and development.



Session 8, Thursday, 4.00pm, p.10

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### **Professor Alan Petersen**

Alan Petersen is Professor of Sociology in the School of Political and Social Inquiry at Monash University, Melbourne. He was previously at Plymouth University, United Kingdom (2001–2007), and Murdoch University in Perth (1992–2001). He has researched and published extensively in the field of the sociology of health and illness and the sociology of emergent technologies. His recent work covers studies of risk and communication; genetics and public health; science, policy and public perceptions of nanotechnologies; and the sociology of bioethics. His recent books include: *The Body in Question* (2007), *Biobanks: Governance in Comparative Perspective* (2008) (edited with Herbert Gottweis), *Health, Risk and Vulnerability* (2008) (edited with Iain Wilkinson), and *Nanotechnologies, Risk and Communication* (2009) (with Alison Anderson, Stuart Allan and Clare Wilkinson). He is currently writing another book, *The Politics of Bioethics*.



Session 1, Thursday 9.30am, p.8

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### **Dr Kane Race**

Kane Race worked and studied at the National Centre in HIV Social Research from 1997 to 2007, gaining a PhD in Health, Sexuality & Culture in 2004. He went on to co-ordinate the postgraduate program in Health, Sexuality & Culture before taking up a position as a Senior Lecturer in the Department of Gender and Cultural Studies at the University of Sydney, where he teaches courses in sexualities, embodiment and nature cultures. He has published widely in the areas of medication use, drug use, sexual practice and HIV risk. His PhD thesis was awarded the UNSW Faculty of Arts and Social Sciences Prize for Best Thesis, and appeared in revised form as *Pleasure Consuming Medicine: The Queer Politics of Drugs*, published by Duke University Press in 2009. Kane is currently undertaking a collaborative ARC project on the politics of bottled water, and is interested in new approaches to everyday practice, intimacy, mundane technologies and distributed agency.



Session 4, Thursday, 4.00pm, p.7



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### Mark Saunders



Session 8, Friday, 4.00pm, p.10

Mark Saunders is a Canberra-based Aboriginal man from South West Queensland, working at the National Aboriginal Community Controlled Health Organisation (NACCHO) as the Sexual Health & Blood Borne Viruses Policy Officer.

He represents NACCHO on the National Indigenous Drug and Alcohol Committee (NIDAC) and is also a member of the Close the Gap Festival committee which aims to close the life expectancy gap between Indigenous and non-Indigenous Australians.

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### Dr Niamh Stephenson



Session 8, Friday, 4.00pm, p.10

Niamh Stephenson is a Senior Lecturer in the School of Public Health and Community Medicine at the University of New South Wales, and currently on sabbatical at BIOS, LSE. Her recent book, *Escape Routes: Control and Subversion in the 21st Century*, interrogates how post-liberal regimes of control are impacting on the politics health, labour and migration (co-authored with Dimitris Papadopoulos and Vassilis Tsianos, Pluto Press). She is interested in the role of experience in socio-political change (as in *Analysing Everyday Experience: Social Research and Political Change*, Palgrave) and is currently researching the securitisation of health and how biopolitics increasingly bypasses the traditional focus of public health—the population.

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### Dr Alex Wodak



Session 8, Friday, 4.00pm, p.10

Dr. Wodak is a physician and has been Director of the Alcohol and Drug Service at St. Vincent's Hospital, Sydney since 1982. Major interests include prevention of HIV among injecting drug users, treatment of drug users and drug policy reform. Dr. Wodak is President of the Australian Drug Law Reform Foundation and was President of the International Harm Reduction Association (1996-2004). He helped establish the first needle syringe programme and first medically supervised injecting centre in Australia when both were pre-legal. Dr. Wodak often works in developing countries on HIV control among injecting drug users.



evolving knowledge and practice



## Sessions and abstracts

## Welcome to the conference

The following distinguished guests and speakers warmly welcome you to this 11th Social Research Conference on HIV, Hepatitis C and Related Diseases:

Mr Allen Madden, Gadigal Aboriginal elder and Cultural and Educational Officer with the Metropolitan Land Council in Sydney

Professor John De Wit, Director of the National Centre in HIV Social Research at The University of New South Wales, Sydney

Professor James Donald, Dean of the Faculty of Arts and Social Sciences at The University of New South Wales, Sydney

Professor Richard Henry, Deputy Vice-Chancellor (Academic) at The University of New South Wales, Sydney

The Hon. Mark Butler, MP, Parliamentary Secretary for Health, Australian Government, Canberra

Chair: **Carla Treloar**

Deputy Director  
National Centre in HIV Social  
Research, The University of New  
South Wales, Sydney



# 1 Communicating health risk in a context of uncertainty: what can we learn from the experiences of emergent technologies?

**Alan Petersen**

School of Political and Social Inquiry,  
Monash University, Melbourne

[alan.petersen@arts.monash.edu.au](mailto:alan.petersen@arts.monash.edu.au)

Those who work in the field of public health constantly grapple with the question of how best to ‘frame’ health information in order to advance public understanding of the pertinent issues, including risks, without also engendering fear. With infectious diseases this is especially challenging given the uncertainties that frequently characterise expert knowledge (e.g. the source and pattern of infection, the vulnerable groups, the appropriate preventive actions). As the history of HIV illustrates, early portrayals of an issue can be crucial for subsequent responses. Drawing on the presenter’s recent research into the science, policy and public representations of emergent technologies, specifically genetics, nanotechnologies, and stem cell treatments, this paper will discuss the factors that may shape the representations of infectious diseases during the early phase of their public visibility. In particular, the significance of the media in its diverse forms will be emphasised.

## Rapid HIV testing: it's about time! 2A

This 90-minute session will aim to examine arguments for and against the introduction of rapid HIV testing in Australia and examine the key issues that may need to be considered if rapid testing were to be made available in Australia.

**Chair:**

Geoff Honnor

**Presenters:**

Iryna Zablotska

David Wilson

Martin Holt

Chris Bourne

Warwick Allan

Yves Calmette

Phillip Keen

### HIV testing among gay men/MSM in Australia

**Iryna Zablotska**

Iryna will describe the current patterns of HIV testing among gay men and MSM in Australia, including testing rates, frequencies and the proportion of untested men in available behavioural surveys across the Australian states. Iryna will also present the patterns of the utilisation of testing services by serostatus.

National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney

[i.zablotska@unsw.edu.au](mailto:i.zablotska@unsw.edu.au)

### Modelling the impact of changes in HIV testing rates and estimating the outcomes from the introduction of rapid HIV testing in Australia

**David Wilson**

David will present mathematical modelling estimating the impact on future HIV transmissions from changes in HIV testing rates and frequencies.

National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney

[d.wilson@unsw.edu.au](mailto:d.wilson@unsw.edu.au)

David will then present an estimate of the sorts of results we may be able to expect from the use of rapid tests in Australia, i.e how many HIV diagnoses may be missed/picked up by these tests and the percentage and total number of false positives that we could expect.

### What do we know about rapid HIV testing from overseas?

**Martin Holt**

Referring to the published literature in developed world contexts (primarily the USA and Europe), Martin will highlight known issues experienced in the implementation of rapid HIV testing (RHT). In particular, he will give an overview of the aims of rapid HIV testing programs, known challenges in implementation, consumer reactions to rapid testing and reported outcomes of rapid testing programs.

National Centre in HIV Social Research, The University of New South Wales, Sydney

[m.holt@unsw.edu.au](mailto:m.holt@unsw.edu.au)




## Considerations about rolling out rapid HIV testing at a service level

**Chris Bourne and Warwick Allan**

Sydney Sexual Health Centre, Sydney  
christopher.bourne@sesiahs.health.nsw.gov.au

Chris and Warwick will speak about the potential impact of rapid HIV testing on services including advantages/disadvantages for clinical operations, clinician-client interactions, pre/post test discussions, and procedures for handling reactive test results.




## Considerations about rolling out rapid HIV testing in non-clinical settings

**Yves Calmette**

ACON, Sydney  
yvalmette@acon.org.au

Yves will present what a community-based response to testing gay men and MSM in non-clinical settings could be. He will look at how this response could leverage the successful integrated clinics at WA sex venues and at WA Aids Council where doctors and nurses collect samples, examine and treat infections while peer educators conduct risk assessments and give results.



## AFAO policy position on rapid HIV testing

**Phillip Keen**

Australian Federation of AIDS  
Organisations, Sydney  
pkeen@afao.org.au

Phillip will outline a policy review undertaken by AFAO in relation to RHT. AFAO has been researching experiences in other countries following the introduction of RHT, examining arguments for and against the introduction of RHT in Australia, and considering the potential consequences if RHT is introduced in Australia.

Proffered papers



# 2B Understanding hepatitis C

Chair: **Carla Treloar**



## Hepatitis C seroconversion: using qualitative research to enhance surveillance

**Rachel Deacon<sup>1</sup>, Jamee Newland<sup>2</sup>, Magdalena Harris<sup>2</sup>, Carla Treloar<sup>2</sup> and Lisa Maher<sup>1</sup>**

<sup>1</sup>National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney

<sup>2</sup>National Centre in HIV Social Research, The University of New South Wales, Sydney  
rdeacon@unsw.edu.au


The Hepatitis C Virus (HCV) Seroconversion study was a multi-method project funded by NSW Health, involving a review of laboratory notifications and in-depth interviews with people diagnosed with newly acquired infection. We present here results from the second, qualitative, phase which aimed to explore the practices, settings, networks and structures contributing to HCV infection.

Interviews were conducted with 24 people in NSW who self-reported HCV seroconversion within the previous two years. While most participants were unable to identify specific events which lead to seroconversion, many identified possible practices and settings in which infection may have occurred, including constraints on access to sterile injecting equipment and vulnerability to unsafe injecting practices prompted by opiate withdrawal. Re-use of injecting equipment between



intimate partners was also identified as potentially contributing to seroconversion. The diagnostic experiences of most participants were sub-optimal according to national testing guidelines.

Recommendations for preventing HCV infection include formulating guidelines for testing (including frequency of testing) dependent on people's risk, including a self-assessment tool; improving access to HCV prevention and opioid substitution treatment in custodial settings; and increasing coverage of syringe distribution programs. The data also indicate a need for policies to support improved HCV diagnosis experiences.



## Leaky meanings: knowledges about sexual transmission of hepatitis C and their impact on intimacy and sexuality

**Emily Lenton<sup>1</sup>, Suzanne Fraser<sup>1</sup>, Carla Treloar<sup>2</sup> and David Moore<sup>3</sup>**

Australian public health strategies aimed at managing the risk of sexual transmission of disease were largely established in response to HIV/AIDS. These strategies were well disseminated in Australia, resulting in very low rates of HIV infection. Did they produce any unintended effects? In this paper we look at one possible effect, the confusion of ideas about HIV transmissibility with hepatitis C, the adoption of generalised notions of sexual contagion, and the misidentification of some forms of hepatitis C risk.

The paper analyses 30 in-depth semi-structured interviews conducted with hepatitis C positive people, most but not all of whom identified as current or former injecting drug users. These data were collected as part of an NHMRC-funded project exploring the changing meanings of hepatitis C over time.


Significant differences in attitudes and understandings were identified in the data. Some participants were clear that hepatitis C is not classified as a sexually transmitted disease and bears little or no relationship to HIV. Others expressed an awareness of the low risk of sexual and vertical transmission, but remained reticent to form sexual relationships or consider reproduction. Still others held inaccurate views about transmission. Drawing on Catherine Waldby's (1996) cultural analysis of the HIV epidemic and Margrit Shildrick's ideas of anomalous bodies (1997, 2000, 2002), this paper explores how categories of risk have direct causes for the ways bodies are imagined and positioned in the social order. The paper suggests that these differences reflect how in culture, women's bodies are constructed as leaky, aberrant and risky.

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## Guilty or angry? The politics of emotion in accounts of hepatitis C transmission

**Kate Seear and Suzanne Fraser**

In biomedical and popular accounts of hepatitis C, distinctions are frequently made between 'innocent' and 'guilty' forms of transmission. Subjects who acquire hepatitis C through iatrogenic means (for example, via 'contaminated' blood products) are often considered less culpable and/or morally questionable than those individuals who acquire the disease through other means (most notably, via injecting drug use [IDU], which comprises a large proportion of the hepatitis C population). Although such distinctions have been the subject of extensive critique, they continue

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to manifest in less obvious ways. For example, in hepatitis C self-help literature, patients' emotions are often expected to be organized in either of two ways; iatrogenic individuals are expected to feel angry, whereas IDU are expected to feel guilty. In this paper we examine the implications of these distinctions and the effects of imposing such expectations upon a diverse population of individuals. Based upon interview material collected as part of an ARC-funded study on hepatitis C, we examine assumptions about guilt, innocence and responsibility with respect to hepatitis C transmission. The study involves 30 qualitative interviews conducted in Melbourne, with a diverse cohort of individuals by gender, age and ethnicity. The data was coded and analysed via the NVivo program. In this paper, we consider the ways in which the imposition of a pre-determined set of expectations about what does/does not constitute 'culpability' operate politically and ethically, and the impacts of such upon individuals with both 'forms' of hepatitis C (iatrogenic and IDU-acquired). We also explore ways in which individuals living with hepatitis C attempt to negotiate these imposed frameworks of guilt/responsibility, as well as the ways in which notions of vulnerability and agency are separated and thus diminished or oversimplified by these assumptions. We conclude with a discussion of the ways in which health promotion and policy materials might be amended to reflect the range of emotional responses to a hepatitis C diagnosis, without reproducing problematic notions of 'guilt' and 'innocence'.



## Treating injecting drug users for hepatitis C: myths and reality

**Rachel Sacks-Davis, Judy Gold, Margaret Hellard and Peter Higgs (presenter)**

Centre for Population Health, Macfarlane  
Burnet Institute for Medical Research  
and Public Health, Melbourne  
rachel@d@burnet.edu.au

**Aim:** Injecting drug users (IDUs) carry a disproportionately large burden of hepatitis C infection but treatment rates amongst IDUs remain low. We aimed to investigate reasons for this discrepancy.

**Method:** Literature published until the end of 2007, pertaining to hepatitis C management and treatment in IDUs was reviewed.

**Results:** Barriers to treatment identified included current drug use, heavy alcohol use and history of depression. The evidence for these barriers was assessed.

Many clinicians and many hepatitis C trials make treatment conditional on IDUs having a period of abstinence from injecting or require concurrent participation in a drug treatment program. However there is only limited evidence as to whether total abstinence or drug treatment improves the likelihood of having a sustained virological response (SVR).

IDUs are more likely to report a history of past or current heavy alcohol use; evidence to date suggests this may impact on IDUs willingness to undergo treatment but does not impact on the likelihood of treatment success, as long as alcohol is not consumed during treatment.

It is well established that there is a high prevalence of depression and other mental health problems amongst IDUs; however the influence on treatment outcomes is unclear.

**Conclusion:** Many of the current barriers IDUs face in regards to accessing hepatitis C treatment are not evidence based. The challenge for IDUs, clinicians and the community is to ensure that treatment decisions are based on the best available evidence and treatment is tailored appropriately on a case-by-case basis.

# HIV and heterosexuality 2C

Chair: **Christy Newman**

## Heterosexual men, HIV & masculinity

**Kate Reakes<sup>1</sup>, Asha Persson<sup>2</sup> and Jessica Elkaim<sup>1</sup> (presenter)**

For men living heterosexually with HIV, their perceived sexual orientation can be a major concern. Frequently in their interactions with service providers and others, these men often seem compelled to articulate and affirm their identity as a heterosexual man. This seeming need to emphasise their heterosexuality can sometimes lead to a perception of homophobia.

In this paper, we draw on our experience with this client population through in-depth service provision and through social research (the Straightpoz Study) to attempt to identify and unpack the meanings surrounding this issue.

Because of the historical association between HIV and homosexuality, these men can feel like they are forced into an "identity corner". In addition, Australian heterosexual men experience a privileged position in society. When this position is compromised and their identity "spoiled" by a condition not frequently associated with the mainstream population, such as HIV, greater importance might be placed on reclaiming their status as a heterosexual man.

Our analysis considers whether reinforcement of sexual orientation and sexual identity is a way to regain a sense of power and normality. While heterosexual men with HIV cannot change or control their serostatus, their perceived sexual orientation and sexual identity might constitute aspects of their life and self that they can perhaps more readily control.

This a complex issue affecting a vulnerable population of men living with HIV, and we should therefore be careful not to fall into the trap of dismissing it as homophobia, but rather try to understand the dynamics behind it.

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## Serostatus identity? HIV-negativity in serodiscordant heterosexual couples

**Asha Persson**

Nearly three decades after the onset of the HIV epidemic, one affected group remains largely invisible and has received little international attention, namely HIV-negative people who are in a committed, intimate relationship with someone who is HIV-positive. Their lives are entwined with the everyday realities of HIV, whether emotional, sexual, social or medical. Yet, paradoxically, given their proximity to the virus, partners' experiences of "living with HIV" are little considered and understood, as are the meanings and practices of being HIV-negative in that context.

In this paper, I consider analyses that suggest a generalised silence around HIV-negativity in the western epidemic, the politico-historical circumstances in which this silence arose, and its relevance to HIV-negative heterosexual partners in Australia today. I go on to note that, when HIV-negative partners appear in the research literature, they are

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routinely pre-conceived as having a distinct identity that is inherently different from and in inevitable tension with HIV-positivity.

On this background, I explore qualitative interviews with HIV-negative partners. These reveal that HIV-negativity in heterosexual serodiscordant couples is profoundly shaped by cultural discourses of gender and sexuality within the context of the local epidemic, thus challenging the presumption of an inherent identity. Drawing on anthropologist Victor Turner's theory, I show that HIV-negativity in this context eludes common classificatory categories that locate identities and positions in cultural space, rendering it a liminal subjectivity. I conclude that, given the rise in HIV infections, a greater understanding of HIV-negativity in serodiscordant relationships might help to 'reframe a virus that thrives on invisibility'.



## Heterosexual African men and HIV

**Nandini Ray, Masha Eisenberg, Effie Katsaros, Barbara Luisi**

Multicultural HIV/AIDS and Hepatitis C  
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Heterosexual transmission is a major mode of HIV infection in many developing countries and migrants from these countries now make up the majority of HIV positive people in some developed countries. In the UK, for example, heterosexual activity accounts for approximately half of all new HIV diagnoses, with the majority of those infected being from African backgrounds.

Nevertheless, heterosexual men have been relatively neglected in the HIV literature and, where they have been considered, they have generally been represented as conforming to a stereotypic idea of maleness and in terms of their impact on women.

This paper focuses on some heterosexual African male clients of the MHAHS. It raises questions about where heterosexual men from culturally and linguistically diverse backgrounds may speak openly without being judged, how they may be enabled to find ways of "living better," and how service providers work with culturally specific attitudes. The paper argues that the feminisation of HIV globally must not mean a denial of male issues and health rights.



## 'I was not some young tourist': acquisition of HIV among WA men while travelling and working overseas

**Graham Brown<sup>1</sup>, Jeanne Ellard<sup>2</sup>, Julie Mooney-Somers<sup>3</sup> and Garrett Prestage<sup>3</sup>**

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Research, Curtin Health Innovation  
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The proportion of men who acquired HIV while travelling or working overseas has risen dramatically in Western Australia (WA) to more than half of new male infections, with most of these infections among heterosexual men, while transmissions within WA have plateaued. There has been little research into the factors that lead to WA men contracting HIV overseas.

In-depth interviews were conducted with WA male residents who have recently acquired HIV while travelling or working overseas to investigate the social, cultural, setting, behavioural and cognitive factors which may have contributed to HIV transmission. 12 men (8 self identified heterosexual, 4 self identified gay) who met the criteria have been interviewed. Interviews were analysed using a modified constant

comparative method to identify major themes. This paper will focus on two themes which relate primarily to the heterosexual male participants.

Firstly, the strong and sustained networks amongst Australian expatriates and longer term travellers heavily influenced the men's understanding of the culture and contexts of the country, how to meet sexual and relationship partners, and created an experience of mentoring and camaraderie. Secondly, participants felt strongly that they understood the culture of the host country in a short period of time, and identified as expatriates or experienced travellers rather than tourists.

The influence and role of social networks amongst these men while in country may be very influential and indicates that prevention interventions that engage with these networks may be effective in targeting programs more effectively, as has been the case with peer network interventions with gay men, people who inject drugs, and sex workers.

Proffered papers

## Health and sexuality in cultural context 2D

Chair: **Evelyn Lee**

An exploration of understandings and concerns towards sexually transmissible infections and blood borne viruses in a group of people who spend time in the long-grass in Darwin

**Verity Slee**

The current study explores opportunities for appropriate, relevant and effective sexually transmissible infections (STIs) and blood borne viruses (BBVs) related health promotion in the long-grass in Darwin. It utilises a public health theoretical perspective, which is based on the understanding that social, economical and environmental factors are determinants of health and well-being. The Northern Territory has one of the highest rates of homelessness in Australia. Often referred to as long-grassers, Indigenous Australians are over represented in Darwin's homeless population.

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Long-grassers generally experience poor health outcomes, face many barriers to accessing appropriate services and have differing health priorities than the general population. Despite this, there is a dearth of research and support services. Understanding and addressing STIs and BBV health needs of people in the long-grass has been a challenge that services, such as the Northern Territory AIDS and Hepatitis Council (NTAHC) continuously face.

The project consists of a comprehensive literature review, observational research and informal interviews with outreach workers and people in the long-grass. In order to provide effective services to long-grassers, Larrakia Nation have developed a health outreach program called Healthy Engagement and Assistance in the Long-Grass (HEAL). This consists of daily outreach in the long-grass which are delivered within the context of needs as identified by people in the long-grass. The current project works alongside these workers to explore the opportunities for STI- and BBV-related health interventions which are relevant and can be effectively delivered within the life view and experience of long-grassers. The findings and recommendations will be shared with services to improve health interventions and the relevance and accessibility of service for long-grassers. Watch this space!

## Experience of stigma and its impact on fertility desire and intentions of people living with HIV in Northern Uganda

**Barbara Nattabi<sup>1</sup>, Jianghong Li<sup>2</sup>, Sandra Thompson<sup>1</sup>, Christopher Orach<sup>3</sup> and Jaya Earnest<sup>1</sup>**

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People living with HIV/AIDS (PLHIV) around the world continue to experience adverse impacts on quality of life and health care as a result of exposure to stigma and discrimination. HIV-related stigma affects fertility desire and family planning behavior among PLHIV in various ways. This study quantified and explored the experiences of stigma and its impact on fertility desire among 476 people living with HIV in Gulu, Northern Uganda using the validated HIV/AIDS Stigma instrument-PLWA (HASI-P) and in-depth interviews. The survey data showed that females more than males, PLHIV aged above 30 years compared to younger PLHIV, and those who had been on highly active antiretroviral therapy (HAART) for longer experienced significantly higher levels of stigma. Stigma in the form of verbal abuse and negative self perception was much more prevalent than stigma that manifested in terms of health care neglect, social isolation, work place discrimination or fear of contagion. PLHIV who had experienced stigma in various forms were less likely to intend to have children or to use health services than those who did not have such experience. Using a conceptual framework developed using stigma experiences of PLHIV in Africa, this paper also explores the stigma process: the triggers, stigmatizing behaviors, whether stigma is exogenous or internalized, outcomes of being stigmatized, and the role of agents (families, communities and health systems) in the process of stigmatizing and/or mitigating stigmatization of PLHIV.

## Gays, and men who like gays: self-understandings, sexual roles, gender expressions and the challenge of HIV among same-sex attracted men in Dar es Salaam, Tanzania

**Kare Moen and Anne-Lise Middelthon**

Section for Medical Anthropology and Medical History, Faculty of Medicine, University of Oslo, Norway

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He wanted to throw a birthday party and had invited five of us to help with some planning. His reply when I asked: “Ungependa kualika magari tu?” [Would you like to invite gays only?] was: “No, no, those who prefer to should be allowed to come with a boyfriend”.

This paper inquires into self-understandings, sexual roles and gender expressions among men who love and/or sex with other men in Tanzania’s main urban center. It explores the distinction between ‘magai’ and ‘men who love magari’; delves into the joys, thrills, distresses and frustrations of same-sex identities, encounters and relationships; and discusses implications of such matters for HIV programming.

Whereas same-sex attracted men have not commonly been explicitly addressed and involved in HIV prevention and care strategies in many African contexts, more targeted programming is currently emerging in some countries. It is argued that it is essential that such programs be informed by emic perspectives and culturally situated understandings.

The paper is based on 15 months of fieldwork in Dar es Salaam, Tanzania. The fieldwork, which was carried out in 2008 and 2009, entailed a mix of qualitative research methods, including participant observation, conversations, interviews and group discussions.



# Social isolation for people living with HIV/AIDS in South East Queensland: determinants and consequences

**Lisa Wojciechowski and Lisa Fitzgerald**

Over the history of the HIV epidemic, there have been developments in scientific knowledge, biomedical technologies and research methods. These developments have affected the lives of people living with HIV/AIDS (PLWHA) in relation to how they construct their identit(ies) and subsequently connect with communities and services. This has implications for how practitioners engage with PLWHA necessitating the incorporation of practice knowledge, client perspectives and research to produce an evidence base.

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Positive Directions (PD) is an information, referral and care coordination service for PLWHA within Queensland. Working from a client-centred, holistic framework within a multidisciplinary setting, staff support PLWHA in addressing both the social and clinical determinants of clients' health.

From their experiences of working closely with PLWHA throughout the state, PD service providers noticed strong anecdotal evidence of social isolation amongst their clients. PD staff, in collaboration from social researchers from the School of Population Health and School of Medicine (University of Queensland) are undertaking a project examining PD clients' experiences of social isolation in South East Queensland.

This paper will discuss the ways in which this qualitative study highlighted the multiple and varied experiences of PLWHA, including older people, culturally and linguistically diverse (CALD), women, people who live in regional or isolated areas. In particular, preliminary findings from focus groups, in depth interviews and write and draw techniques will be discussed.

Additionally, this paper will outline the collaborative research process by which an evidence base for practice knowledge was developed through partnership between Positive Directions practitioners and academics from the University of Queensland.

## 3A BBV issues for CALD communities

Chair: **Henrike Korner**

Targeted approaches to HIV prevention among immigrants living in high-income countries: a review of evidence relevant to the development of culturally appropriate interventions

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Globally over 95% of people acquiring HIV each year live in developing and middle income countries. Immigrants from these countries now make up a significant proportion of people living with HIV in many high-income countries including Australia. Dominant modes of HIV transmission tend to be atypical among these immigrants and there is some evidence of disparities in health outcomes.

In Australia, targeted and appropriate interventions are central to HIV prevention among sub-cultures of gay men, sex workers and people who inject drugs. A key gap in our evidence base includes what we can learn from other high-income countries to guide new, or strengthen existing approaches, to HIV prevention with immigrants in Australia.

Research, in the form of a review of evidence, explored HIV prevention with immigrants and sought to 'unpack' the mechanisms for achieving cultural appropriateness in interventions. Two types of studies contributed to the research: studies of interventions and qualitative studies of immigrants' views on HIV/AIDS prevention.

Seven preliminary mechanisms—'authenticity', 'understanding', 'consonance', 'specificity', 'embeddedness', 'endorsement' and 'framing' were generated from a scan of the literature. These mechanisms were then tested and refined against evidence—73 peer-reviewed and 'grey' studies relevant to HIV prevention with immigrants—found in systematic searches in major public health databases.

The paper will provide a summary of the findings which pointed to the pivotal, moderately important and least critical mechanisms to enhance cultural appropriateness in HIV-prevention interventions with immigrants. It will also discuss the implications for policy and practice in addressing HIV among culturally and linguistically diverse communities in Australia.

Addressing Asian MSM issues in an ethnically diverse international city over 12 years of programs

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**Issues:** Asian MSM in Australia can face specific sexual health issues, at least partially related to regional mobility, including lower rates of HIV testing, compromised negotiation skills due to language difficulties, displacement into an unfamiliar sexual culture, and an increased reliance on sexual capital resulting from a lack of financial and/or social support.



**Project:** ACON's Asian Project has responded to the needs of Asian MSM in Sydney over the last twelve years. The Asian Project implements a range of strategies through a community development and peer education framework. Most activities are groups and workshops as well as other activities that build community cohesion, reduce social isolation, challenge racism and increase visibility. Education materials have also been produced.

**Results:** The Asian Project has contributed to the growth of a distinctive Asian GLBT community in Sydney and has initiated many responses to the complex social circumstances that effect Asian MSM's sexual health.

**Lessons learned:** Much of the Project's work has not focused on mobility issues specifically. Although attention to mobility issues has increased and we are now using settlement data (e.g. eligibility for migration, number of students or visitors etc.) to inform our programs and addressing migration issues in group work, this issue requires greater attention.



## Women and HIV fact sheets: review and update

**Marina Suarez**

**Aims:** This project addressed a gap of plain English information available for HIV-positive women from culturally and linguistically diverse (CALD) backgrounds in NSW.

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CALD women represent 60% of the female HIV notifications in NSW (NCHECR. 2007 Annual Surveillance Report, p. 25). People from CALD communities are one of the priority populations listed in the NSW HIV/AIDS Strategy 2006–2009.

**Method:** The project was a partnership between Family Planning NSW, The Heterosexual HIV/AIDS Service, Multicultural HIV/AIDS and Hepatitis C Service and ACON Women and Families affected by HIV Project.

A consultation process with a wide range of stakeholders was undertaken to review the previous 2002 women and HIV fact sheets, decide on the most relevant topics, content and style. The agreed topics were: Testing, Recently Diagnosed, Treatment, Pregnancy, Looking After Yourself and Services.

Draft fact sheets were focus tested with women living with HIV from different CALD groups for language, content and design.

Fact sheets were written in plain English to make them accessible for women from CALD backgrounds and to facilitate future translation into community languages.

**Results:** Six reviewed and updated fact sheets in PDF format are available for download from a number of websites.

A comprehensive plan will ensure the factsheets are disseminated to all relevant services that may be in contact with HIV positive women and women at risk of HIV.

**Conclusions:** An evaluation plan was developed and currently being implemented to ascertain the number of downloads and the usefulness of the factsheets for women with HIV/CALD backgrounds and service providers.

## Australian Egyptian community's understanding of HCV, their knowledge of virus transmission, attitudes towards HCV and treatment

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Egypt contains the highest prevalence of hepatitis C (HCV) in the world, with up to 15 to 20 per cent of the Egyptian population testing positive for HCV antibodies. This high prevalence is largely due to an unsterile mass vaccination program for schistosomiasis that was conducted prior to 1980. In Australia, 57% of the Egyptian born population migrated to Australia before 1976. As such, the Australian Egyptian born adult community represents a population at high risk of HCV-related liver disease. Little is known about the level of knowledge of HCV among this Egyptian born community living in Australia. The limited data available suggests that HCV knowledge is poor among both the general population and among particular groups at risk of acquiring HCV (e.g. injecting drug users), with many holding fundamental misconceptions about HCV transmission, symptoms and treatment. This study examined the Egyptian born community's understanding of HCV, their knowledge of transmission, attitudes towards HCV and treatment. One hundred and twelve participants were recruited through Coptic Churches and other Egyptian community organisations in inner city and suburban sites of NSW. Knowledge of HCV and of HCV treatment among this group was found to be low and inaccurate. Such findings suggest that targeted community awareness campaigns, screening of high-risk populations and culturally sensitive education programs need to be developed and implemented to reduce risk of HCV transmission and increase access to appropriate support and treatment amongst this population. A follow-up study is in progress to explore the impact of targeted community health promotion.

Proffered papers

## 3B Decisions about treatment for hepatitis C

Chair: **Max Hopwood**

## Consideration and uptake of treatment for hepatitis C infection among injecting drug users


**Peter Hull<sup>1</sup>, Joanne Bryant<sup>1</sup>, Max Hopwood<sup>1</sup>, Jason Grebely<sup>2</sup> and Carla Treloar<sup>1</sup>**

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The aim of this study was to determine which factors may be associated with consideration and uptake of hepatitis C treatment. A cross-sectional study was conducted in 2008 in which participants were recruited through mailing lists, opiate pharmacotherapy clinics, needle-syringe programs, and pharmacies. Participants completed self-administered surveys containing information on socio-demographics, health status, HCV knowledge and previous treatment. A total of 633 people with self-reported HCV infection completed surveys. Logistic regression analysis of variables assessing sense of discrimination and disclosure with consideration and uptake of HCV treatment showed that people scoring higher on a disclosure scale, which indicated a tendency to non-disclosure, and people currently receiving pharmacotherapy for drug treatment, were more likely to consider HCV treatment.



## The politics of place(ment): treating hepatitis C within opiate substitution

**Jake Rance, Jamee Newland, Max Hopwood and Carla Treloar**

Although treatment for hepatitis C (HCV) is available for those with chronic infection, uptake is low and there is a policy imperative to double the numbers of people undertaking treatment. A number of initiatives are underway to expand access to HCV treatment with significant interest and investment in the provision of HCV care and treatment in opiate substitution treatment (OST) settings.

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To explore the critical questions raised by the possibility of integrating OST and HCV treatment, we draw on data collected in a qualitative study involving both clients and health professionals of OST.

This paper argues that despite the apparent logic and advantages of providing two treatment modalities within the one service, their relationship is a complex and uneasy one. Foucault's power/knowledge formulation — the materiality of knowledge as 'discourse' — and its intrinsic relationship to institutional (non-discursive) sites, networks and supports, provides us with the conceptual means with which to frame our argument. We contend that conceiving of OST clinics as medical services primarily concerned with technocratic questions of dosage titration, administration and treatment outcomes overlooks the myriad of power relations that both shape and reflect drug treatment. We argue that the OST clinic can more usefully be understood as a particular social and discursive site; an assemblage of discourses, practices and arrangements operating under the rubric of the science of drug dependence treatment — itself a set of competing scientific, political, and populist discourses.



## Adjudicating injecting drug users' candidacy for hepatitis C treatment: conflicting provider, patient and public health realities?

**Heidi Coupland and Lisa Maher**

Uptake of antiviral treatment for hepatitis C infection by injecting drug users (IDUs) remains low and little is known about barriers to treatment uptake among culturally diverse groups of IDUs. This presentation explores notions of 'candidacy' for treatment, or the dynamic process of 'negotiation' between individuals and providers to 'accomplish' access to treatment in a cross-cultural context.

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Ethnographic research methods (fieldwork and in-depth interviews) were used to explore barriers to antiviral treatment uptake experienced by Indo-Chinese (Cambodian, Lao or Vietnamese) IDUs in south western Sydney. Seventy-two participants were recruited using theoretical and snowball sampling. Data were analysed using grounded theory.

In view of participants' cultural contexts, everyday realities and disengagement from the health system, most did not consider themselves candidates for antiviral treatment at present. Only four were assessed for treatment and adjudications of candidacy were perceived by participants to be embedded in power dynamics. Demonstrating abstinence from injecting drug use and complying with other 'tests' of candidacy were believed to be central to accessing treatment. Participants' responses to these adjudications will be presented, exploring both their resistance and, to a degree, acceptance of the clinic's position.

Findings highlighted how adjudications of candidacy by clinic staff could act as barriers to antiviral treatment uptake and as a form of symbolic violence given Indo-Chinese IDUs' everyday realities. Further research is needed to explore factors influencing clinicians' adjudications of candidacy, and the impact of power differentials between health professionals and IDUs on treatment provision and equitable access to treatment for diverse groups of IDUs.



## Guilt, fear, depression and toxicity—hep C: when the cure is worse than the disease

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For many people who inject drugs, the experience of being hepatitis C positive and the experience of contemplating and undertaking treatment for hep C is complex and influenced by factors ranging from and including fear of death; guilt at being positive and guilt about passing on hep C; mistrust of medical authority; fear of disclosure; misunderstanding of treatment options and fear of treatment itself. Within the individual these influences combine to make very difficult any decision around undertaking treatment. In addition, myth, gossip and truth have always mingled when people have talked to one another about undertaking hepatitis C treatment. Horror stories about botched biopsies have sat with grim warnings about hanging out feelings for a year in the minds of many people when they have thought about undertaking hepatitis C treatment.

Despite advances being made in certain aspects of treatment and this impacting positively, it is also apparent that more side and after-effects are being reported as more people go through treatment. Unfortunately, and in a process that seems to mirror people's experiences of side effects from pharmacotherapy treatments, clinicians are too often dismissing or downplaying these complaints. In a community used to being mistrusted, all this does is ensure that possibly serious issues go undiagnosed and that users will simply advise their networks and peers not to undertake treatment – especially if they experience no sickness from hep C but do experience sickness from treatment.

It is important that people's concerns and experiences are carefully documented and properly investigated and researched both for the sake of the individuals who are entering into treatment somewhat lightly and for those who have had negative experiences as well as for anyone wanting hepatitis C treatment to have an impact on the epidemic as a whole. Failing to do so will only ensure that half-truths and worst case scenarios will continue to take on the currency of truth.

This paper will look at some of the complex interactions of these factors not because we want to have less treatment but because we want more positive and effective individual experiences of hepatitis C treatment.

## Evaluating health promotion 3C

Chair: **Graham Brown**

## Different strokes for different blokes: comparison of two HIV education campaigns

**Kathy Triffit**

Drawing on a review of 'SERO DISCO: Why let HIV get in the way of a good relationship?' and 'SEX PIGS: Dark and dirty sex and managing your health' produced by Positive Life NSW, this paper will describe some of the current HIV education issues affecting educators and gay men. It will look at the relationships and conflicts between targeted health promotion messages and mainstream condom reinforcement campaigns. Specifically, the challenge was to develop HIV prevention campaigns and messages that included the way new understandings of risk, safety and health are incorporated in gay men's sexual lives.

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This paper will describe a more sophisticated understanding of prevention and highlight values and models of behaviour, and harm minimisation applied to condom use. While condom use with casual partners of unknown HIV status is a key message, campaigns also acknowledge gay men continue to redefine the limits of risk and safety.

The effectiveness and credibility of HIV prevention depend on recognising there are different limits and boundaries for gay men in different sexual circumstances. For sexually adventurous gay men, condom reinforcement messages can be seen as incongruous or contradictory when in the pursuit of pleasure and 'sexual freedom'. While some couples in serodiscordant relationships are using undetectable viral load without condoms not only to reduce their risk of passing on or getting HIV, but also 'for intimacy and connection'. For others, undetectable viral load is more of an added reassurance, rather than a replacement of condoms and safe sex.

### Understanding risk: lessons from the evaluation of HIV prevention initiatives in Victoria and learnings from men through a younger perspective

**Alisa Pedrana<sup>1,2</sup>, Margaret Hellard<sup>1</sup>, Rebecca Guy<sup>3</sup> and Mark Stoové<sup>1</sup>**

Between 2007 and 2008 there was a significant decline in the median age of HIV diagnosis among men who have sex with men (MSM) in Victoria. As part of an evaluation of social marketing campaigns undertaken by the Victorian AIDS Council (VAC) during 2007–2009 we explored factors potentially influencing the increase of notifications among younger MSM. Two data collection methods were used: a repeated survey of an online cohort of MSM and regular in-depth focus groups.

To date, three rounds of surveys ( $n=231$ ) and six focus groups ( $n=50$ ) have been conducted. Amongst survey participations, 88% recalled at least one of the HIV prevention campaigns. Themes emerging from the focus groups included: recognition that the gay community was becoming more diverse and dispersed within the mainstream community; that the campaigns were perceived as targeting a broad base, particularly younger gay men; and that the campaign were helping normalise sexual health testing and sexual health discussions. Younger gay males suggested that

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trends in 'coming out' earlier meant that younger gay males were becoming more sexual adventurous at a younger age, potentially impacting on their risk of acquiring HIV/STIs.

This evaluation has provided valuable information to the Victorian Department of Health and the VAC regarding the effectiveness of HIV prevention campaign strategies, in addition to offering some suggestions as to why we are seeing increases in HIV notifications among younger gay males.



## Condom Credit Card

### Michelle Horner and Kate Weston (co-presenters)

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**Introduction:** The Warehouse Youth Health Centre is a free and confidential reproductive and sexual health service for young people aged 12–24. The service operates within the Hawkesbury, Penrith and the Blue Mountains Local Government Areas, NSW Australia, just west of Sydney. The Condom Credit Card Project (CCC) is a free condom dissemination program conducted in partnership with The Junction Youth Health Medical Centre. Dissemination of Safe Sex Packs is disseminated through other youth services and is monitored monthly

**Objectives:** The project is based on a capacity building model, which includes training and supports STI strategies for aiming to reduce the transmission of STI amongst priority groups such as young people.

**Methods:** Training in proper condom use and youth health issues is provided to participating Youth services. The relevant workers are trained in issues of confidentiality and mandatory reporting. Referral to The Warehouse and The Junction are also promoted. Through this we're able to utilise their connections and access their at risk young people as they function as a CCC dissemination centre in the Hawkesbury, Penrith and the Blue Mountains Local Government Areas.

**Results:** At present there are 700 card holders and 20 CCC dissemination centre's involved. As a result of the CCC Project, access of male clients to the Warehouse has risen from 2% to an average of 6.7% reaching a highest percentage of 9% over the last year.

**Discussion/Conclusion:** The CCC has been a highly effective method of accessing young men directly with The Warehouse and The Junction. The CCC can be disseminated in conjunction with other youth health projects The Warehouse has undertaken. Dissemination points for the cards are not just restricted to youth services. The CCC can be utilised during outreach at community events, University events, Sports Fairs and other youth events and is promoted through schools, youth services and various local interagencies.



## Making HIV+ peer support work: the Positive Life/ACON Peer Support review

### Robert Lake<sup>1</sup> and Graham Brown<sup>2,3</sup>

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In 2008 Positive Life NSW and ACON commenced a joint project to review the peer support groups and programs operated for people with HIV in NSW. The aims of the research were to:

- undertake research to support the review of peer support models and programs

- review the effectiveness of peer support programs for people with HIV
- support the development of effective evaluation tools for peer support

The methods used included:

- 2 workshops with staff and others with expertise to agree objectives and approach and to develop tools for evaluation
- 4 focus group discussions, observational evaluations of groups and online survey
- Review of data and development of report
- Workshop to finalise results and consider implementation
- Follow-up evaluation 6 months later.

The presentation will highlight the findings of the research, its implications for HIV+ peer support in NSW and elsewhere, implications for current models and possible new models, better defined objectives for peer support and consideration of the social support and other aspects that make up effective peer support.

Proffered papers

## Redesigning service models for people who inject drugs 3D

Chair: **Hannah Wilson**

'Re-focusing HCV clinical services in a primary health centre setting': findings from the HCV project, Kirketon Road Centre

**Kate DeMaere, Wendy Machin and Ingrid van Beek**

Kirketon Road Centre (KRC) is a primary health care centre located in Sydney's Kings Cross. A range of services within harm reduction and health promotion frameworks are provided to local priority populations including sex workers, 'at risk' young people and injecting drug users. Since 2001 KRC has provided a specialist HCV clinic where KRC clients with HCV are assessed by an infectious diseases medical specialist for HCV treatment; monitoring, genotyping, PCR testing and HCV education are also available. However, despite KRC having considerable access to these HCV affected populations, their utilisation of the HCV clinic has been suboptimal.


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**Aim:** To undertake a project to assess, identify and address key barriers to increase clinic service opportunities and enhance clients' opportunities to access HCV services.

**Method:** A client needs assessment was carried out in late 2009; 100 participants completed an HCV-focused survey. Additional information was also drawn from routinely collected HCV clinical data, health promotion activities and a review of clinic systems.

**Results:** Long duration of treatment, side effects, other life priorities and significant social determinants such as homelessness were key barriers to HCV treatment uptake; clinic systems also played a role.



## Changes in the age distribution and patterns of drug use in the Queensland arm of the Australian Needle and Syringe Program Survey, 1995–2008

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**Introduction:** Throughout the 1980s and up until the late 1990s injecting drug user (IDU) populations were generally characterised by an age distribution with a peak in the mid twenties. It was often estimated that approximately 5% of IDUs began injecting while a further 5% ceased each year (Thorley A, 1981) thereby maintaining a similar age structure.

**Method:** Anonymous annual survey of all clients accessing sentinel NSP sites. All participants complete an anonymous survey and provide a finger-prick blood sample. In Queensland five sites have participated since the inception of the survey in 1995.

**Results:** From 1998 the mean age of NSP survey participants started to increase, from 25 in 1998 to 34 in 2008, as did the median years of injecting from 5 years in 1998 to 14 years in 2008. At the same time the number of IDU aged 20 years old or less declined from a peak of 16.42% of the sample in 1996 to 3.42% in 2008. If one assumes that the rate of exit/cessation from IDU remained constant at approximately 5% then over the past decade the IDU population in Queensland has been going through a period of sustained contraction.

**Discussion:** This finding has major implications for NSPs and other services providing treatment, interventions and/or support to injecting drug users. An ageing IDU population is more likely to experience a range of chronic health problems/complications associated with a life course of low income/poverty, poor mental health, poor dental health, repeated injection related injuries and exposure to a range of diseases.



## Challenges ahead for improving coverage and service delivery in geographically diverse, low population density regions in New Zealand for needle exchange activities

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Often NEP capacity within the larger cities and/or major conurbations throughout Australasia is greater; mostly because it is easier to implement services and access injecting drug users (IDUs) via regular urban infrastructural means compared to what is available in rural, smaller towns with large geographical areas in-between.

The west coast of the South Island of NZ is a region with a paucity of health services combined with a lack of infrastructural investment. Conversely, the region supports a rapidly growing tourism industry and attracts individuals seeking alternative lifestyles, slower pace and less obtrusive 'state controls'.

In 2004 a dedicated Needle Exchange trialed a rural, mobile outreach scheme targeting IDU situated in the West Coast.

Monthly contact by an authorised, trained worker in a modified vehicle capable of transporting hazardous waste (used injection equipment) enables those wishing to participate in the scheme (designated 'key contacts') by delivering injection equipment and collecting the used



ones. The key contacts primary role is to use new injection equipment and possess enough for their peers also. Reuse & sharing behaviours are highlighted, education imparted, and health outcomes improved.

Comparisons will be made between this mobile scheme vs. a static outlet, risk behaviour analyses via qualitative self report questionnaires, quantitative BBV results compared against self report BBV status and placed in context within the national population using the same research methods.

Ottawa Charter principles underpin the entire vision and delivery of this unique scheme and much of its success lies in the peer service model adopted from the outset.



## Institutional dynamics governing sterile needle and syringe accessibility for people who inject drugs: mini workshop

**Jo Holden<sup>1</sup> and Jason Prior<sup>2</sup> (co-presenters)**

Providing access to and encouraging utilisation of sterile needles and syringes by people who inject drugs is now considered an important and necessary component of Hepatitis C Virus prevention programmes. Within the Australian and New South Wales context a wide variety of structural and environmental interventions have been developed to improve access to and utilisation of sterile injecting equipment such as Needle Syringe Programs, peer education interventions, Supervised Injecting Facilities, vending machines through to policies and education programmes to encourage more appropriate disposal of used needles and syringes. The accessibility of these structural and environmental initiatives to people who inject drugs is dependent on a broad range of institutions – NSW government (Parliament, agencies and departments), through to local councils and non-government organisations – which are responsible for the implementation of programs and services through their legislation, planning instruments and policies.

This interactive workshop is part of a broader research project being conducted by the Institute for Sustainable Futures, University of Technology, Sydney which seeks to survey the way that the legislation, planning instruments and policies created by institutions promote sterile needle and syringe accessibility for people who inject drugs. The aim of the workshop is to engage the participants in discussion on how these diverse institutions independently facilitate accessibility, e.g. through their own policies, legislation and planning instruments; and discuss how the inter-relationships between these institutions facilitates accessibility in the NSW context. The outcomes sought from the workshop, like the broader project of which it is part, are the identification of opportunities for enhancing accessibility.

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# 3E Sex and risk: men who have sex with men

Chair: **John de Wit**

## Meanings of HIV in a changing epidemic

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**Background:** The meaning of HIV has changed for gay men in recent years, but what do we really know about what HIV means to gay men in Australia today?

**Methods:** Men participating in the Pleasure and Sexual Health (PASH) study were asked to tell us how important HIV was to them and how that meaning influenced the way they have sex; 2306 responses were collected.

**Results:** While the majority of men (54.9%) no longer see HIV as a death sentence, their views differ according to their sexual behaviour. Whereas 40.8% of men who reported unprotected anal intercourse with casual partners (UAIC) in the previous six months believed that HIV was a controllable disease, only 27.8% of men who reported never having engaged in UAIC felt this way ( $p < 0.001$ ). Also, while 30.2% of men who reported recent UAIC told us that there are some things they do now which they previously thought were too risky, this was true for only 13.4% of men who always used condoms ( $p < 0.001$ ).

**Conclusion:** There are strongly divergent views among men around the meanings of HIV. While there is still a significant proportion of men who have a morbid fear of HIV, many men feel confidently that they protect themselves from HIV sufficiently not to worry about it, while for a smaller, but important, group of men, HIV is even less of an issue and these men continue to engage in ostensibly much riskier behaviours.

## Reasoning risk reduction

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Although most gay men remain committed to using condoms most of the time, this commitment is no longer as strongly held as it once was. We investigated current beliefs about risk and HIV among gay men.

PASH (Pleasure & Sexual Health) was an online survey of 2306 gay men recruited during mid-2009.

About one in six HIV-negative men indicated they were willing to do some things now that they had previously thought were too risky. Nonetheless, such decisions are not without some regard to perceptions of relative risk: Whereas 59.9% of HIV-negative men said they might consider insertive unprotected anal intercourse (UAI) with someone who had told him he was also HIV-negative, only 43.6% would do so in the receptive position. If they did not know their partners' HIV status then only 30.6% would consider insertive UAI and 20.1% would consider receptive UAI. Very few would consider UAI with a partner they knew to be HIV-positive, even

if they believed his viral load was undetectable, whether they were the insertive (7.5%) or receptive (3.4%) partner.

Like everyone, gay men balance risk and pleasure, and are willing to take some degree of risk. However, these decisions are not always rational: Some HIV-negative men will contemplate UAI with a partner even when they do not know his HIV status and will only decide otherwise if they are actually informed that he is HIV-positive.



## Surveys of gay men in metropolitan Sydney and rural/regional NSW: comparison of sexual practices

Iryna Zablotska<sup>1</sup>, Martin Holt<sup>2</sup>, Garrett Prestage<sup>1</sup>

**Introduction:** Little is known about how sexual risk and risk reduction practices of gay men are shaped by their social and sexual environment. These practices differ across communities and may also differ when men travel. We compared risk and risk reduction approaches used by gay men living in metropolitan Sydney and in regional NSW while in their respective home communities and when visiting other places.

**Methods:** The August 2009 Gay Community Periodic Survey in metropolitan Sydney and a similar survey in rural/regional NSW in August–November 2009 were designed to address this research aim. Recruitment was conducted through gay events, venues and sexual health clinics. 1,371 and 467 men completed the survey in metropolitan Sydney and in rural/regional NSW, respectively. We compared the profiles of men recruited into these two surveys and assessed similarities and differences in practices depending on location.


**Results:** The number of men recruited in the metropolitan Sydney and rural/regional NSW surveys differed, which reflects the actual gay communities surveyed. There has been more travel of men from regional areas to Sydney [for sex?] than the other way. There were some differences in the profiles of men recruited into the samples. More than 80% of men in Sydney had sexual partners in metropolitan Sydney area in the past 6 months, and about 23%, 28% and 34% had sex with men in regional NSW, other states and overseas, respectively. When visiting other places and having sex there, a substantial number of men engaged in unprotected anal intercourse with casual partners (UAIC). However, this happened somewhat less frequently if compared to the UAIC rate when at home. Significantly fewer men engaged in UAIC with unknown serostatus partners in the communities where they travelled compared to their home community.

**Discussion/Conclusion:** These findings have Implications for HIV prevention and health promotion not only in Sydney but also in regional NSW. HIV prevention campaigns should address the issue of safe sex practices when at home and travelling (locally, interstate or overseas). The ability to negotiate and maintain safe sex practices independently of where men find partners could help to reduce HIV transmission among gay men.

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## Gay men talk about the place of extra-relational sex in their committed relationships: orientations to the therapeutic terrain

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This paper will draw on findings from doctoral research I have just completed which suggests that while many partnered gay men now have an adequate vocabulary for discussions of safer sex they often experience difficulty in asking for what they want in terms of extra-relational sex (ERS). I will argue that this is because such conversations invariably must lean towards emotional and spiritual themes such as meanings of love and sex, how commitment will be defined, questions of autonomy and connection, the place of trust and so on. These conversations can be hard because gay men are not immune from processes of male socialisation which undervalue expressions of vulnerability and the development of an emotional and relational vocabulary in men

No matter what version of monogamy or non-monogamy the participants in my study preferred or worked towards, an ability to engage with their partner in order to work towards a negotiated sexual agreement or to tolerate differences in their positions on the place of ERS seemed to increase personal and relationship satisfaction. This paper will suggest how therapists and others who care about the relational concerns of gay men and male couples can be of assistance to those they work with by orienting them to the inevitable features of the terrain of managing ERS while remaining alive and responsive to the unique goals and aspirations of the individual or couple before them.

## The NCHSR 20 year alumni plenary: evolving knowledge and practice 4

Chair: **Susan Kippax**

### The medicalisation of hepatitis C: ethical considerations for harm reduction

**Suzanne Fraser**

In 2010 the International Conference on the Reduction of Drug Related Harm will share its 21st birthday with one of its most constant companions: hepatitis C. The co-occurrence of these significant anniversaries provides an opportunity to reflect critically on the formative role played by hepatitis C, and our responses to it, in the development of harm reduction. This presentation highlights two trends, both of which emerge from hepatitis C's place as a thoroughly medicalised object. First, the medicalisation of hepatitis C has contributed to a now widely documented emphasis on individual responsibility in prevention initiatives, second, and apparently paradoxically, it has contributed to the homogenisation of affected individuals in relation to treatment. While acknowledging the benefits for people who inject drugs that have flowed from the medicalisation of hepatitis C, I consider some key conceptual, ethical, political and strategic challenges that harm reduction must confront as it continues to place the status and well-being of drug users at the centre of its rationale and work.

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### 'Are there any gay spots in Sydney?': reframing queer citizenship, from persons to places

**Kane Race**

In Gay New York, historian George Chauncey describes how the term 'gay' was originally used in the pre-Stonewall era to refer to places and events rather than persons. Thus, when asked of a stranger, the question "Are there any gay spots in Boston?" could serve to disclose homosexual interests to those who knew the code, while leaving the uninitiated none the wiser. Indeed, it was only in the post-Stonewall era that the term 'gay' made the definitive move from attaching-to-places to describing-persons, casting a vibrant history of subcultural activity in the shadow of a (putatively more enlightened) identity politics.

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Inspired by this anachronism, this paper explores the political advantages of thinking the term 'gay' once again in relation to space and place rather than persons. It is argued that several issues which are highly material to queer citizens in terms of how we live our lives – but which do not seem to register on the radar of formalised Gay and Lesbian politics – can be framed more effectively by considering the effects of the recent spatial politics of Sydney on queer life and sociability. These initiatives include recent interventions in the government of the night-time economy, such as the policing of illicit drug use with sniffer dogs and the policing of

homophobic violence (the conflation of which has had the paradoxical effect of reducing gay visibility and safety in key leisure precincts). And they include the effects of urban entrepreneurialism and gentrification, not only on the vibrancy of queer and youth communities in the city, but also on the increasingly endangered civil rights of sex-workers, people who use beats, injecting drug users, the homeless and the derelict. I argue that these interventions and forces are having the (intended? unintended?) effect of shutting down queer life in Sydney.

Certainly, the promotion of gay villages and gay events like Mardi Gras is very much a feature of a new urban order which aims to maximise revenue from tourism and global investment. But these recent (and affiliated) attempts to purge city space of its 'less desirable' elements are having a damaging effect on queer life, public health, and social justice. Not only do these interventions fail to recognize how the elements they target are actually constitutive of the queer character of cities. They are also making it necessary to ask once again—straight-faced, as it were—“Are there any gay spots (left) in Sydney?”



## Addiction and its others: diagnosing dependence and non-dependence

**Helen Keane**

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This paper is about the category of addiction and its constitution as a disorder or disease. The new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is currently in preparation and changes in the nomenclature and diagnostic criteria of addiction have been proposed by some of the leading figures in addiction medicine. The debate about addiction in the DSM-V provides a useful context for an examination of addiction as a medical entity.

The paper explores how addiction is constituted in different contexts, given that its identification relies on the subjective judgment of behaviour and evaluation of feelings and thoughts. It focuses on two elements of the biology of addiction: physiological dependence and neurochemical dysfunction, and the role they play in this enterprise.

I begin by discussing the criteria for substance dependence found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a rendering of the characteristics of addiction which is both succinct and expansive. I contrast this with the model of addiction developed in the field of pain medicine which insists on a distinction between physiological dependence on opiates and addictive disorder. Finally, the paper considers the neuroscientific account of addiction as a chronic relapsing brain disease and the prospects for its incorporation into the DSM-V.

## Drugs, injection and risk 5A

Chair: **Loren Brener**

### Patterns of drug use and sexual risk among a sample of gay, lesbian and bisexual regular methamphetamine users

**Amanda Roxburgh<sup>1</sup> and Angela Matheson<sup>2</sup>**

**Aims:** Convenience samples of urban, community-attached gay, lesbian, bisexual and transgender (GLBT) people indicate relatively high levels of methamphetamine use among this group, compared to population-based samples from the general Australian community. However, there is currently limited data available on prevalence of drug dependence among sexually diverse populations. Previous research in other populations has demonstrated that problematic patterns of drug use and dependence are associated with sex and injecting risk behaviours. This paper examines sexual and injecting risk behaviours among frequent and/or dependent methamphetamine users among a Sydney-based gay, lesbian and bisexual sample.

**Method:** Approximately 100 regular methamphetamine users (defined by use weekly or more often in the past 3 months) who identified as gay, lesbian or bisexual, were interviewed face to face. Past 6 month drug use and injecting drug use were assessed, as well as cannabis, methamphetamine and alcohol dependence. A number of questions were asked about sexual behaviour, including whether participants used drugs for the purpose of having sex.

**Results:** Findings from the study will be available for release in early 2010. We intend to present key findings regarding study participants' demographic profile, patterns of drug use, levels of drug dependence and any correlated sexual and injecting risk behaviours.

**Conclusions:** The findings of this study will have implications for how health professionals can target sexual health and drug use harm reduction strategies that are appropriate for sexually diverse people who use methamphetamine. Early intervention may be a key strategy for reducing various risk behaviours among frequent and dependent methamphetamine users.

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### Sharing of injecting equipment and the perception of HCV risk among injecting drug users who obtain injecting equipment from pharmacies in Western Australia

**Hannah Wilson and Joanne Bryant**

Previous studies in Western Australia have found that 27.7% of IDU pharmacy clients used a needle after someone else in the past month, compared to 15.9% of respondents who attended an NSP. The goal of our study was to explore the perception of HCV risk and the correlation of risk perception to injecting equipment sharing among IDUs in WA who use pharmacies, using risk-related attitude factors applied in Racz et al. (2007).

In total, 145 valid surveys were collected from 30 metropolitan and non-metropolitan pharmacies in WA. The average duration of injecting was

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12 years. The majority of respondents reported amphetamine as their last drug injected (57.2%) and half reported being tested for hepatitis C in the last 12 months.

Two-fifths (43.4%) of respondents reported sharing injecting equipment (needle and syringes and/or ancillary equipment). However, around 80% strongly agreed that using unsterile needles increases the chances of hepatitis C, while under one-third (28.3%) strongly agreed that they were at risk of getting hepatitis C. In multivariate analysis, sharing injecting equipment was associated with lower self-efficacy for sterile equipment use, being unemployed and female, but was not associated with perceived severity of hepatitis C or susceptibility to hepatitis C, among others. Such findings suggest that for this particular group of IDU, perceptions of HCV risk do not impact their risk practices.

The high levels of injecting risk behaviours suggests that injecting drug users who use pharmacies need to be carefully monitored and targeted in harm reduction and HCV prevention interventions.



## Intimate injectors: towards a systemic awareness of drug injecting practice within intimate relationships

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Clients entering needle and syringe programs (NSP) often encounter workers imparting information on risk management practices, in relation to their injecting drug use. Primary risks include transmission of blood borne viruses, vein management and broader risks, such as, poverty and violence. These workers engage in a range of activities that include support, as well as psycho-education to up-skill clients in many areas of health and mental health management. However, many of these processes work with the individual in isolation. Recent research, into the risk management practices of heterosexual injecting drug users, reveals the majority are initiated by an intimate partner, relative or friend. Moreover, risk management practices may be negotiated through a series of co-existing pressures, like sexual practice and relationship dynamics. Some research presents intimate relationships as a site of increased safety for at-risk populations, while other research reveals that this dynamic plays out less favorably in relation to the transmission of blood borne viruses.

In this paper, findings from in-depth interviews with fifteen injecting drug users in Sydney, Australia, will be presented. Analysis of the data will raise awareness of the relational dynamics inherent to injecting drug use, with emphasis on Systemic Counselling techniques to facilitate and enhance risk management practices and ultimately increase the opportunities for clients to avoid exposure to HIV/AIDS and hep C.



## Needle sharing in regular heterosexual relationships: serodiscordance and the gendered character of injecting

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This paper examines correlates of needle and other equipment sharing among injecting drug users (IDU) in regular heterosexual relationships. A cross-sectional survey collected data from people obtaining sterile needles and syringes from pharmacies in New South Wales, Australia. 181 IDU in regular heterosexual relationships provided information about their own drug and



injecting practices and those of their partners. Compared to female partners, male partners reported more frequent injecting, more commonly injected their partners, scored and prepared the drugs, and obtained the needles. Couples were less likely to share needles with each other if they reported a low-to-moderate connection with drug using networks compared to a moderate-to-high connection (AOR 0.4, 95%CI 0.19-0.95) or if the respondent partner reported sharing injecting equipment (needles and/or ancillary equipment) with friends in the last six months (AOR 3.2, 95%CI 1.34-7.86). Couples were more likely to share ancillary equipment with each other if they spent most or all of their injecting time together (AOR 4.1, 95%CI 1.40-11.31) or if the respondent reported sharing injecting equipment with friends (AOR 5.3, 95%CI 1.73-16.37). Couples with discordant hepatitis C status were no more or less likely than those with concordant status to share needles or ancillary injecting equipment. Injecting practices in regular heterosexual relationships do not appear to be organised around hepatitis C status but are influenced by gender, the couples' connection with other IDU, and extent to which they share equipment with those outside of their relationship.

Proffered papers

## Practices of research 5B

Chair: **Peter Hull**

### Capacity building with front-line health workers in qualitative research: impact in a sensitive area

**Rebecca Gray<sup>1</sup>, Gary Gahan<sup>2</sup> (presenter), Loren Brener<sup>1</sup> and Carla Treloar<sup>1</sup>**

A particular area of concern with regard to the transmission of hepatitis C is the practice of injecting performed within sexual or intimate relationships. Australian surveillance data shows that rates of sharing equipment amongst sexual partners is high. However, there is limited research about the understandings of how risk practices are negotiated by couples with respect to trust and intimacy. The HIV/AIDS & Related Programs Unit of South Eastern Sydney and Illawarra Area Health Service agreed to fund a pilot study of interviews with up to 15 people who inject drugs. A stipulation was that the project includes a capacity-building component for the staff of the area health service needle and syringe programs (NSPs).

The National Centre in HIV Social Research (NCHSR) had previously conducted research which utilised NSPs to recruit participants for qualitative and quantitative studies. Our interaction with the staff had been formal and focused on the processes of recruitment. However, research teams do not generally engage with services at the outset of a project. The plan for the capacity building arm included providing background literature about the topic under investigation and a training component in qualitative methodology so that staff could understand the research process and through this mechanism become more engaged in the research.

This paper reports on the response of NSP workers to the capacity building workshops and the impact of this on the research process. The paper also outlines the very valuable contribution of up-skilling and engaging Needle & syringe Program staff in research and acknowledges the contribution that staff can make to ensuring that research is adequately conceptualised and outcomes are linked to practical interventions.

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## Off road: undertaking the Gay Community Periodic Survey in regional New South Wales

**Dermot Ryan<sup>1</sup>, Ian Down<sup>1</sup>, Martin Holt<sup>2</sup>, Iryna Zablotska<sup>3</sup> and Garrett Prestage<sup>3</sup>**

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The Gay Community Periodic Survey (GCPS) has been conducted in Sydney biannually since 1996. In 2009, it was decided to conduct the survey in regional towns throughout NSW to gain a better understanding of the needs of rural gay men. The GCPS is funded by NSW Health and conducted jointly by the National Centre in HIV Social Research and the National Centre in HIV Epidemiology and Clinical Research in collaboration with ACON and Positive Life NSW.

The survey is a cross sectional survey of gay and homosexually active men recruited through a range of gay community events and sites. It provides a snapshot of sexual practice, HIV risk behaviours and patterns of drug use of participants. It provides important information about the behaviours that may lead to HIV transmission and the groups which may engage in high these risk behaviours. The survey has been instrumental in providing an evidence base for the development of education campaigns designed to prevent HIV infection.

This paper will outline the process undertaken to conduct the study in regional and rural areas. It will explore and describe how the sample population group was accessed in different rural areas, what the coordination and resource implications are for conducting such a rural study of this nature, as well as examine some of the recruitment challenges that were encountered which are not usually experienced when doing research of this nature in metropolitan settings. This paper will not report on the results of the survey.

This paper will also examine the benefits of conducting community driven research in regional and rural towns and make recommendations for future research initiatives in rural areas.

## Pilot study of respondent driven sampling among gay men in Sydney: lessons learned

**Iryna Zablotska and Ian Down**

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**Introduction:** Traditional behavioural studies see individuals as independent of each other, even though they are not independent of the environment they live in. If studies were to take the latter into account, they would need to use methods that allow tracking connections between individuals. Respondent driven sampling (RDS) was developed to address this issue as well as recruit hidden populations and study the role of networks in infectious disease spread. This pilot study tested the application of RDS among gay men in Australia.

**Methods:** The study was conducted in Sydney from November 2008 to July 2009. We enrolled initial recruits ('seeds') who were allowed to refer up to three peers by handing out coupons with unique serial numbers. Successive waves of recruitment continued until the sample of 100 men was recruited. A system of incentives was applied to reimburse both participation in the study and successful recruitment of referred peers. The brief self-administered survey was conducted using handheld computers with audio support.

**Results:** Ten seeds launched recruitment chains and the recruitment of a desired sample was successfully reached. Sliding schedule was used so

that four seeds started the study and new seeds were added as the referral chains stopped. The longest chain included seven recruitment waves and enrolled 30 men. The total active recruitment time was about 5 months. We review the effectiveness of recruitment over time, usefulness of incentives and lessons learned from the pilot recruitment. The effective application of RDS among Australian gay men depends on the selection of seeds and the recruitment management process.

**Conclusion:** RDS has been effectively used among homosexual men worldwide. Its pilot application in the Sydney gay community has also proved to be successful. The lessons learnt from this pilot study will be used in a larger study of norms and behaviours in gay communities in Sydney, Melbourne and Perth.

Proffered papers

## Queer(y)ing sex and drugs 5C

Chair: Kane Race

### Responsibility, risk and negotiation in the discourse of gay men's group sex

David McInnes<sup>1</sup>, Jack Bradley<sup>2</sup> and Garrett Prestage<sup>2,3</sup>

Responsibility for the practice of (un)safe sex, for taking or not taking risks in relation to HIV transmission and for the negotiation of (safe) sex have been concerns in HIV prevention-oriented research for a sustained period (Flowers et al., 2000; Davis, 2002; Offer, 2007; Adam, 2007; Keogh, 2008). There is, to date, little in-depth analysis of the way in which understandings of responsibility might weave through men's understandings of related aspects of their sexual activity such as processes of negotiation and erotics. This paper seeks to address this gap in the research by presenting a discourse analysis of interview texts from the Three or More Study (TOMS). This paper aims to provide a description of responsibility and negotiation as they operate within and as part of the discourse of gay men's group sex. The intended outcome of such a description is an in-depth account of how the discourse shapes responsibility as connected to risk taking and as integrated with the processes of negotiation about sex and sexual practices in group sex contexts, including the negotiation of unprotected anal intercourse (UAI).

In conclusion, the paper considers what, in the discourse examined, constrains and enables 'response-ability'—the capacity to respond to others and one's self in light of the complex contingencies that operate to enliven sexual contexts. Different axes of responsibility are manifest in the way men talk about sex and risk. These axes of responsibility are not reducible to the actions of a single person nor are they easily seen as the result of specific or singular forms of negotiation or action. We identify three key findings from the discourse analysis: that there is an absence of 'explicit' (verbally communicated) negotiation and the presence of action-perception links which are understood as forms of negotiation; that some sexual contexts appear to involve the passivity of participants to the sexual event, interaction or to other men but that there is agency in and as part of this passivity; and, that there exists a social obligation to being individually responsible for sexual decision making, including the taking of risks.

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## The balance of risk and reward

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**Background:** As gay men's beliefs about HIV and the prospects of HIV transmission change, so too does the role of pleasure and desire in their risk calculations. Do they have the tools they need to make good decisions?

**Methods:** 190 recently diagnosed men were enrolled into the HIV Seroconversion Study, and 21 men were interviewed in-depth about their attitudes and beliefs concerning risk and the pursuit of pleasure.

**Results:** Many men engaged in unprotected anal intercourse (UAI) with partners they perceived to be special or trustworthy: Men they had some familiarity with (boyfriends—13%, fuckbuddies—16%, or prior acquaintances—47%); or men who offered an exceptional experience or unusually good sex.

**Participant:** "...magical times ... a lot of times we were not using condoms... And I would fuck him, and he would fuck me... You know, hours and hours ... it was a very unique thing. An intimate thing... For me it was. Spending time with him and shutting the world out."

**Conclusion:** When negotiating sexual encounters, gay men take into account many factors. The potential risk of HIV transmission is one consideration but for each individual encounter this is balanced by considerations of pleasure, intimacy, desire and trust. Often these considerations take precedence, potentially leaving them exposed to additional risk. HIV prevention activities usually focus heavily on condom use, but often gay men make decisions about reducing their risk situationally and this may not include condoms. Tools to assist with decision making in specific circumstances are required.

## Hep C transmission prevention and knowledge among gay, lesbian and bisexual regular methamphetamine users

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**Aims:** Gay, lesbian, bisexual and transgender (GLBT) populations have a range of specific needs in relation to hepatitis C transmission and access to mainstream drug and alcohol and health services. Anecdotal evidence suggests that people in Sydney's GLBT community may have limited knowledge about hepatitis C transmission risks compared to their knowledge about HIV transmission risks. This paper investigates knowledge about hepatitis C transmission risk among regular methamphetamine users in an urban sample of gay, lesbian and bisexual people, followed by discussion of the implications for ACON's work providing BBV prevention education for people who use drugs in this community.

**Method:** ACON partnered with the National Drug and Alcohol Research Centre to interview approximately 100 regular methamphetamine users (weekly or more frequent use in the past three months) who identified as gay, lesbian or bisexual. Past six month drug use and injecting drug use were assessed, as well as cannabis, methamphetamine and alcohol dependence. A number of questions were asked to assess participants' knowledge about hepatitis C transmission risks.

**Results:** Study results regarding injecting risk practices and hepatitis C transmission knowledge levels will be available for release in early 2010. We expect to find variable levels of hepatitis C knowledge among the sample.

**Conclusions:** Strategies currently employed by ACON currently to provide information and support to populations who are at risk of hepatitis C transmission will be discussed. Ways of further targeting harm reduction and engagement strategies to meet the needs of the GLBT community will also be discussed in the context of these findings.

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## Young men and women's experiences with the lesbian/gay/queer scene in Sydney

**Toby Lea**

In recent years, there have been considerable changes in the way that same-sex attracted people perceive, experience and define their sexual identity. Concealment of non-heterosexual identity and significant anguish about coming out are experienced among increasingly fewer people. It is possible, however, that this phenomenon is more pronounced among the urban, white, middle-class, and especially among young people. It has been argued that these changes, along with other social and structural factors, have signalled a decline in the significance of gay community and the bars, clubs and parties that have traditionally comprised the commercial lesbian/gay/queer scene.

Research conducted in Australia and internationally has consistently demonstrated that alcohol and other drug (AOD) use is more prevalent among same-sex attracted people than in the wider population. Explanations for this have included experiences of homophobia and discrimination, higher prevalence of mental health problems, and sociality centred around the bars and nightclubs of the lesbian/gay/queer 'scene'. Much of this research has been conducted with gay or bisexual men, with a substantial focus on the relationship between AOD use and HIV sexual risk. Women, for the most part, have been ignored.

The current study aimed to explore the relationships between sexual identity, the lesbian/gay/queer scene, and AOD use among same-sex attracted young people in Sydney. This paper will present data from in-depth, face-to-face interviews conducted with 20 same-sex attracted men and women aged between 18 and 25 years. The interviews examined the changing meanings of sexual identity, experiences with the scene, and the context and meaning of AOD use. The results of this study will inform health interventions targeted for same-sex attracted young people who may be difficult to engage and target with health interventions related to AOD use, sexual health, and women's health in part due to growing diversity and fragmentation of the lesbian/gay/queer community.

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Proffered papers

## Reinvigorating prevention 5D

Chair: **Jeanne Ellard**

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## The less it's seen, the better it works: novel approaches to health promotion

**Althea Mackenzie and Kay Bazley**

In recent years there have been a number of innovative health promotion projects that borrow from the community arts and community development disciplines rather than relying on traditional methods of information dissemination via brochures and media campaigns.

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This presentation will explore the importance of creativity, fun, social and cultural meaning and their potential to add context and power to health promotion messages.

While health promotion messages may hold deep meaning for practitioners, they may be less meaningful for communities than cultural, social and sporting events. These often promote genuine community participation and provide fun, belonging and a sense of community.

Health promotion messages that are contextualised within such events have greater social currency and therefore hold more powerful meaning and relevance for people. From a practitioner viewpoint, embedding health promotion messages in this way renders them almost invisible, yet paradoxically it can achieve far greater results.

This presentation will examine a number of these projects to ascertain the key common factors in their success as well as some of the constraints that need to be fielded, such as funding and policy environments and availability of resources. It will pose some challenging and inspiring questions to encourage health promotion practitioners to consider innovative approaches to improving the health of their target communities.



## One size does not fit all anymore

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HIV and STIs prevention programs are facing new challenges: HIV not being seen as a death-sentence penalty any longer, lack of interest for STIs, safe sex fatigued audience, new gay media landscape, lower participation in traditional community infrastructure, new forms of gay sociability and sexuality via internet, sub-gay populations and sub-sex cultures where HIV and STIs have very different meanings and implications. At the same time and within limited budgets, those programs have to stand out of the more than 3,000 messages per day sent by marketers, advertisers, educators.

How can we be heard? How can we be listened to? To make HIV and STI prevention programs relevant and sound, we have no other choice but to talk to the right person with the right message. One campaign or program model does not fit all gay men anymore.

This presentation will explore how to redefine the traditional health promotion mix to better target, reach and engage with totally different gay audiences. We will look in particular at:

How to talk to highly sexually active and adventurous men (e.g. sex pigs) or what approach, language, imagery work best with them

How to be part of the Gen Y's digital world or how message placement strategies can be highly relevant in health promotion programs

How to reach as many gay men as possible way beyond Oxford Street, in particular those who are less community-attached or how piggybacking on corporate brands' marketing power may be an effective option to explore.



## We're not beyond the basics: getting the balance right from HIV to syphilis and condoms

**Rob Sutherland (presenter: Ben Tart)**

HIV education and prevention approaches have constantly been evolving to respond to the changing nature of HIV, influenced by emerging biomedical research on transmission risk through to deeper insights into sexual behaviour and concepts of risk and pleasure. A range of current behavioural research supports the general high sexual health literacy levels of gay men while concurrently identifying significant knowledge gaps in relation to HIV, other STIs including syphilis through to testing and treatment.

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This session will highlight a number of case studies including a recent condom reinforcement campaign, a qualitative evaluation of a young gay men's project and a partnership approach to developing resources for culturally and linguistically diverse gay men, to demonstrate that there is still a need to provide interventions that serve the basic information needs of a range of gay men. There is today significant attention on increasingly sophisticated and complex communication around issues of risk reduction. Maintaining and updating the basic knowledge of gay men through new and innovative programs that acknowledge the changing nature of gay community and the way that gay men seek information is of key importance.

It is only through an invigorated approach to addressing basic knowledge gaps that we will ensure a culture of safe sex practice is maintained alongside high level of sexual health literacy. It also helps ensure that gay men can effectively negotiate sexual decision making and manage their sexual and broader health throughout their lives.



## Enlightened self-interest or 'cultures of care'?

**Garrett Prestage<sup>1,2</sup>**

Australia's response to HIV was originally framed by an appeal to collective spirit: protect our community, support those in our community, defend our rights as a community. Recently, especially during the Howard years, we have appealed more to self-interest: protect yourself, take care of yourself and your partner, demand your rights. But in this version of prevention there is little evidence that gay men are significantly more concerned about their sexual health, or that this focus on individuals has resonated with those at greatest risk. The expectation that individuals seek to protect themselves is well-founded and obvious. However, context is critical. Norms and expectations need to be addressed, and sometimes challenged, to facilitate individuals' capacity to make self-interested behavioural change. Whether these are community norms, or values and beliefs within particular social and sexual networks, or transitional expectations in particular circumstances, an appeal to self-interest alone appears likely to have only limited short-term effect. Fundamental shifts in behaviour need to be grounded in changes in attitude and belief.

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While the concept of 'gay community' is contested, it has nonetheless been a useful touchstone for appeals to altruism. Whether it be protection of the community, particular subcultures, or specific sexual and social networks, gay men have repeatedly been willing to respond collectively in ways that invoke shared systems of mutual care. If we want to move beyond the current 'stability' in rates of new HIV infection, we need to be willing to challenge established values and beliefs, including our own.

## 6A Advancing health and research with indigenous communities

Chair: **Clair Jackson**

### Issues for Aboriginal and Torres Strait Islander people living with HIV: a social justice perspective

**Meggan Grose and Michael Blakeney-Campbell (co-presenters)**

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**Rationale/Background:** The HIV diagnosis rate in the Aboriginal and Torres Strait Islander population is equivalent to that in the non-indigenous population but the demographics are different and continue to diverge from the mainstream. There are more women, more heterosexual men and six times more sero-conversions through injecting drug use. There is a greater burden of morbidity for Aboriginal people and Torres Strait Islanders living with HIV, consistent with poorer general health outcomes. Anecdotally there is a higher rate of treatment resistance and it is unclear whether this is due to inconsistent compliance due to social issues or whether there are other influencing factors.

**Project:** Our exploration of knowledge and practice is based on community discussions that took place at ACON's November 2009 Aboriginal and Torres Strait Islander HIV Health Retreat and participant evaluations completed. The retreat was developed by and for the target population to be culturally appropriate, creating a safe space for disclosure, sharing and cultural expression. Special effort was made to recruit and support the attendance of people from regional areas and those not connected to HIV services via the NSW Aboriginal Sexual Health Worker Network, consisting of workers in Aboriginal communities across the state.

**Expected Outcome:** The issues discussed have implications for ongoing HIV prevention, treatment and support for this priority population. Of particular concern is the ability of Aboriginal and Torres Strait Islander people with HIV to be peer educators and advocates in their own communities, which can only be possible through enhanced support for them to do this work.

### A secondary analysis of Pharmacy Needle and Syringe Survey data to describe injecting drug use among Aboriginal people in New South Wales

**Monique McEwan**

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This presentation will describe an internship funded by the Consortium for Social and Policy Research on HIV, Hepatitis C and related Diseases (Consortium) offered to the Aboriginal Health & Medical Research Council of NSW (AH&MRC) to work on data analysis project with the National Centre in HIV Social Research (NCHSR).

The AH&MRC is the peak organisation for Aboriginal Community Controlled Health Services in NSW. The role of the AH&MRC is to support Aboriginal Community Controlled Health Services and to represent the sector at a state level.



Over the last few years, injecting drug use among Aboriginal communities has been identified as an issue of growing concern for community members, services providers and policy makers. There is, however, limited research on the services that Aboriginal people who inject drugs access. In 200X, NCHSR collected data through the Pharmacy Needle and Syringe Survey. This data included a larger than expected cohort of people identifying as Aboriginal.

NCHSR approached the AH&MRC to assist in exploring this data to contribute to the body of knowledge of Aboriginal people's access to NSPs, as well as to inform policy and program development. An internship was offered to the AH&MRC Harm Minimisation Project Officer to assist with the development of an ethics application, analysis of the data, and writing up publications. The internship is for a 6 week period which can be broken into blocks over 12 months. The student works closely with a tutor, supervisor and work space NCHSR. For this project, an Aboriginal reference group comprised of key Aboriginal people with experience in the harm minimisation sector was also established.

The presentation will describe the development of the project, and where we are up to now. If ethics approval is granted, preliminary findings will also be presented.



## Evolving hepatitis C prevention projects for young Aboriginal people

**Jennifer Daylight and Sallie Cairnduff (presenter)**

This presentation will explore the development of hepatitis C health promotion projects in Aboriginal communities in NSW.

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The Aboriginal Health and Medical Research Council of NSW (AH&MRC) is the peak Aboriginal health organisation in NSW.

In recent years, there has been increasing awareness of the impact of hepatitis C on Aboriginal communities. Though data is limited in NSW, other states and territories report that hepatitis C rates are up to twice that compared to the non-Aboriginal population. Strategies to improve hepatitis C prevention, treatment and support programs in Aboriginal communities has been a focus of the AH&MRC over the last 6 years, and includes the employment of a Hepatitis C Workforce Development Project Officer, the development of a number of state wide resources, and working in partnership with key non-government agencies, training providers, research organization and funding bodies. The AH&MRC also works closely with the Aboriginal Sexual Health Worker Network, a key hepatitis C workforce in Aboriginal communities in NSW.

This presentation will explore the increasing incorporation of state-wide hepatitis C health promotion initiatives aimed at Aboriginal communities in NSW that AH&MRC has been involved in. In particular, we will examine:

- The Deadly Shots photo project – a youth focused prevention project based on the Hepatitis C Council of NSW's Street Shots project.
- The 2008 and 2009 NSW tours of the play Chopped Liver which is written, performed and directed by Aboriginal people from the Ilbjerri Aboriginal & Torres Strait Islander Theatre Cooperative and focuses on hepatitis C education.
- The development & distribution of interactive learning tools for workers such as the board game Dr BBV.

## The Aboriginal Cancer Care Project: an evolving partnership process

**Loren Brener<sup>1</sup> (co-presenter), Clair Jackson<sup>1</sup>, Priscilla Johnson<sup>1</sup>, Veronica Saunders<sup>2</sup> (co-presenter), Magdalena Harris<sup>1</sup>, Carla Treloar<sup>1</sup> and Christy Newman<sup>1</sup>**

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Cancer is the second biggest killer of Aboriginal Australians. For some cancers the mortality rate is more than 3 times higher in Aboriginal people and overall it is 60% higher. While differences in stage at diagnosis and the type and duration of care received by Aboriginal people may contribute to the higher mortality, this has not been studied in detail. The Aboriginal Patterns of Cancer Care Study (APOCC) was initiated in 2007 and funded by the NHMRC. This presentation describes the collaborative, organically evolving, process in which the Aboriginal and non-Aboriginal researchers took time to learn from one another and to develop a culturally safe data collection procedure. One of the outcomes of this process was the formalizing of a cultural mentor to oversee the project and to be involved in the data collection, data cleaning and analysis. In-depth interviews are presently being conducted with 30 Aboriginal people with cancer, 20 carers of Aboriginal people with cancer and 20 health care workers who work with Aboriginal people with cancer. Historical trauma arose as a consistently powerful theme within the content of these interviews. This had an intense impact on the Aboriginal researchers involved in the project and led to the official implementation of a cultural mentor to oversee the well being of the interviewees as they travelled to conduct in-depth and often distressing interviews. An outcome of this process has been the development of a culturally-safe and appropriate model for Aboriginal interviewees conducting sensitive qualitative research in Aboriginal communities.

Proffered papers

## 6B Health promotion in hepatitis C

Chair: **Joanne Bryant**

### Hepatitis C and men's health promotion: the where, why and wherefore

**Paul Harvey<sup>1</sup> and Janaki Amin<sup>2</sup>**

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Gender has a significant impact on hepatitis C health promotion. Males are over-represented in hepatitis C prevalence (roughly 2:1). On a pro-rata basis, they are also over-represented in hepatitis C liver failure (2.43:1). In general, Australian men are shown to access GP services at a lower rate than females, and men with hepatitis C in NSW are shown to under-utilise hepatitis C services such as the Hep C Helpline. This pattern of under-access of health care access also reflects that found among Aboriginal men.

We will argue that given the poorer morbidity and mortality outcomes for men with hepatitis C, and the lower rate of access to health care by men, specific consideration should be given to the packaging of hepatitis C health promotion to men in general, and to men within key target groups: people who inject drugs (including 'at-risk' youth, people from CALD backgrounds and people from rural and remote areas), people in custodial settings and Aboriginal people.

We aim to explore these issues drawing from *Causes of death after diagnosis of hepatitis B or hepatitis C infection* (Amin, 2008), *Development of a national men's health policy: an information paper* (Commonwealth 2008), *Review of indigenous male health* (Centre for Indigenous Australian Education and Research 2009) and the work of men's health promotion consultant, Greg Millan.



## One shoe fits all: a train-the-trainer program that aims to empower those living with hepatitis C in South Island New Zealand

**William Jang**

**Background:** After numerous attempts over the last twelve years to train groups of peer educators, including injecting drug users (IDUs) past and present and other non-IDU people with experiential knowledge of living with hepatitis C, it became increasingly evident that retaining trained people who are regarded as peers is difficult, especially when their time is volunteered. People move on from current situations that motivated them to get involved i.e. IDU decide to 'clean-up' and therefore cut association with people who are still using; an educator who has had chronic HCV for many years is cured following treatment and loses interest in being part of the support network or they find paid employment and no longer have the time.

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**Aim:** To train people in the Community who work for agencies who are in daily contact with large numbers of hepatitis C infected people such as Needle Exchange Programmes and Community Alcohol and Drug Service, including opiate substitution programmes; so they are equipped to provide hepatitis C training to their immediate colleagues, allied agencies and key stakeholders and client populations.

**Method:** This presentation will outline the key components of the training programme designed to target hepatitis C infected people who are accessing other community organisation. This approach will set up each of the participant's agencies as 'learning organisations' who will continue to expand and update their understanding of hepatitis C so that their respective client groups can learn more about hepatitis C and become more active in maintaining their own health and wellness.

**Description and Results:** The workshops are held over six two-hour sessions covering the topics:

- The history of hepatitis C in NZ.
- Who needs to know about hep C and why
- Initiating peer education programmes
- Providing pre- and post-test discussions
- Medical: testing, getting a diagnosis and monitoring, self-maintenance and treatment options
- Lifting the stigma, addressing discrimination and protecting the rights of people living with hepatitis C.

The learning of the group is facilitated by mixture of lecture, group discussion and activities and the provision of written resources to supplement information being presented at each session. The first Training group is about to finish and participant evaluation at the end will be used to inform and make necessary changes to future courses to optimise learning.



## Breaking down barriers: an evolving partnership

**Sophie Bannar-Martin**


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People in custody are disproportionately affected by viral hepatitis. In Australia, up to 40% of male and 70% of female prison entrants have been exposed to the hepatitis C virus. Transmission of hepatitis C in custodial settings is facilitated by the absence of harm reduction options for safer injecting, piercing and tattooing, and limited provision of personal items (i.e. toothbrushes, hair clippers and razors).

Securing support and collaboration within the custodial framework is essential in addressing viral hepatitis in prisons. The Hepatitis Council of Queensland (HCQ) has worked diligently to evolve its partnership with Queensland Corrective Services (QCS) and Offender Health. This strengthened relationship, illustrated through HCQ's collaboration on the QCS HIV, Hepatitis C and Sexual Transmissible Infections Strategy 2008-2011, is aimed at developing and implementing projects that can increase awareness in Queensland custodial settings.

The Prison Postcard Project provides inmates postcards highlighting themes including hepatitis C transmission, hepatitis B transmission, self management and treatment. Postcards are reply-paid so inmates can request further information from HCQ. Education workshops and Prisoner Awareness Days are held with partner organisations aimed at increasing knowledge and skills in the areas of hepatitis transmission, self management and treatment for both inmates and custodial staff. In 2009, a new initiative was also launched in all Queensland prisons allowing inmates to call HCQ directly for viral hepatitis information and support.

This collaborative model adopted by HCQ, QCS and Offender Health promotes the health of inmates through providing much needed policy change, education and support. Within this evolving partnership, barriers have been broken, and changes on the inside can continue.



## Hep C—take control: a chronic disease self-management intervention for people with hepatitis C

**Louisa Walsh<sup>1</sup>, Helen McNeill<sup>1</sup>, Richard Osborne<sup>2</sup>, Jenni Livingston<sup>2</sup> and Melanie Hawkins<sup>2</sup>**

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Organised education programs to support people with hepatitis C has been a neglected area. The aims of the project are to design and pilot a chronic disease self management program specifically tailored for the needs of people with hepatitis C; to begin to build an evidence base around self management models that can be utilized by hepatitis organisations across Australia; to build self management education capacity of nursing staff within the participating liver clinics; and to design a self management program that is transferable to other marginalised groups.

Program content was determined through international literature and a series of concept mapping workshops held with people with hepatitis C (N = 14) and workers from this sector (N = 9). A six module program was generated and combines hepatitis C-specific health education and health-related problem solving skills in a supportive group environment. Participants were recruited from three Victorian hospital liver clinics.

A comprehensive evaluation is being undertaken and will inform future directions of chronic disease self-management in hepatitis C. Participant evaluation consists of pre- and post assessment with the Health Education Impact Questionnaire (heiQ) and hepatitis C-specific knowledge. Broader evaluation questions examine the extent to which participants needs were met, impact of chronic disease self management education sessions on health professionals at the participating clinics, and the transferability of the information presented in the course to other hepatitis organisations across Australia.

The project is funded under the Chronic Disease Self-management/ Lifestyle and Risk Modification Grants from the Australian Government Department of Health and Ageing.

Symposium

## HIV-related stigma: experiences and implications for policy and practice **6C**

The experience of HIV has changed dramatically over the past decade or so. Nevertheless, living with HIV continues to pose many and evolving challenges for individuals and communities affected. According to both anecdotal evidence and findings from mostly international research, stigma and discrimination remain major ongoing challenge for individuals living with HIV. This stigma and discrimination may take many different forms and occur in a range of contexts. Directly or indirectly, via individuals' decision to disclose or not disclose their HIV status, HIV related stigma and discrimination in various ways negatively impacts on individuals' mental health, their social relations and sexual relations, their sexual and risk reduction practices, their employment and educational opportunities as well as limits their access to optimal and timely health care.

In view of the significant consequences of HIV-related stigma and discrimination for people living with HIV and their communities, the AFAO/NAPWA Education Team initiated a program to address HIV-related stigma and discrimination. To ensure a strong evidence base for policy and practice the initial phase of this program included a broad suite of research, including reviewing the literature, conducting focus group discussions with people living with HIV, stakeholder interviews and a community survey. This symposium will for the first time bring together presentation of some of the key components of this research program. Four presentations and a discussion are proposed that will in particular address findings and implications emerging from:

- a comprehensive review of the literature
- focus group discussions with gay and other men who have sex with men
- focus group discussions and stakeholder interviews regarding HIV-related stigma and discrimination experienced in non-gay communities
- a community survey of stigma and discrimination experienced by people living with HIV and expressed by people not living with HIV.

Chair:  
**Dean Murphy**

Presenters:  
**Jude Byrne**  
**Daniel Reeders**  
**Simon Donohoe**  
**David Menadue**  
**John de Wit**



## “Why don’t they like us?” General population views on injecting drug users

**Jude Byrne**

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A change in attitude is necessary if the treatment campaigns and other encouragements for drug users to commence hepatitis C treatments are to be successful. While drug users feel discrimination weighing down so heavily on them in all other facets of their lives, they are not knowingly going to expose themselves to more of hostility and negativity on a voluntary basis. The Australian Injecting & Illicit Drug Users League (AIVL) was therefore interested in developing an anti-discrimination campaign among the general community to determine attitudes to injecting drug users and to see if and how these could be influenced.

AIVL embarked on a small targeted tender process to conduct the research, and GFK Blue Moon was the successful candidate. GFK’s Director of Social Research then attended AIVL’s annual national meeting to provide members with an overview of market research and to get input and insights into how drug users felt the general community responded to them and the using community generally. This allowed GFK to form a more detailed understanding of the levels of discrimination, how it most affected drug users and if there were any exceptions. GFK were subsequently in a position to define the target groups for research. It was felt that either end of the general population spectrum should be left alone. At one end we had our supporters and at the other people who were implacable in their dislike for our drug-using community.

GFK came up with a list of sections within the general community that they felt would be amenable to a positive campaign about injecting drug users. Groups subsequently involved in focus testing include: parents of older children, drug users who considered themselves to be non-injectors, and medical professionals.

This paper, in reflecting on the question ‘why don’t they like us?’, discusses the outcomes of the AIVL members/BFK meeting, the selected focus groups and the outcome of those focus group meetings.



## Developing shared language around stigma reduction

**Daniel Reeders**

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This paper will review the literature around strategies for culture-level stigma reduction, following a review undertaken to guide AFAO in developing a campaign for this purpose. Along with a discussion paper, skills workshop and article in HIV Australia, it aimed to encourage the elaboration of a shared language around the reduction of HIV stigma. Using a keyword search of published articles and working knowledge, it found productive contributions toward the conceptualisation of stigma as a social process, and related issues around power/hegemony; a schema differentiating stigma from discrimination; and the effects of personal contact and social learning within a media ecology of prejudice. The presentation will report back on a workshop discussing these issues at the 2009 LGBTI Health Summit in Chicago — including whether social marketing may sometimes amount to ‘applied stigma’, since many of its techniques (in particular, audience segmentation and targeting) may support and call upon the social processes constituting and reinforcing HIV stigma. It will conclude with a reflection on the challenges of integrating social and health promotion theory.



## Formative research for a national HIV stigma and discrimination campaign

**Simon Donohoe<sup>1</sup>, Jenny Duggan<sup>1</sup> and Dean Murphy<sup>1,2</sup>**

**Background:** In recognition of the complexity of the task in of addressing HIV stigma and discrimination, the Australian Federation of AIDS Organisations (AFAO) and its member organisations have undertaken a phased approach to the development of a social marketing campaign. Phase 1 of the project included a series of focus groups and in-depth interviews with gay men and other men who have sex with men (MSM). The aim of the research was to explore HIV-related stigma and discrimination to assist in the development of a social marketing campaign brief.

**Method:** The first round of data collection included 11 discussion groups and four in-depth interviews. The discussion groups were segmented according to age, HIV status and were conducted in metropolitan and regional locations across four states. Each in-depth interview was of approximately 45–50 minutes duration. A subsequent round of research specifically targeting HIV-positive men aged 35 years and younger followed. This consisted of six in-depth interviews, one small discussion, and a paired in-depth interview.

**Results:** Younger HIV-negative men did not raise HIV as an issue at all. Older HIV-negative men were more likely to spontaneously raise the issue of HIV as a current issue, but this was in relation to prevention and disclosure rather than stigma and discrimination. For HIV-positive gay men, stigma and discrimination related to sexual encounters, prevention and disclosure was the single most important issue of concern. Some of these men identified feelings of rejection and helplessness when engaging with other men both online and in face-to-face situations.

There were notable differences in awareness and knowledge of HIV among different groups of men. These differences have a direct impact on attitudes to HIV-related stigma and discrimination. Awareness and knowledge of HIV was directly dependent on age and personal knowledge and experience of someone who was HIV-positive. There was a distinct lack of knowledge about HIV among some younger men in their early 20s, beyond prevention messages of using condoms.

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## Stigma and discrimination towards HIV-positive people in diverse communities in Australia

**David Menadue, Ronald Woods and John Rule**

The National Association of People Living with HIV/AIDS (NAPWA) commissioned Ronald Woods and David Menadue to conduct a series of interviews on the impacts of stigma and discrimination against the following communities of people living with HIV: women, heterosexuals, Aboriginal and Torres Strait Islanders, people from a culturally and linguistically diverse background, and people with haemophilia.

The twenty interviews were conducted in September and October 2009 with people with HIV from these communities and with workers from their community organisations. Woods and Menadue found that while instances of discrimination against people with HIV had decreased, according to the interviewees, HIV-related stigma was a constant in many people's lives. Many people feared the consequences of having

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their HIV status disclosed to such an extent, that they would not tell members of their own family, their community or sometimes even health professionals. This can lead to significant social isolation, low self-esteem and mental health problems, with poor socio-economic and general health consequences.

To quote one interviewee, “In contrast to the situation for gay men, HIV amongst heterosexuals in Australia doesn’t feature as a community experience and ends up being a very individual experience” with the impacts of stigma being highly individualised and unpredictable. A broad-based campaign that sought to turn around current community misconceptions about living with the virus, and encouraged greater acceptance and self-acceptance of being HIV-positive amongst these communities is sought as a part of the solution to address this, as well as initiatives to develop resilience and combat the internalised stigma felt by these people with HIV.



## HIV-related stigma in gay and other men who have sex with men: mostly a matter of a serostatus-based sexual divide

**John de Wit<sup>1</sup>, Dean Murphy<sup>1,2</sup> and Simon Donohoe<sup>2</sup>**

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A substantial body of research has accumulated that documents HIV-related stigma and discrimination. While illustrating the diversity of problematic experiences of people living with HIV, the range of contexts in which these occur and the people involved, the literature is also patchy in terms of the aspects of stigma and discrimination that are assessed and assessments of experiences of people living with HIV are mostly not comparable with those that explore stigmatising attitudes of people who do not live with HIV. Also, not much research on HIV-related stigma and discrimination has been conducted in Australia. To address these gaps we conducted an online survey to explore HIV-related stigma and discrimination in a focused and systematic way and to directly compare experiences of people living with HIV and attitudes of people not living with HIV. In particular, the HIV Stigma Barometer focuses on stigma related attributions, feelings and exclusion. To ensure comparability of experiences of stigmatisation and stigmatising attitudes similar questions were asked of people living with HIV and not living with HIV, accounting for their different perspectives. The survey went live on World AIDS Day 2009, to run for 4 weeks. Respondents were recruited through banner advertisements on a range of websites that linked them to the dedicated survey website. The survey is anonymous and self-completed online; data are securely stored. Within 5 days 415 individuals over 18 years of age living in Australia had completed the survey. The vast majority ( $n=406$ ) were gay or other men who have sex with men and interim analyses were restricted to this sample. HIV positive men generally experienced little stigmatising attributions, feelings and exclusion from people not living with HIV. Experiences of stigma and discrimination were highest in the relationship and sex domains. Similarly, HIV-negative and status-unknown men generally did not hold stigmatising attitudes regarding people living with HIV, with the exception of not wanting to engage in romantic relationships and sex with people living with HIV. This serostatus-based sexual divide in the gay community seems related to a motivation of men not living with HIV to protect themselves from infection. These men hold high expectations of serostatus disclosure of their partners and perceive significantly higher risk of HIV transmission from virtually all sexual practices.



# Biomedicalisation: the interface of research, practice and policy 6D

Chair: **Rebecca Gray**

## Maintaining HIV social research in the era of biomedicalisation: the strategies of social and political researchers

**Martin Holt<sup>1</sup> and Susan Kippax<sup>2</sup>**

HIV research has always been dominated by biomedical research, particularly since the advent of combination antiretroviral therapy. The development of successful treatments generated optimism that technological solutions to HIV might be found. As a consequence of this (re)medicalisation, HIV social and political research has struggled to maintain its salience within the field. This is despite the continued need for i) social and political analysis of the contexts in which HIV transmission occurs, ii) the impact of HIV on communities and societies, iii) the most effective ways to deliver HIV prevention programs and iv) ways to assess the responses of affected communities to HIV interventions, particularly technological developments.

As the push for biomedical interventions for HIV gathers pace, we were asked to assess the state of HIV social and political research for the International AIDS Society. We asked experts to consider the contribution of HIV social and political research, challenges to future work and ways to reinvigorate the field. 50 experts took part. In this presentation we consider how respondents viewed the biomedicalisation of the HIV field, and strategies to respond to biomedical dominance (such as accommodation or resistance). We also highlight some of the challenges identified by participants, such as the need to assess the social consequences of partially efficacious biomedical interventions, the lack of a clear social science framework for implementing structural interventions, and the need to challenge randomised controlled trials as the 'gold standard' of evidence for community- or population level interventions.

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## Standards of care in HIV biomedical prevention trials in the developing world: a comparison

**Bridget Haire and Chris Jordens**

**Introduction:** The ethical conduct of HIV prevention research in the developing world has been hotly contested since 1997 when the use of 'double standards' was denounced in the NEJM. There remains a lack of consensus in the literature about the scope of researchers' obligations to trial participants regarding standards of care in clinical trials. This is reflected in a range of international research guidelines that vary significantly as to requirements for ethical conduct, particularly benefits offered to participants. While many such guidelines have lessened the benefits required for participants, this has not necessarily been reflected in practice.

**Methods:** Search register of clinical trials on HIV-biomedical prevention efficacy trials of horizontal transmission conducted from 1997–2009 and compare standards of care, and supplement register information with publications of results, grey literature and literature detailing SoC provisions.

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**Results:** Twenty-four trials were identified searching the clinical trial database [clinicaltrials.gov](http://clinicaltrials.gov). Excluding PMTC studies, nine different biomedical prevention strategies were investigated. All studies provided risk reduction counselling as standard of care in control arms. Free access to male and female condoms, STI testing and contraception varied considerably according to reports on [clinicaltrials.gov](http://clinicaltrials.gov). Only 11 trials stated provisions regarding access to ART for seroconverters. Neither trial targeting injecting drug users (IDUs) provided access to clean injecting equipment. Cross referencing with peer-reviewed publications and grey literature on these trials showed a greater range of benefits, excepting trials targeting IDUs.

**Conclusions:** Reporting on standard of care varied widely across trials. Injecting drug users received the lowest standard of care.



## Attitudes towards biomedical HIV prevention technologies among a cohort of HIV-negative gay men in Sydney, Australia

Mary Poynten<sup>1</sup>, Jeff Jin<sup>1</sup>, Garrett Prestage<sup>1</sup>, John Kaldor<sup>1</sup>, John Imrie<sup>2</sup>, Andrew Grulich<sup>1</sup>

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**Aims:** A number of partially effective biomedical HIV prevention technologies, including pre-exposure prophylaxis (PrEP) and rectal microbicides will potentially be available in the near future. It is important to explore 1) awareness and attitudes towards these technologies among communities who may use them, prior to their widespread promotion, and 2) willingness to participate in HIV prevention trials. Such information on effectiveness and acceptability may provide guidance for policy makers, health-care providers and educators.

**Methods:** In a community-based cohort study, HIV-negative gay men in Sydney were questioned about rectal microbicides, PrEP use, and willingness to participate in prevention trials. Predictors of awareness and participation were analysed by logistic regression. Use of PrEP was examined prospectively.

**Results:** Only 14% had heard of rectal microbicides. Older ( $p = 0.05$ ) and university educated men ( $p = 0.001$ ) were more likely to have knowledge of rectal microbicides. Almost a quarter (24%) of men were likely to participate in rectal microbicide trials. Willingness to participate in trials using antiretroviral drugs (ARVs) to prevent HIV infection was reported by 43% of men. There was no evidence of PrEP use.

**Conclusions:** This cohort of Australian gay men had little experience with PrEP use and rectal microbicides. Other risk reduction strategies have been increasingly adopted as alternatives to condom use, thus it appears likely that there will be uptake of these new strategies. It is crucial that potential users are provided with information to make informed choices. These results indicate that extensive community consultation and education is required if such products were to be trialled in Australia.



## A love-hate relationship: the impact of differing attitudes towards condoms for gay men in Australia

Pol McCann<sup>1</sup> and Garrett Prestage<sup>1,2</sup>

**Background:** Condoms continue to be the key component of safe sex for most gay men, but how important is this when they are having sex.

**Methods:** 2306 men completed the Pleasure and Sexual Health (PASH) online survey.

**Results:** When asked about the reasons why they used condoms for their last episode of protected anal intercourse, men who had used condoms cited reasons such as having the worry removed from sex (92.7%) and that condoms were not a problem (61.3%). When men were asked about their last unprotected anal intercourse (UAIC), 78.9% of men who had not used condoms said they prefer sex without condoms. In the qualitative answers, the main response was that using condoms is simply taken for granted. Those who did not use condoms frequently cited being in 'the heat of the moment' as well as reasons why condoms make sex less enjoyable – irritation, erection problems, the desire for intimacy.

**Conclusion:** Men who used or did not use condoms had very different attitudes towards them. While most men who use condoms report little difficulty with them, and that they derived a sense of security from them, some men expressed strong dislike of them. Condoms make sex particularly difficult or unfulfilling for a significant minority of men. Condoms are unlikely to be made appealing to these men so they require other information about how and under what circumstances they might consider UAIC so they can reduce their degree of risk.

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## 7A Peer education and self-determination

Chair: **Jake Rance**

### How social networks of people who inject drugs influence hepatitis C discussions in New South Wales

**Jamee Newland**

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In Australia, peer education is a commonly used harm reduction strategy for the prevention of blood-borne viruses such as hepatitis C in people who inject drugs (PWID). It aims to improve the health and wellbeing of people who use drugs by minimising the adverse health, social and economic consequences associated with drug use.

The paper presents the findings from the study. The study aim was to understand how informal exchanges in PWID social networks impact on hepatitis C harm reduction. Using a qualitative methodology grounded in social and network theory, 38 in-depth interviews were conducted with PWID in four New South Wales sites, including Sydney City, Liverpool, Lismore and Newcastle. Social network mapping was used to document the composition and relationships of the social networks and informal discussions documented the informal, day-to-day informal discussions and exchanges that occurred with respect to social network relationships, injecting drug use, hepatitis C and health.

The results from the study highlighted that PWID social networks are an effective way to transfer harm reduction messages and health information to PWID who may not otherwise come into contact with health services, especially young people and people from CALD backgrounds. However, irrespective of network connection factors, such as trust and obligation, PWID social networks were somewhat ineffective for hepatitis C information transfer. In the majority of cases this was because hepatitis C discussions were completely absent from informal discussion. This absence of discussion was explained by the real, or perceived, consequences of stigma, prejudice or social and economic exclusion that resulted from initiating discussions about hepatitis C in people's social networks.

Until PWID are empowered to initiate hepatitis C discussions, hepatitis C will continue to be the 'silent' epidemic.

### Idealism and realism in equality driven community development: reflections on the theory and practice of peer education with drug users—a project worker's perspective


**Jeffrey Wegener**

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There is a body of work in the social sciences that describes many of the organisation features of modern capitalist societies, including those associated with social welfare as sophisticated social control. At the same time, peer education practices can be linked to a tradition of popular

education within which information exchanges can hopefully avoid hierarchical power exchanges. This is a more emancipatist view. Drug users seldom feature comfortably in many political or similar discussions. But they are consummately objectified, studied, researched, policed and put on rigid pharmacotherapy programs that normal consumers would shudder to endure. While they are very much the subject and object of much enquiry and associated practices they are often the most marginalised of marginalised and as such have a limited public voice. While some marginalised groups in society have advanced in social equity status in the last several decades drug users are often vilified and in the popular media discussed in terms of moral panic. This paper will attempt to link this background to community development theory and practice. It will address complex questions, such as, 'how can an external agent, even whilst nominally a peer, legitimately guide and successfully facilitate these marginalised communities towards true self-determination?' This will be a frank and provocative discussion about how well idealistic education theory can successfully drive the reality of project work, and will note the difficulties of reconciling this idealism with the constraints around funding and public accountability.



## Authentic and self-determined peer education: creating an evidence base, and challenges for funders and researchers


**Carla Treloar<sup>1</sup>, Jake Rance<sup>1</sup>, Sione Crawford<sup>2</sup>, Suzanne Fraser<sup>3</sup>**

Peer education is one of the foundations of HIV and hepatitis C prevention. However, new qualitative data from Australia shows that discussions about hepatitis C seldom occur spontaneously in peer networks. Hence, an evidence-base is needed for training of peer educators to initiate conversation addressing hepatitis C prevention. The literature gives little direction regarding training for people who inject drugs (PWID) in developing and delivering messages and strategies for peer education. This research project asked PWID to develop peer education messages, trial these and report on their success in a series of three focus groups. Participants' strategies for peer education were profoundly shaped by the varying contexts in which injecting occurs, recognition of the immediate needs of their peers, and concerns about not offending or challenging others' perceived social status. Some participants (particularly male participants) preferred only to influence others' injecting practice using non-verbal strategies, such as strategic placement of equipment or modeling of safe practice. Further, it was important to address participants' immediate needs (such as extreme fatigue resulting from night-based sex work and precarious physical health) to facilitate their engagement in the research process. These results indicate the need for peer education training to be open to heterogeneous personal styles, be grounded in context, sufficiently flexible to address participants' immediate needs, open to issues beyond those directly relating to health and provide ongoing support to peer educators. This may be complicated to achieve in situations where funders and drug user organisations operate in purchaser-provider relationships and where the funder expects formal, structured, uniformly implemented peer education programs. Further, the need for open, flexible, authentic, self-determined and ongoing programs for peer education challenges researchers to generate evidence of the effectiveness of such programs.

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## Peer distribution: a harm reduction practice that is necessary and illegal

**Jamee Newland**

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Peer distribution is the term used for the distribution of sterile injecting equipment. In New South Wales, it is legal to possess sterile injecting equipment although the distribution of this equipment through people who are not employed through primary and secondary needle and syringe programs (NSPs) or pharmacies is an illegal activity.

The aim of this study was to assess the extent of peer distribution in the study sites in an attempt to understand the reasons why people distribute sterile injecting equipment and to document the strengths and weaknesses of this form of distribution. Using a qualitative methodology, 38 in-depth interviews were conducted with people who inject drugs in four New South Wales sites including Sydney City, Liverpool, Lismore and Newcastle.

The results from this study highlighted that every participant in the study had recently participated in peer distribution, or the receiving, of sterile injecting equipment. For a large number of participants, this was a daily activity. In nearly all cases, participants were unaware of the legal implications of peer distribution. In most cases, peer distribution was the result of altruistic motives. However, market mechanisms and issues of reciprocal obligation were also evident in the study. Peer distribution was able to provide important health benefits to the study participants through the provision of otherwise unobtainable equipment at a time when it was required. For young people who do not access NSP or pharmacy services and people who can not access services due to health or legal issues, peer distribution was their only source of sterile injecting equipment.

The implications of these findings highlight an area of peer-delivered harm reduction that could positively impact on the health of people who use drugs. However, peer distribution requires legislative or policy change and innovative and achievable strategies to ensure people who use peer distribution as their primary source of equipment still come into contact with potentially life saving information.



## It's all smoke screens and mirrors: self-determination, representation and identity from the drug user's perspective

**Annie Madden<sup>1</sup>, Nicky Bath<sup>2</sup> and Jude Byrne<sup>1</sup>**

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Much of the success of the response to HIV and AIDS is attributed to the partnership approach that involved and promoted collaboration and engagement with the affected communities.

Today, however it is true to say that the strength of those partnerships has for people who inject been diluted, minimised and restricted.

This panel discussion will track and assess the internationally acclaimed rise of the drug users movement in Australia and the subsequent slow erosion of self-determined representation, self-advocacy, peer controlled community development and peer controlled education.

# Treatment for viral hepatitis 7B

Chair: **Robyn Horwitz**

## More than a liver: the role of the social work practitioner in hepatitis C treatment centres

**Marlize Mouton**

Hepatitis C is a fast growing infectious disease in Australia and is often associated with related psycho-social and mental health problems. The conventional treatment process for hepatitis C is challenging due to a number of reasons. The aim of this study was to explore social workers' contribution to hepatitis C treatment in relation to the treatment experience of patients. The roles that social workers fulfil, their contribution to the multidisciplinary team and towards a culturally competent service, were explored. The broad theoretical frameworks that inform social work practice were considered, especially the biopsychosocial model, the strengths perspective, the critically reflexive approach and communications theory.

This qualitative study used a semi-structured interview method for data collection. Ten social workers in hepatitis C treatment clinics participated in the study. The findings highlight the needs of patients and how social worker participants described helping to address and meet these needs by employing their knowledge, skills and values through their social work roles and interventions in a team context in a multicultural and multifaceted work environment.

In conclusion the findings lead to a number of recommendations to improve social work services in hepatitis C treatment settings. More research was recommended in areas such as motivational techniques, psychiatric support, and effective group work strategies. The need for increased funding for social work positions in the hepatitis C field was also highlighted.

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## What happens when treatment fails? An investigation into the development of better practice models to prepare patients for relapse post HCV therapy

**Christine Janssen**

### **Aims:**

- a) to record and explore the experiences of patients who have relapsed post HCV anti-viral therapy
- b) to illustrate the benefits of pre- and post-test counselling to prepare patients for the possibility of relapse
- c) to develop a practice model that will provide appropriate information and support for patients who relapse post HCV anti-viral therapy.

**Methods:** Research will be conducted using a qualitative approach. Patients who have failed to respond to treatment will be invited to participate in a semi structured interview and to complete a questionnaire. The interviews will be digitally recorded and transcribed verbatim. Information gathered from the questionnaire will be analysed to identify themes and provide the basis for the development of appropriate practice.

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**Arguments:** Anecdotal evidence suggests that patients who have relapsed post HCV anti-viral therapy, experience a sense of failure and exhibit symptoms of anxiety. Numerous studies have reported that pre- and post-test counselling reduces anxiety and facilitates the acceptance of positive HCV diagnosis.

To date there have been no studies into the benefits of pre- and post-test counselling for patients who have relapsed post HCV anti-viral therapy completion.

**Recommendations:** Our study findings will improve patient health outcomes, facilitate the development of a model of care to prepare and support patients prior to and immediately following test results, and also identify strategies that may help patients negotiate ongoing issues resulting from the failure of treatment.



## Interferon-based hepatitis C treatments: contested notions of treatment success

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This paper explores conflicting notions of treatment success between clinicians and people who have been treated for hepatitis C infection. The focus is on reports of health and quality of life following completion of hepatitis C treatments.

Twenty-seven participants were recruited for in-depth semi-structured interviews via the Hepatitis C Council of New South Wales and Hepatitis C Victoria. To be eligible for participation, people had to have completed an interferon-based hepatitis C treatment regimen at least six months prior to the interview. The study comprised approximately equal numbers of men and women, and equal numbers of people who had responded and not responded to treatment.

The notion of treatment ‘success’ was contested by participants; clearing infection did not necessarily translate to feeling well. On the contrary, it could actually mean feeling worse than before treatment. Interview participants reported a variety of persistent physical and psychological after-effects from treatment. Some after-effects were seen to be a continuation of side effects from treatment while for others new symptoms emerged following completion of treatment. Persistent side effects and new health problems were often debilitating and substantially impacted on quality of life.

The findings of this study highlight the need for people with genotype 1 in particular to give careful consideration before deciding to commence the current interferon-based hepatitis C treatment regimens. Clearing hepatitis C infection can come at a high cost for some people.



## The INSURE Project—‘Investigation into necessary support: uncovering real-life examples’

**Nicola Hodge**

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It is well documented that a number of people receiving treatment for hepatitis C will experience side effects. These side effects, and how they affect people, have been the focus of several research projects and consensus is that they cause substantial decline in the quality of life of those on treatment. What is less clear, is how treatment affects the more



practical aspects of individuals lives and what support is available. The INSURE Project was conceived to investigate the barriers experienced by people who are receiving, have received, or are considering treatment for hepatitis C and their ability to access suitable services to assist them overcome these barriers, enhance their quality of life and improve their health outcomes.

This presentation will provide an overview of the INSURE Project including research that reviewed the types and levels of support currently available to people who were on, or considering treatment for hepatitis C, and their support needs. Details on the two services piloted will also be provided: including Hep Call, a peer-based telephone support service, and a home assistance program, which provided practical 'helps' to people living with hepatitis C who had been unable to access support through other agencies.

It is apparent from investigations carried out by INSURE, that the majority of people receiving treatment report experiencing greater difficulties in performing routine, everyday tasks, and support, apart from direct medical services is not readily available. Furthermore, there is a need and desire for a more robust, comprehensive system of non-medical support for people undergoing treatment.



## Patient experiences of adherence to hepatitis B antiviral medications

Suzanne Polis<sup>1,2</sup>, Lisa Maher<sup>1</sup> and Amany Zekry<sup>2</sup>

**Background and aims:** Current estimates suggest that 90,000–160,000 people are living with chronic hepatitis B viral (HBV) infection in Australia. HBV treatments are limited to 3–4 antiviral drugs, either as monotherapy or in combination, and treatment duration is uncertain. Adherence to anti-viral therapy is imperative to prevent hepatic flares, liver decompensation, liver sequelae and possible drug resistance. Anecdotal data suggest poor patient knowledge of adherence and associated health risks may contribute to missed doses and compromised individual health outcomes. However, there are limited data describing HBV treatment adherence or confounding variables. Our study aims to explore treatment adherence, identify factors impacting on adherence and describe patient knowledge of adherence, drug resistance and treatment outcome. This presentation will summarise preliminary results from the first phase.

**Methods:** In-depth semi-structured interviews will be conducted with people living with chronic HBV undergoing anti-viral monotherapy or combination therapy. A proportion of the interviews will be with patients from a culturally and linguistic diverse (CALD) population. Interviews will be digitally recorded and transcribed verbatim. Data will be analysed using the constant comparative method to establish key themes and analytical categories.

**Discussion:** This presentation will describe participant's experience of HBV treatment, with a focus on non-adherence and factors that potentially impact on adherence, including cultural background. In addition, recommendations for future larger studies and development of adherence tools will be discussed.

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## 7C Media and technology in research and health promotion

Chair: **Philippe Adam**

### Determinants of a culturally inclusive website: recommendations on developing a friendly culturally and linguistically diverse website

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The Web is an increasingly important resource in many aspects of life: education, employment, government, commerce, health care, recreation, and more. However, despite its widespread use, access to it remains limited amongst many sections of our community, including people from culturally and linguistically diverse background.

In 2001, the Multicultural HIV/AIDS and Hepatitis C Service (MHAHS) developed a multilingual website to provide HIV/AIDS information in seven languages. Over the years, the website has increased its number of languages and now covers HIV and hepatitis C information in more than 20 languages. In 2008, the MHAHS conducted a usability study to understand its online visitors' perception of the site as well as identify areas for further improvement.

This paper will highlight the process of conducting a more inclusive usability study and presents some of the tangible changes brought to the website by its recommendations. The paper demonstrates how organisations can develop a culturally inclusive website without translating their entire website content into different languages and enable marginalised populations into becoming a more active participant in our multicultural society.

### Young people, heterosex and condom agency

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Recent sexual health campaigns targeting young people in Australia primarily focus on young people's need to use condoms to prevent sexual infection. The promotion of condom use has circulated for many decades yet surveys indicate that condom use remains infrequent in much young heterosex.

This paper aims to show that these messages fail due to their de-materialisation of the condom. Messages ask young people to add condoms to current sex practices as though condoms do not change these practices. Interviews with 12 young people (aged 18-25), conducted in late 2009, reveal participants' multiple and shifting relationships with condoms. Findings suggest that there is no uniform condom practice and that the (non-)use of condoms is negotiated alongside various factors including different partners, different sex acts, and different condom styles.

Actor-network-theory is applied to this data to discuss the condom as not simply an addition to a uniform sex act, but as a device that is

co-constitutive of sex practices. Along with bodies, body parts, spatial arrangements, and other material and technological devices, condoms form part of the assemblage of sex. Young people's narratives of sex highlight the difficulty in isolating the condom (and its promotion) from this assemblage.

Comparatively, I review discourses of young people's condom use found in sexual health websites, highlighting instances where these assemblages and multiplicities of condom use appear. This leads to the recommendation for an alternative approach in which agency is not located solely in condom users, but also in condoms.

## hivstigma.com: an innovative web-based stigma-reduction intervention for gay and bisexual men

**Barry Adam<sup>1,2</sup>, James Murray<sup>3</sup>, Suzanne Ross<sup>4</sup>, Jason Oliver<sup>5</sup> and Stephen Lincoln<sup>5</sup>**

An intervention to address stigmatizing behaviours directed toward HIV+ men and enhance the sexual health of gay and bisexual men was developed through a community-based process involving HIV prevention workers, public health, government, and researchers, and representing a range of ethnocultural, francophone, HIV-positive, and transgender communities. The message, "if you were rejected every time you disclosed, would you?" was intended to bring men to the website, hivstigma.com, to advance a de-stigmatizing ethic of social interaction. The intervention sought to challenge reliance on disclosure as a prevention measure (salient in the Canadian legal context). By diminishing stigma, it also aimed to create greater support for HIV-positive men, make disclosure safer, and encourage HIV testing. Eight bloggers moderated lively debates over six months. There were 20,844 unique visits to the site averaging more than five minutes each; 4,384 visitors returned more than 10 times. 1,942 participants answered a pre-test survey on squirt.org and 1,791, a post-test evaluation. Results showed a statistically significant shift among those aware of the intervention toward agreeing that "gay men with HIV are reluctant to disclose their HIV status to their sexual partners because they do not want to be rejected" and "gay men with HIV face stigma and discrimination within the gay community." Post-test participants were less likely to agree that "if a gay man has HIV there is no excuse for him not to talk about his HIV status before having sex" and "I use terms like 'clean' or 'disease-free' when I cruise for sex on-line."

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## Gay Community Periodic Survey and online survey of gay men (e-male) in Australia: comparison of sexual practices

**Iryna Zablotska<sup>1</sup>, Garrett Prestage<sup>1</sup>, Martin Holt<sup>2</sup>, Patrick Rawston<sup>3</sup>**

**Introduction:** Behavioural surveillance of gay-community-engaged men in Australia has traditionally employed time-location sampling and recruited men in gay community venues, events and sexual health clinics. With the growing Internet use, gay men increasingly communicate with other men online and many choose it as their only way to look for sex partners. Little is known about how Australian gay and other homosexually active men negotiate Internet technologies and whether Internet as a virtual venue affects sexual practices.

**Methods:** We used data from the Gay Community Periodic Surveys (GCPs) conducted in 2006–2007 in six Australian states/territories and

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from the online e-male survey conducted in 2008. GCPSs recruited gay men through gay events, venues and sexual health clinics. E-male was conducted in the same states, but online only. It was concerned about reaching a more diverse group of gay and other homosexually active men. e-male adopted the GCPS questionnaire and expanded it to explore sexual practices with partners met through Internet and offline. We compared the profiles of men recruited by these two surveys and focused on similarities and differences in sexual practices with casual partners.

**Results:** The composition of samples recruited by these two studies differed significantly: GCPS were representative of gay community engaged gay men, while E-male included a higher proportion of men who did not identify as gay and would have not been reached by time-location sampling because they did not attend traditional gay venues. Sexual practices of these men also differed. About 38% of E-male participants reported engaging in some unprotected anal intercourse with casual partners (UAIC) whom they met online and 34% had UAIC with partners met offline. These proportions were higher than among GCPS participants. There were some variations across the states. E-male participants also tended to be better aware of the serostatus of partners met offline than those met online.

**Discussion/Conclusion:** These results suggest that online recruitment was able to reach a more diverse group of gay and other bisexually active men that were not recruited by behavioural surveillance before. Their sexual practices and ability to negotiate safe sex with casual partners is often affected by the role of Internet in finding such partners. These findings not only inform HIV prevention programs, but also indicate that Internet can be used as a medium for HIV education and prevention.



## Gen Y: an urgent need to re-think health promotion strategies

**Yves Calmette**

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Even if the 16 to 24 yo age group (Gen Y) is not the population most at risk of getting HIV, our responsibility is to ensure a culture of safe sex practice within this group.

The social networks (MySpace, Facebook, You Tube...) and more broadly the new media are their key channels to communicate/interact/get health information. This group pays nearly no attention to traditional gay print media or print health resources. To make things even harder, educators don't have a second chance with them: if you don't do it right the first time, they switch off and might not listen to you anymore.

In this session, we will explore 3 different ways of effectively engaging Gen Y within its digital world:

A "messages placement" strategy in the first Australian online gay series. With 8 first episodes released on samesame.com.au and You Tube through October and November 2009, this series attracted more than 80,000 unique users, and received over 36,000 views. Safe sex message placements helped ACON reinforce condom use in a very innovative approach.

A viral game to profile safe sex in a fun and interactive way. This game was the digital part of the ACON new condom reinforcement campaign launched in October 2009 and designed to invigorate safe sex messages. The game was played more than 15,000 times and got international attention.

An interactive web-based resource with iPhone and Facebook elements, based upon online game playing, social networking and music browsing to be launched in Jan 2010.

# Depression, stigma, isolation 7D

Chair: **Martin Holt**

## Gay men's discourses of depression: the medical, the social and the personal

**Henrike Korner<sup>1</sup>, Christy Newman<sup>1</sup>, Limin Mao<sup>2</sup>, Michael Kidd<sup>3</sup>, Deborah Saltman<sup>4</sup>, Susan Kippax<sup>5</sup>**

This paper is an outcome of the collaboration between social researchers, primary care researchers, general practitioners and community partners to investigate the management of depression in gay men in general practice. The project had quantitative and qualitative arms. As part of the qualitative arm, in-depth interviews were conducted with 40 depressed gay men in Sydney and Adelaide, recruited through high HIV case load general practices. This paper reports on gay men's understanding and meaning of the concept 'depression'. Using linguistic analysis, six constructions of depression were identified: (1) depression as a constellation of symptoms; (2) symptoms constructed as experience; (3) depression as agent; (4) depression as mental processes; (5) not meeting social expectations; and (6) engaging with psychiatric discourse: constructing alternative positions. Gay men draw on the biomedical model of depression as low mood and loss of pleasure as well as on constructions of depression in terms of social experience. However, gay men do not position the biomedical model of depression as unproblematic, rather, they align with or reject this discourse according to their own experience. The discourses of depression of the gay men in this sample are inextricably linked to the community activism of gay men and their community organisations in the context of the HIV epidemic, as well as a synergy between gay men and their doctors.

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## 'I definitely wouldn't talk to random doctors like that': the role of the general practitioner in the lives of Australian gay men with depression

**Christy Newman<sup>1</sup>, Susan Kippax<sup>2</sup>, Limin Mao<sup>3</sup>, Deborah Saltman<sup>4</sup>, Michael Kidd<sup>5</sup>**

As the Primary Health Care Project on HIV and Depression has confirmed, the health concerns of gay-identified men include a vulnerability to depression, due in no small part to ongoing marginalisation. However, contrary to much of the international literature, this study also suggests that not only do many Australian gay men—at least in the major cities—have access to a supportive general practice workforce, they also talk openly with their general practitioners (GPs) about sexuality and HIV-related issues.

This paper explores two key themes relating to the perceived role of the GP in the interview accounts of Australian gay men with depression. Forty gay-identified men (recruited from surveys completed at high-HIV-case load general practices in Sydney and Adelaide) took part in semi-structured interviews between February and May 2008. Seventeen men were HIV-positive and ages ranged from 20 to 73 years.

These men articulated three distinct representations of the GP when describing their role in the diagnosis and management of depression: GP as *wise listener*, *shepherd*, and *conduit*. Three additional representations were

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articulated regarding the role of the GP in the broader lives of these gay men: GP as *provider*, *confidant*, and *peer*. This suggests that while these men appreciate the openness of gay-friendly medical practice settings, they place high expectations on their GPs to be more than 'random doctors'. This has the potential to create productive, but also potentially harmful tensions around the many social and political dynamics the GP must negotiate in addition to their clinical responsibilities.

## Shame, stigma and covert moralism: barriers to counselling clients in alcohol and other drug settings

**Rebecca Gray**

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Counsellors who work in alcohol and other drug (AOD) settings often encounter shame in therapeutic interactions. This shame relates to the stigma and sense of failure when acknowledging addiction, where the identity of the client becomes imbued with a sense of defect or monstrosity, as well as, shame inspired by long term intra-psychic processes that emerge from personal and social adversity in relation to significant relationships and cultural phenomena. However, the therapeutic process is wrought with contradictory issues relating to treatment models and relational dynamics.

Qualitative data presented here are drawn from 17 in depth interviews with counsellors and AOD workers based in New South Wales, Australia. The aim of this study is to gain a greater awareness of the dynamics of shame through the perceptions and experiences of frontline workers. This is to build upon current practice and contextualise the extensive clinical literature on shame. Analysis was conceptualised through person centred counselling and included a reflexive research approach informed by grounded theory. Recurring themes suggest that stigma is a significant barrier to recovery, and participants expressed professional tensions when managing the social and moral perspectives of problematic drug use, alongside the alienating and isolating manifestations of shame. In this paper, I will present findings that highlight the potential treatment barriers of stigma and covert moralism when counselling clients in AOD settings. Implications for practice and future research will be discussed.

## CHINWAG: stigma, identity, and 'counterpublic' health promotion

**Kath Albury**

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This paper explores the ways that lived experiences of stigma and identity are embodied by performers and participants in the National Association of People Living with HIV/AIDS/Treataware CHINWAG forums. Billed as 'a chat show all about HIV treatments and Healthy HIV Living', CHINWAG has been performed in various regional and rural sites (as well as some capital cities) for nearly a decade. Like its precursor, 'Vanessa Wagner's Wheel of Misfortune', CHINWAG has been described by Kane Race (2009) as a successful 'counterpublic' health initiative.

Drawing on cultural theorists such as Elspeth Probyn, Michael Warner, and Eve Sedgwick I consider the ways that CHINWAG's hostess, Vanessa Wagner (Tobin Saunders), and her sidekick, Nurse Nancy (Kath Albury), simultaneously embrace and reject stigmatised and potentially shameful

identities for audiences of poz men and women, health care workers and allied service providers.

Can CHINWAG's formula for successful dialogue with (mostly) middle-aged gay, male poz audiences be translated into other spaces and contexts? Do the very elements that make the program successful for these audiences signal 'exclusion' to others, i.e. gay men under 35, or positive heterosexuals? Reflecting on recent research into positive people's experiences of stigma and discrimination, I suggest that some groups of poz people may 'do' shame and stigma quite differently to others. However, while CHINWAG reflects a relation to stigma and identity that may not be shared by all positive people, it offers valuable tools and strategies that can be creatively adapted for various contexts.



## Attitudes towards heavy co-occurring drug/alcohol use and mental illness amongst people with severe mental illness, and their carers

**Grenville Rose**

Both mental illness and substance abuse are associated with stigmatising attitudes and those attitudes are associated with lower help-seeking behaviour. There are a number of psychological attributes that contribute to the formation of stigmatising attitudes and amongst these are perceptions of dangerousness and personal responsibility for illness. While it has been shown that contact with the stigmatised group can reduce stigmatising attitudes it has also been shown that not all types of contact reduce stigma, but that some forms of contact seem to induce stigmatising attitudes and this seems to be particularly so for health professionals. Non-Government mental health NGOs provide a service that is significantly different from those provided by the general public system, and it is arguable that the attitudes of staff and clients of these services are different to those in both the general community, and the public health system. There is, as yet, no publicly available data on attitudes of those who participate in mental health NGO services towards co-occurring mental illness and drug issues. Anonymous self completed questionnaire based data was gathered from people participating in mental health services provided by two Sydney NGOs. At time of writing the data had been collected but not analysed, but it is intended to present baseline data, and insight into; the types of attitudes held by people with mental illness, the attitudes of staff providing services for those people and those of people with co-occurring mental illness and substance use difficulties.

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## 8 Closing plenary

Chair: **John de Wit**

### Evolving knowledge and practice: inter-relationships with policy and the law

Facilitator:

**Professor Michael Kidd**

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In this final session of the conference, attention will turn to the responses at the macro level, including policy and law, to evolving knowledge and practice. This panel of eminent thinkers, practitioners and advocates will engage with these issues from the perspective of their own work and communities, and will also respond to comments and questions from the delegates.

Panel members:

**The Hon Michael Kirby, AC CMG**

Former Justice of the High Court of  
Australia

**Elena Jeffries**

President, Scarlet Alliance—The  
Australian Sex Workers Association,  
Sydney

**Annie Madden**

Australian Injecting & Illicit Drug Users  
League, Canberra

**Annmaree O’Keeffe**

The Lowy Institute for International  
Policy, Sydney

**Mark Saunders**

National Aboriginal Community  
Controlled Health Organisation, Canberra

**Dr Alex Wodak**

Director,  
Alcohol and Drug Service, St Vincent’s  
Hospital, Sydney



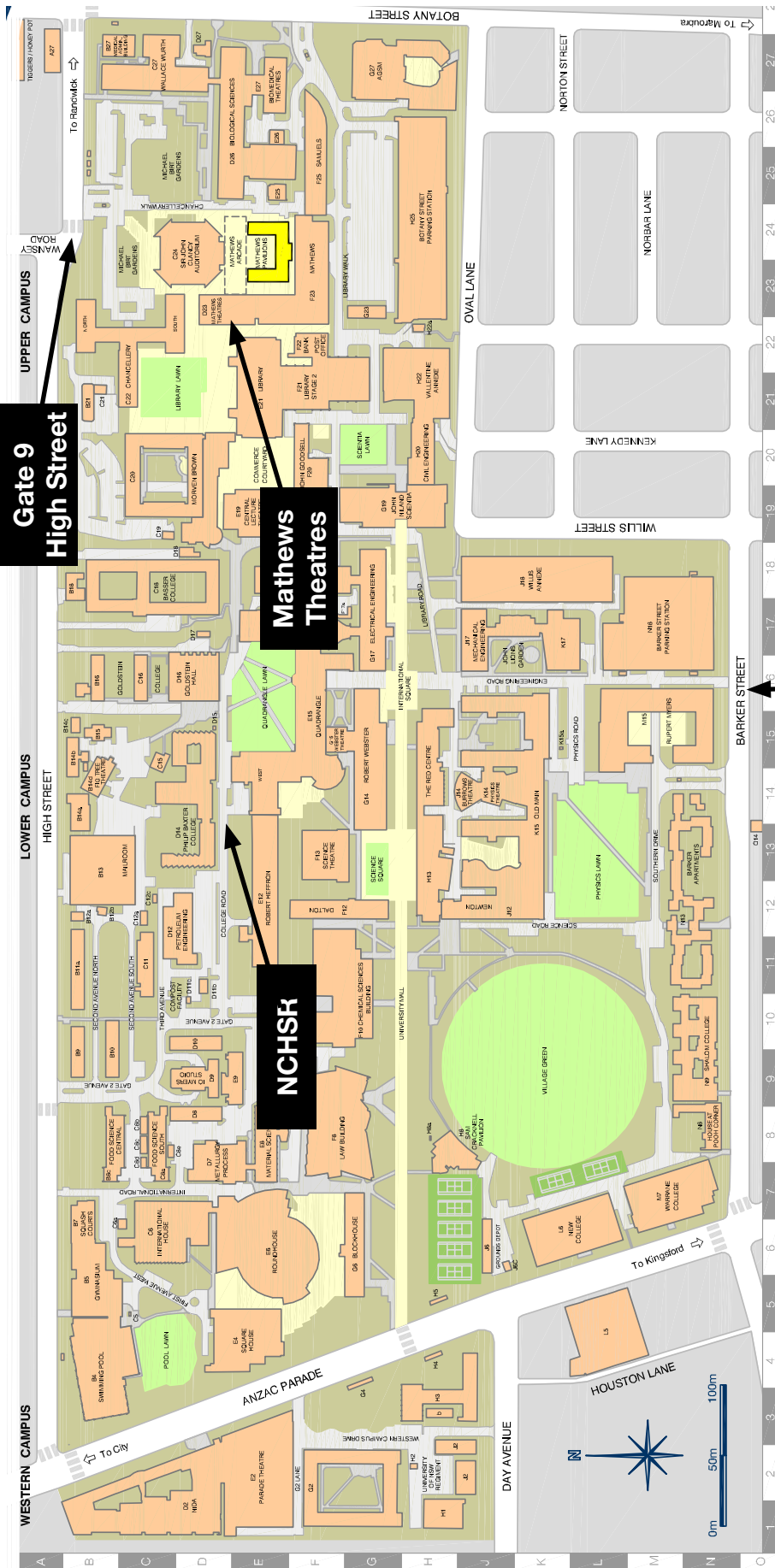
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# Map of UNSW kensington campus



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