PROGRAM AND ABSTRACTS

UNSW
THE UNIVERSITY OF NEW SOUTH WALES

silence&articulation

12th Social Research Conference on HIV, Hepatitis C and Related Diseases

Never Stand Still | Faculty of Arts and Social Sciences | National Centre in HIV Social Research

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

12–13 April 2012

silence&articulation

NCHSR

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Welcome

It is my pleasure to welcome you to the 12th Social Research Conference on HIV, Hepatitis and Related Diseases. This year's conference theme, silence&articulation, draws attention to the different and changing ways in which stigmatised practices and conditions are understood. It emphasises human rights, non-discrimination, respect for difference and informed debate. An important reason for shifts in how and what we talk about with respect to illness, practices and affected communities, is the diversification of stakeholders contributing to the production of knowledge, including representatives of affected communities, political activists, public health advocates, policy makers, and service providers as well as social and behavioural scientists and biomedical researchers.

The outstanding keynote speakers who have agreed to present at the conference illustrate the range of perspectives, as does the exciting panel session. The panel of eminent speakers will in particular debate how silence and articulation operate in communities that are less prominent in discussions about HIV, viral hepatitis and sexually transmissible infections (STIs). The diversity of voices that shape our evolving responses to HIV, viral hepatitis and STIs will also be heard in the many conference sessions. We encourage all delegates to join the speakers and reflect on what is emphasised and what is muted, what is seen as acceptable or unacceptable. What do such silences and articulations achieve and why, and what impact do they have on individuals, relationships, families and communities?

As in previous years, the conference continues to attract a large number of registered delegates with diverse backgrounds, roles, expertise and interests. This once again attests to the important role the conference plays as a platform that facilitates networking and knowledge sharing between social and behavioural science researchers, policy makers, health professionals and community organisations. Increasingly, the conference attracts interest from our colleagues overseas, enabling us to engage in broader discussions and facilitate wider exchange and collaboration.

The 12th Social Research Conference marks an innovation; for the first time we have invited stakeholders to provide sponsorship as a way of maintaining the high quality of the conference at a cost that is affordable for participants. We are very excited about the positive responses we have received and gratefully acknowledge the sponsorship provided by the ACT Health Directorate, ASHM, Gilead, NUAA, the UNSW Bookshop and the UNSW Faculty of Arts and Social Sciences.

I would also like to thank the conference co-chairs and organising committee for all their work in bringing us together around an engaging program. The program is made possible thanks to your participation, presentations and contributions and debate, and I would like to thank you for that.

I hope you will enjoy this stimulating and inspiring conference.

Professor John de Wit
Director

General information

Venue

The 12th 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).

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.

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 392, 394, 396, 397 or 399 bus from Circular Quay or Taylor Square, a 30-minute journey. From Railway Square or Cleveland Street take a 393 or 395 bus.

There are special university buses to the **High Street entrance** of UNSW. From Eddy Avenue, Central Station take a 891 (mornings) and 895 (evenings) from Anzac Parade to Central, a 30-minute journey. Special university buses can also be taken from Sydney city; 890 (mornings) to High Street and 892 (evenings) from Anzac Parade to Sydney city. The 890, 891, 892 and 895 buses are 'pre-pay only'; tickets can be bought at newsagents and from shops displaying the Sydney Transport logo.

From the airport, take bus 400 or 410 to the **High Street entrance** (Gate 9), a 20–30-minute journey; a taxi takes about 20 minutes.

For public transport information, phone 131 500, or go to 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 3 hours) and $2.50 (each hour thereafter). Lower floors of the car park are only available to staff; heavy parking fines apply.

Food and drink

Lunch and morning and afternoon teas are included in the registration fee. They will be served 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 conference 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.

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).

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.

Disabled access

See *venue*.

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.

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.

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 conference registration desk.

Personal mail

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

Photography and filming

No photography or filming of sessions is permitted.

Post office

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

Printing or photocopying

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.

Registration desk

The registration desk will be open from 8.30 am to 5.15 pm on both days.

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 if not already done prior to the conference. 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.

The program at a glance

Thursday 12 April					
8.00–9.00	Registration (foyer of Mathews Theatres)				
9.00–9.15	Welcome to Country **Uncle Les Davison** Conference welcome **John de Wit**				
9.15–10.15	**1** Opening plenary **Jane Ussher**				
10.15–10.45	Morning tea				
10.45–12.15	**2A** Proffered papers **Stigma and BBV** followed by report launch *Stigma and discrimination around HIV and HCV in Healthcare Settings Research Project* (ASHM), launched by Nikki Woolley	**2B** Proffered papers **Consumer representations in drug treatment services**	**2C** Proffered papers **Asian gay men**	**2D** Proffered papers **HIV in international settings**	
12.15–1.15	Lunch and Scarlet Alliance discussion *Join us for hot sex over lunch*				
1.15–3.00	**3A** Proffered papers **HIV prevention in Australia I**	**3B** Proffered papers **Hepatitis C treatment**	**3C** Proffered papers **Sexuality and sexual health**	**3D** Proffered papers **Immigrant and CALD communities and HIV**	
3.00–3.30	Afternoon tea and book launch *Making disease, making citizens: The politics of hepatitis C* (Suzanne Fraser and Kate Seear), to be launched by Carla Treloar				
3.30–4.30	**4** Plenary **John Della Bosca**				

Friday 13 April					
8.00–9.00	Registration (for delegates only attending day 2 of the conference)				
9.00–10.15	**5** Plenary **Alison Ritter** **John Godwin**				
10.15–10.45	Morning tea and DVD launch *C me, hear me: hepatitis C in our own words* (ASHM WDP), launched by Carla Treloar				
10.45–12.30	**6A** Proffered papers **Sex work**	**6B** Proffered papers **Hepatitis C health promotion and prevention**	**6C** Proffered papers **Gay men, HIV, health issues**	**6D** Symposium **Critical reflections on drug treatment policy in Australia and the UK: addiction and recovery**	**6E** Proffered papers (**Re)emerging issues in the gay community**
12.30–1.30	Lunch				
1.30–3.00	**7A** Proffered papers **Heterosexuality, HIV, discordance**	**7B** Proffered papers **Drugs, addiction, harm reduction**	**7C** Proffered papers **HIV prevention in Australia II**	**7D** Symposium **Articulating and enacting biomedical HIV prevention**	
3.00–3.30	Afternoon tea				
3.30–5.00	**8** Closing plenary panel discussion				
5.00–5.15	Closing remarks				
5.30–7.00	Cocktail party				

Breakdown of sessions

Session		First author/ Presenter	Title of presentation
THURSDAY 12 APRIL			
1	**Chair: Susan Kippax**		
9.00–10.15 Mathews Theatre B	9.00	Uncle Les Davison	Welcome to Country
	9.05	John de Wit	Opening and welcome to the conference by the NCHSR Director
	9.15	Jane Ussher	***Opening plenary*** Silencing sex and sexuality
	10.15	Morning tea	
2A	**Chair: Christy Newman**		**Stigma and BBV (Proffered papers)**
10.45–12.15 Mathews Theatre C	10.45	Loren Brener	HIV Stigma in Australia: quantitative results from a study of the effects of stigma on gay men living with HIV
	11.05	Sean Slavin	HIV Stigma in Australia: qualitative results from a study of the effects of stigma on gay men living with HIV
	11.25	Anne Wagner	Conceptualising HIV-related stigma in terms of discrimination, stereotyping and prejudice among health care providers
	11.45	Denton Callander	Stigma and discrimination related to HIV and HCV in healthcare settings in NSW
	12.05	Discussion	
		Report launch	*Stigma and Discrimination around HIV and HCV in Healthcare Settings* Research Project, by ASHM, to be launched by Nikki Woolley.
2B	**Chair: Suzanne Fraser**		**Consumer representations in drug treatment services (Proffered papers)**
10.45–12.15 Mathews Room 102	10.45	David Martin and Simone Cass	Consumer representation in drug and alcohol services in South Eastern Sydney Local Health District (SESLHD): the Challenges and the Changes?
	11.05	Hannah Wilson	Service user participation among non-government drug and alcohol services
	11.25	Carla Treloar	Evaluation of consumer participation demonstration projects in five Australian drug treatment facilities: the impact of individual versus organisational stability in determining project progress
	11.45	Sione Crawford	Innocent fun or guilty pleasure? Depictions of people who use drugs and access treatments by service providers
	12.05	Discussion	
2C	**Chair: Maheswar Satpathy**		**Asian gay men (Proffered papers)**
10.45–12.15 Mathews Room 104	10.45	Shih-Chi Kao	‘I can be a young gay boy in Sydney because I don’t have to look after anything or care about’: being Thai and gay in Sydney
	11.05	Min Fuh Teh	Behind the mask: Asian gay men and HIV prevention
	11.25	Evelyn Lee	Minority among minority? Profile of Asian gay men in Australian Gay Community Periodic Surveys, 2000–2009
	11.45	Discussion	
2D	**Chair: Limin Mao**		**HIV in international settings (Proffered papers)**
10.45–12.15 Mathews Room 107	10.45	Jonathan Stadler	Revealing and concealing: public silences about AIDS in the South African lowveld
	11.05	Edward Reis	Human rights and public health in the international HIV response: issues of contested control
	11.25	Benjamin Bavinton	Identities, practices and understandings of sexuality and gender among men who have sex with men and transgender people in the Fiji Islands
	11.45	Alan Li	Translating research to action: pilot results of anti-stigma training for health providers and people living with HIV/AIDS in Shanghai, China
	12.05	Discussion	
	12.15	Lunch	**Optional symposium by Scarlet Alliance** *Join us for hot sex over lunch*

Symposium

A panel of sex workers will guide discussion over lunch, providing insight into HIV-positive sex work, and migrant, CALD and sex work practice and policy in Australia. If you join us for this lively lunchtime interlude, you will learn more about contemporary issues intermingled with analysis of current policy and its impact on sex workers’ work and sex practices. While evidence doesn’t inform policy on sex work legislation in Australia, policy, laws and policing practices definitely impact on work and sex practices. How do we maintain success in such a changeable policy space?

This is an important time for HIV and STI prevention in Australia as policy changes threaten to shift the context of sex work. Large sectors of the sex work community are likely to be criminalised by the end of 2012. While globally sex workers are advocating for decriminalisation, in NSW it is likely to be reversed.

Session		First author/ Presenter	Title of presentation
3A	**Chair: Dean Murphy**		**HIV prevention in Australia I (Proffered papers)**
1.15–3.00 Mathews Room 102	1.15	Martin Holt	Enacting gay men, risk and HIV prevention knowledge: the looping effects of behavioural surveillance in Australia
	1.35	Michelle McKechnie	Acceptability of risk reduction strategies in gay men's networks in three Australian cities
	1.55	Matthew O'Dwyer	The effect of age difference on condom use in Australian gay men
	2.15	Limin Mao	Perceptions of HIV transmission risk, range of sexual practices and self reported HIV status: how do they align with each other?
	2.35	Michelle McKechnie	Characteristics and structure of networks in Sydney, Melbourne and Perth
	2.55	Discussion	
3B	**Chair: Max Hopwood**		**Hepatitis C treatment (Proffered papers)**
1.15–3.00 Mathews Theatre C	1.15	Suzanne Fraser	Silence and signals: the politics of 'medical progress' on hepatitis C
	1.35	Kate Seear	Centre and periphery: exploring the ethics and politics of treatment for people living with hepatitis C
	1.55	Jake Rance	'There's only win-win-win': stories of hepatitis C treatment and transformative possibility from opiate substitution clinics
	2.15	Robyn Horwitz	Evaluation of an integrated care service for the treatment of hepatitis C in New Zealand
	2.35	Carla Treloar	What's trust got to do with it?: building, maintaining and brokering trust as a key issue for service planning and delivery
	2.55	Discussion	
3C	**Chair: Philippe Adam**		**Sexuality and sexual health (Proffered papers)**
1.15–3.00 Mathews Room 107	1.15	Maheswar Satpathy	Deciphering the anal monologues: why anal sex is so attractive; why anal health is not
	1.35	Judy Wilyman	Human papillomavirus (HPV): are HPV vaccines a safe and effective management strategy for cervical cancer disease in Australia?
	1.55	Philippe Adam	Do young gay men have specific sexual health needs? results from the online survey *How much do you care?*
	2.15	John de Wit	HIV/STI testing as a sexual health routine among gay men in NSW: results from the online survey *How much do you care?*
	2.35	Alischa Ross and Felix Scholz	Facilitating youth empowerment in youth sexual health promotion
	2.55	Discussion	
3D	**Chair: Shih-Chi Kao**		**Immigrant and CALD communities and HIV (Proffered papers)**
1.15–3.00 Mathews Room 104	1.15	Jill Sergeant	HIV and sub-Saharan African communities in Australia: questions unanswered
	1.35	Tadgh McMahon	HIV among CALD communities in Australia: articulating ways to frame the 'problem'
	1.55	Barbara Baird and Anne Bourne	Endangering life
	2.15	Alan Brotherton	Lest we beget: HIV, immigration and national protection
	2.35	Discussion	
	3.00	Afternoon tea **Book launch** *Making disease, making citizens: The politics of hepatitis C,* by Suzanne Fraser and Kate Seear, to be launched by Carla Treloar	
4	**Chair: Bill Bowtell**		
3.30-5.00 Mathews Theatre B	3.30	John Della Bosca	***Plenary*** The politics of establishing the Medically Supervised Injecting Centre
	4.30	Discussion	

Session		First author/ Presenter	Title of presentation
FRIDAY 13 APRIL			
5	**Chair: Peter Aggleton**		**Plenary**
9.00–10.15 Mathews Theatre B	9.00	Alison Ritter	Privileging researchers: knowledge brokerage, policy processes and implications for other voices in the illicit drug policy landscape
	9.30	John Godwin	Power, rights and citizenship in the age of biomedical prevention
	10.00	Discussion	
	10.15	Morning tea **DVD launch** *C me, hear me: hepatitis C in our own words* produced by ASHM WDP, to be launched by Carla Treloar	
6A	**Chair: Elena Jeffreys**		**Sex work (Proffered papers)**
10.45–12.30 Mathews Room 104	10.45	Rigmor Berg	How moral pressures and flawed implementation of decriminalisation reintroduced risk to the sex industry in NSW
	11.05	Paul Mathews	Adult/Asian Cam Models (ACMs) in the Philippines: health implications and advocacy
	11.25	Hilary Caldwell	Long-term clients who access commercial sexual services in Australia
	11.45	Kane Matthews	Maintaining sex workers as HIV leaders = ‘same old bold targets’
	12.05	Discussion	
6B	**Chair: Hannah Wilson**		**Hepatitis C health promotion and prevention (Proffered papers)**
10.45–12.30 Mathews Theatre C	10.45	Rebecca Winter	The shaping of hepatitis C prevention messages in Australian educational print resources
	11.05	Marty Janssen	‘10 pack please, and can you have a look at my ...?’
	11.25	Kate Pinnock	The Jailbreak Radio Project develops innovative health promotion strategies for radio
	11.45	Sonam Paljor	How to make your website more accessible and socially inclusive
	12.05	Jenny Douglas	In custody, do I disclose or not?
	12.25	Discussion	
6C	**Chair: Toby Lea**		**Gay men, HIV, health issues (Proffered papers)**
10.45–12.30 Mathews Room 107	10.45	Fengyi Jin	Experiences of being gay: data from the Health in Men study
	11.05	Emma Jeffs	Exploring professional and layperson perspectives on the needs and service engagement of HIV-positive South Australians
	11.25	Kane Race	Prudent homosexuals
	11.45	Brett Stevens	Gay men: personal, community and health services barriers to sexual health testing
	12.05	Jeanne Ellard	What is PrEP for gay men? exploring HIV-negative gay men’s understandings of pre-exposure prophylaxis
	12.25	Discussion	
6D	**Chair: Carla Treloar**		**Critical reflections on drug treatment policy in Australia and the UK: addiction and recovery (Symposium)**
10.45–12.30 Mathews Theatre B	10.45	David Moore	Episodes of care and the production of ‘addiction’: alcohol and other drug treatment provision in Victoria
	11.05	Jo Neale	The rise of the UK recovery agenda: strengths, weaknesses, opportunities and threats
	11.25	Sione Crawford, Marianne Jauncey	Discussants
	12.05	Discussion	

Session		First author/ Presenter	Title of presentation
6E	**Chair: Asha Persson**		**(Re)emerging issues in the gay community (Proffered papers)**
10.45–12.30 Mathews Room 102	10.45	Ian Down	Intensive sex partying associated with risk of hepatitis C
	11.05	Rachel Deacon	At the intersection of two marginalised identities: lesbian, gay, bisexual and transgender people’s experience of injecting drug use and hepatitis C seroconversion
	11.25	Christy Newman	What moves a general practitioner to specialise in HIV? interviews with ‘key informants’ from government, non-government and professional organisations
	11.45	Loren Brener	Attitudes towards hepatitis C and perceptions of hepatitis C risk practices among gay men
	12.05	Kathy Triffitt	Negotiating invisible boundaries: re-positioning the positive voice in HIV health promotion and prevention
	12.05	Discussion	
	12.30	Lunch	
7A	**Chair: Pene Manolas**		**Heterosexuality, HIV, serodiscordance (Proffered papers)**
1.30–3.00 Mathews Room 107	1.30	Christy Newman	‘Straight’ men and ‘gay’ clinics: the changing cultural politics of Australian HIV health services
	1.50	Kath Albury	‘There’s really no community group that deals to heterosexuals who play blood sports, or heterosexuals/bisexuals who engage in promiscuous activity’: listening to NSW non-gay and lesbian identified sex/play partiers
	2.10	Susan McGuckin	The impact of HIV on meanings of health and well-being for heterosexual people with HIV
	2.30	Asha Persson	Critical reflections on the concept of ‘risk’ in serodiscordant couples
	2.50	Discussion	
7B	**Chair: Jake Rance**		**Drugs, addiction, harm reduction (Proffered papers)**
1.30–3.00 Mathews Theatre C	1.30	Toby Lea	Substance use among same-sex attracted young people: associations with minority stress and the ‘scene’
	1.50	Kenneth Yates	Articulating bodies: addiction and representation
	2.10	Max Hopwood	Occupy harm reduction: a story of silence and articulation
	2.30	Discussion	
7C	**Chair: John de Wit**		**HIV prevention in Australia II (Proffered papers)**
1.30–3.00 Mathews Room 102	1.30	Ian Down	‘I always disclose. Not explicitly, but it's certainly implied’: exploring post-diagnosis HIV-positive status disclosure to sex partners
	1.50	Garrett Prestage	Confidence in HIV-negative status
	2.10	Geoff Honnor	Making wellness
	2.30	Garrett Prestage	Semen play: hidden risky pleasures?
	2.50	Discussion	
7D	**Chair: Martin Holt**		**Articulating and enacting biomedical HIV prevention (Symposium)**
1.30–3.00 Mathews Theatre B	1.30	Jonathan Stadler	Unanticipated outcomes of a microbicide trial: the case of the MDP301 trial, South Africa
	1.50	Marsha Rosengarten	Inventiveness in the face-off with a ‘biomedical fix’
	2.10	Bridget Haire and Alan Brotherton	Discussants
	2.50	Discussion	
	3.00	Afternoon tea	

Session		First author/ Presenter	Title of presentation
8	**Facilitator: Norman Booker**		
3.30–5.15 Mathews Theatre B	3.30	Brandon Bear Pene Manolas Monique McEwan Daniel Reeders David Riddell	***Closing plenary panel discussion*** How do silence and articulation operate in communities that are less prominent in discussions about HIV, viral hepatitis, drug use and sex?
	5.00	Carla Treloar	**Closing remarks**
	5.30	Cocktail party	

Biographies of keynote speakers and panel members

Mr Brandon Bear

Brandon Bear is the Health Projects Manager at Yfoundations where he advocates for the unique health needs of young people who are homeless or at risk, and coordinates training and resource development initiatives to support youth workers and marginalised young people to obtain better health outcomes. Brandon has served on the boards of the NSW Association for Youth Health and the Centre for the Advancement of Adolescent Health. He is working towards a Bachelor of Science (Health Promotion).

Before coming to Yfoundations, Brandon worked as a Youth Worker and Health Educator for WAYS Youth Services in Bondi where he developed his passion for discussing the taboos and stigmas that surround youth health and sexual health and honed his skills in education and advocacy. Brandon has also been involved in a number of community development projects, including coordinating the Creative and Community Working Group for the Sydney Gay and Lesbian Mardi Gras and developing camps and social activities for young people affected by HIV through his work with the Sydney Children's Hospital Camp *Goodtime*.

Session 8, Friday 3.30pm, p.65

The Hon. John Della Bosca

John Della Bosca was Special Minister of State in the NSW Labor Government in 1999 during the establishment of the Medically Supervised Injecting Centre in Kings Cross, of which he was a strong proponent and leading advocate. John joined the Australian Labor Party in 1973 and held numerous executive roles including 15 years on Labor's National Executive and 11 years as NSW General Secretary. During his 11 years in The Legislative Council as Deputy Leader and Leader of the Government, John held all major human services and statutory insurance portfolios, as well as the Finance and Commerce ministries, and initiated a number of important reforms including the Stronger Together initiative in Disability Services.

He resigned from parliamentary service in August 2010 and is currently the National Campaign Director for the National Disability Insurance Scheme.

Session 4, Thursday 3.30pm, p.41

Mr John Godwin

John Godwin is a consultant in HIV, law and development. He has expertise in public policy and human rights. He has over 20 years experience in the HIV sector. He has worked with ACON, AFAO and other community-based organisations, government and UN agencies. In the 1990s he practised as a lawyer at UNSW's Kingsford Legal Centre, specialising in discrimination cases. He co-authored the Australian HIV/AIDS Legal Guide. From 1998-2002 he was Head of Policy at the National AIDS Trust (UK), managing a range of UK, European and international projects. From 2004-2008 he was the lead HIV adviser to AusAID. He currently provides consultancy services to a range of HIV projects in the Asia Pacific region and is a member of the Legal Working Group of the Ministerial Advisory Committee on Blood Borne Viruses and STIs.

He holds degrees in Arts (Politics), Law, and a Masters of International Social Development.

Session 5, Friday 9.00am, p.43

Ms Pene Manolas

Session 8, Friday, 3.30pm, p.65

Pene Manolas is Manager of Community HIV Services, Heterosexual HIV/AIDS Service and Positive Central (Sydney Local Health District). Pene holds a Bachelor of Applied Science (Occupational Therapy), Diploma of Business (Frontline Management) and is undertaking a Masters of International Public Health. Pene provides leadership and support to the Community HIV Team, managing day to day operations and strengthening service delivery across the Sydney Local Health District and statewide area covered by 'Pozhets'.

Pene has worked in HIV/AIDS since approximately 1990, initially as an Occupational Therapist in Melbourne and then in the United Kingdom as Occupational Therapy Team leader at the Chelsea and Westminster Hospital, London. Following her return to Australia in 1996, Pene was involved in two new Sydney programs, The 'Colao' and 'Reconstruction' Projects focussing on group support for PLWHA on HAART, exploring early day challenges to adherence. Pene has extensive experience in group facilitation, project management, and capacity building, and has recently visited South Africa where she worked alongside a multidisciplinary team delivering comprehensive HIV care on the Eastern Cape.

Ms Monique McEwan

Session 8, Friday, 3.30pm, p.65

Monique McEwan is a Wiradjuri woman from Warren, central western NSW. Her diverse employment background includes positions in both the community sector and customer service, and working with many different Aboriginal communities in NSW.

Monique is currently employed as Harm Minimisation Project Officer at the Aboriginal Health and Medical Research Council where she has worked for over three years. Although new to the harm minimisation sector, she has developed a range of strategies within her projects to improve access for Aboriginal people to harm minimisation programs. These strategies include capacity building in workforce development through cultural competency training, and publishing Needle and Syringe Program: Mapping service provision in Aboriginal Community Controlled Health Services Report.

She has a Graduate Diploma in Indigenous Health Substance Use.

Mr Daniel Reeders

Session 8, Friday, 3.30pm, p.65

Daniel Reeders is Senior Project Worker at the Multicultural Health and Support Service, a program of the Centre for Culture, Ethnicity and Health in Melbourne. In 2010 the Centre published his report "Double Trouble: the health needs of culturally diverse MSM", and in 2011 he completed a two-year project assessing the sexual and reproductive health needs of heterosexual and same sex attracted international students in Victoria, funded by Department of Health in Victoria. Daniel has previously worked as Campaign Coordinator at PLWHA Victoria and as a gay men's health educator at VAC/GMHC. He has a particular interest in reflective practice, community-based research, and getting 'practice into research'.

Mr David Riddell

Session 8, Friday, 3.30pm, p.65

David Riddell currently works as the client services manager at The Bobby Goldsmith Foundation (BGF) in Sydney which provides practical, emotional and financial support to people living with HIV/AIDS (PLWH) across NSW. BGF accepted 200 new clients last year, equivalent to over 60% of all new diagnosis in NSW. Prior to working at BGF, in Sydney David has worked with Carers NSW, St Vincent's Hospital Drug and Alcohol Detox, ACON as a counsellor, and sat on the board of Positive Life NSW for two and a half years, a period which marked their name change from PLWHA (NSW). In 2007 he completed a postgraduate Diploma in Counselling at the Australian College of Applied Psychology, which marked the end of his first year in Sydney. In the UK he was employed in the National Health Service to deliver improvements to patient access and outcomes at GP level by working with doctors, staff and patients and bolster primary care interventions. David has worked in the UK Probation Service, sat on the board of an HIV-positive persons support charity in south west London and volunteered at London Lighthouse during the early 1990s.

Professor Alison Ritter

Session 5, Friday, 9.00am, p.42

Alison Ritter is Director of the Drug Policy Modelling Program with adjunct appointments with the Regulatory Institutions Network, The Australian National University and the Key Centre for Ethics, Law, Justice and Governance, Griffith University. After completing her Masters in Clinical Psychology, she worked full-time as a clinical psychologist. During this time, she commenced her PhD in treatment outcomes associated with acquired brain injury. A subsequent move to a policy position with the Victorian Department of Human Services led to a secondment to establish the Turning Point Alcohol and Drug Centre on behalf of government in 1994. As Deputy Director of Turning Point Alcohol and Drug Centre (1995–2005), Alison completed numerous clinical research projects, including trials of new medications for the treatment of heroin dependence and managed epidemiological, health services research and evaluation.

With an NHMRC Research Fellowship and a significant philanthropic grant, Alison is currently director of a major illicit drug policy research program, the Drug Policy Modelling Program in collaboration with scholars from the ANU, Turning Point Alcohol and Drug Centre and Griffith University School of Criminology. The goal of the work is to advance illicit drug policy through improving the evidence base, developing new policy decision-making tools and understanding the best mix of policy options (law enforcement, prevention, treatment and harm reduction) and the ways in which these different policy options dynamically interact.

Professor Ritter is Executive Editor of the Drug and Alcohol Review, President of the International Society for the Study of Drug Policy and a member of the College of Problems on Drug Dependence (CPDD). Professor Ritter reviews for a range of competitive funding bodies and international addictions journals.

Professor Jane Ussher

Session 1, Thursday, 9.15am, p.20

Jane Ussher is Professor of Women's Health Psychology, at the University of Western Sydney, Australia. She has published widely on the construction and lived experience of health, in particular women's mental health, the reproductive body and sexuality. She is editor of the Routledge *Women and Psychology* book series and is author of a number of books, including *The Psychology of the Female Body* (Routledge, 1989), *Women's Madness: Misogyny or Mental Illness?* (Harvester Wheatsheaf, 1991), *Fantasies of Femininity: Reframing the Boundaries of Sex* (Penguin, 1997), *Managing the Monstrous Feminine: Regulating the Reproductive Body* (Routledge, 2006), and *The Madness of Women: Myth and Experience* (Routledge, 2011). She has also edited a number of books: *Gender Issues in Clinical Psychology*; *The Psychology of Women's Health and Health Care* (with Paula Nicolson); *Psychological Perspectives on Sexual Problems*; *Bodytalk: The Material and Discursive Regulation of Madness, Sexuality and Reproduction,* and *Women's Health: Contemporary International Perspectives*. Her current research focuses on sexual and reproductive health, with particular emphasis on premenstrual experiences, and sexuality in the context of cancer.

Sessions and abstracts

Welcome to the conference

Welcome to Country
Uncle Les Davison, an Elder of the La Perouse Aboriginal Community of Botany Bay who belongs to the Dharawal people

Welcome to the conference
Professor John de Wit, Director of the National Centre in HIV Social Research, The University of New South Wales, Sydney

1 Silencing sex and sexuality

Chair: Susan Kippax

Jane Ussher

Director
PsyHealth: Gender, Culture and Health Research Unit, School of Psychology, University of Western Sydney

Michel Foucault argued that "what is peculiar to modern societies… is not that they consigned sex to a shadow existence, but that they dedicated themselves to speaking of it ad infinitum, whilst exploiting it as the secret" (1976, p.13). This paper will explore the silences associated with sex and sexuality in health research and practice, as well as the implications of this secrecy for the regulation of subjectivity, and experience of the sexual body.

Outside of the field of HIV and hepatitis C, health research and policy rarely acknowledges sex: the impact of illness on every other aspect of experience is explored, but sex remains unmentioned. When sex is examined, "normal sex" is defined within the coital imperative, marginalising practices which do not conform to hetero-normative gendered ideals. This has implications for the diagnosis of 'sexual dysfunction' and for the re-negotiation of sex in the context of illness, such as cancer and vulvadynia. It also impacts upon the construction and experience of sexual pleasure and pain; and sexual desire in older people, where an active sex life is deemed to be an aberration.

The "subject" investigated in scientific research is assumed to be heterosexual, leaving the complexity of sexual subjectivity unexplored. At the same time, researchers who do acknowledge sexual diversity have been accused of narrow and dichotomous theorising, negating the experience of bisexual, transgender and intersex individuals, in their focus on gay and lesbian sexuality. This has implications for theoretical understandings of sex outside of the heterosexual matrix, as well as for individuals whose sexual subjectivity does not fit within these narrowly defined parameters.

Drawing on a series of recently conducted research studies, as well as critical theory on sex and sexuality, this paper examines these silences, and explores avenues for articulation.

Stigma and BBV 2A

Chair: Christy Newman

HIV Stigma in Australia: quantitative results from a study of the effects of stigma on gay men living with HIV

Loren Brener[1], John de Wit[1], Denton Callander[1], Sean Slavin[2] and Philippe Adam[1]

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Introduction: PLHIV continue to experience stigma related to their HIV status. This study documents the range of experiences associated with HIV stigma to strengthen understanding of its social and psychological effects and assess what characteristics enable some PLHIV to be resilient to stigma.

Method: The survey assessed HIV stigma, depression, anxiety, stress, resilience, quality of life and self- esteem using modified versions of existing scales and newly developed measures.

Results: 611 HIV positive men who identified as homosexual completed the survey. Among these men the mean score of stigma as measured on a revised stigma scale (alpha = .92) was 59 out of 100, where higher scores indicate more stigma experienced. Scores on this scale were correlated with the role participants felt that HIV played in their lives, the more central HIV, the greater their reported experiences of stigma ($r = 1.75$, $p < .01$). The sample was divided into those who noted that they had visible symptoms as a result of their HIV ($n = 170$) as compared to those who reported no visible symptoms ($n = 441$). Preliminary data analysis revealed that despite the stigma being visible, those who had physical symptoms associated with their HIV showed higher resilience scores than those with no visible symptoms.

Conclusions: The finding that people with visible stigma show higher resilience will be explored in more detail with the idea that building resilience and coping amongst those who experience stigma is likely to have a positive impact on their well-being, and hence will mitigate against the negative consequences of stigma.

HIV Stigma in Australia: qualitative results from a study of the effects of stigma on people living with HIV

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Background: PLHIV continue to experience HIV-related stigma that impacts upon their health and well-being. This study documented experiences associated with HIV stigma to understand its social and psychological effects and assess what characteristics support resilience.

Method: In-depth interviews were conducted by HIV-positive peers. Questions sought narratives of particular instances of stigma and asked participants to discuss their coping strategies and how these may have changed over time. Thirty-five interviews were conducted nationally and included MSM, women, heterosexual men and people from CALD backgrounds. Interviews were coded for themes following a grounded theory approach.

Result(s): Most PLHIV have experienced stigma in various forms and contexts. For some, stigma involved social or emotional ostracism driven by external 'stigmatising' factors such as the behaviour of peers or healthcare professionals. For others stigma was primarily an internal phenomenon that left them feeling tainted and led them to withdraw from some relationships. Individuals discussed coping strategies that included seeking information and support from community organisations or healthcare providers. For some, this empowered them to confront those who stigmatised. Most PLHIV sought to actively manage knowledge of their status in various contexts.

Conclusion: This study suggests strategies for addressing stigma that place the person living with HIV who experiences stigma at the centre of any response. It suggests that resilience can be developed over time and suggests particular strategies for doing so. Such strategies are likely to be more effective and durable than working with stigmatisers because they focus on achievable change within a defined population.

Conceptualising HIV-related stigma in terms of discrimination, stereotyping and prejudice among healthcare providers

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Objective: To examine the theoretical model of discrimination, stereotyping and prejudice as a comprehensive description of HIV-related stigma among health care providers. To assess how the narratives of four focus groups fit within this conceptual model.

Method: Four focus groups ($N = 26$ participants) were conducted examining the attitudes and beliefs believed to be held by health care providers about people living with HIV (PWAs). Focus group participants were medical and nursing students, health care providers with at least two years of experience working with PWAs, female PWAs and male PWAs. Transcripts of the focus groups were first analysed with a critical lens using an immersion/crystallization approach. Themes were then assessed for fit with the model of HIV-related stigma consisting of three distinct elements of discrimination, stereotyping and prejudice as described by Earnshaw and Chaudoir (2009).

Results: All four focus groups provided concrete examples of discrimination, stereotyping and prejudice within their description of stigmatising attitudes of health care providers towards PWAs. Discrimination, as a behavioural act, was deemed to be the less prevalent and often more covert expression of stigmatisation. Stereotyping and prejudice were seen to be more insidious and perpetuated by both the medical and educational establishments.

Conclusions: Our results suggest that assessing the affective (prejudice), cognitive (stereotyping), and behavioural (discrimination) aspects of stigmatisation will lead to a more thorough understanding of health care provider attitudes and beliefs. Interventions to specifically address these acts within medical education are warranted.

Stigma and discrimination related to HIV and HCV in healthcare settings in NSW

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Objective: This project sought to assess the current experiences of stigma and discrimination within the healthcare system among people living with HIV and/or hepatitis C (HCV) in NSW and to make recommendations around dealing with these issues in a meaningful way.

Method: To address these objectives, a comprehensive literature review, individual interviews, and a workshop with community partners were undertaken. The literature review included Australian and international peer-reviewed and gray literature on HIV/HCV stigma and discrimination in healthcare settings. Twenty-four interviews were conducted with key stakeholders from sectors related to health, HIV and HCV. Community partners were invited to brainstorm and develop tangible approaches to meeting the complex needs related to HIV/HCV-stigma.

Results: Stigma and discrimination were identified by stakeholders as primary fears faced by people living with HIV/HCV and an ongoing challenge in NSW health settings. While reported incidents seem to be quite rare in the state, many interviewees had witnessed or heard of incidents of discrimination. Participants identified confidentiality, unclear policy and non-specialised care as key areas for concern.

Conclusions: The results of this project highlight stigma and discrimination in healthcare as important issues for people living with HIV/HCV in NSW. Recommendations constructed as part of this project include the promotion of standard precautions and further research into resilience-building factors for people living with HIV/HCV. Another primary recommendation was the implementation of an educational marketing campaign directed at healthcare workers to increase knowledge around HIV/HCV in the hopes of decreasing discriminatory behaviour and stigmatising beliefs.

Proffered papers

Consumer representations in drug treatment services 2B

Chair: **Suzanne Fraser**

Consumer representation in drug and alcohol services in South Eastern Sydney Local Health District: the challenges and the changes?

Amanda Morris[1], Tracey Brown[2], David Martin[2] (co-presenter) and Simone Cass[1] (co-presenter)

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Introduction: In mid 2010 a consumer participation (CP) project team was set up within the South Eastern Sydney Local Health District (SESLHD), which consisted of both consumer representatives as well as SESLHD drug and alcohol staff. The main aims of this project were to formalise and consolidate CP, with the hope of increasing the quality and relevancy of treatment for service users.

Methods: Key stakeholder consultations were conducted across the area, including four consumer and one clinician forum. The forums were semi-structured and questions were asked by a researcher/clinician and a consumer representative. The forums were audio taped and the data generated was collated and thematically analysed. The results were used to inform a framework and implementation plan for CR across the area.

Results: Consumers described their experiences and perceptions of 'trying to be heard' by DAS. Few consumers or staff knew what the mechanisms of CP were or how to use them. Some consumers appeared fearful of the repercussions of speaking out and spoke of being sceptical of the difference that CP could make to their experiences of treatment. However, despite this most people expressed enthusiasm about having and being involved in more effective CP.

Conclusion: Effective, sustainable CP requires clear defining, strong leadership as well as adequate, on-going resourcing. The main challenges will therefore be drug and alcohol services' limited experience of CP, ensuring on-going leadership and commitment to CP and securing government funding.

Service user participation among non-government drug and alcohol services

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Introduction/aims: In Australia, a good example of service user participation is demonstrated in the area of mental health, where the consumer movement has been in existence since the 1970s. The successful implementation of service user participation programs in mental health highlight that consumer involvement is possible and, in particular, that it is possible with marginalised groups of people whose views and experiences have traditionally been devalued and excluded. The context of drug and alcohol services brings with it particular sensitivities and complexities, and these can present some challenges to implementing service user participation. The aims of this study were to explore current knowledge, activities and challenges in implementing service user participation models in non-government drug and alcohol services in NSW.

Method: A survey was developed, consisting of questions around service user participation, and was sent to all Network of Alcohol & Other Drugs Agencies (NADA) member organisations.

Results: The majority of respondents reported that they believed their service could benefit from implementing service user participation into planning and policy development. However, over half of the sample agreed that a main barrier to implementing service user participation in their service was that staff were concerned about service users having access to confidential information.

Discussion: Service user participation has the potential to benefit those who plan and provide health care services, as well as patients who use the service. For staff and service users within the drug and alcohol sector to benefit from service user participation, consumers and staff need to develop a stronger network of shared trust.

Evaluation of consumer participation demonstration projects in five Australian drug treatment facilities: the impact of individual versus organisational stability in determining project progress

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This project evaluated consumer participation projects in five drug treatment services in metropolitan and regional areas in three Australian states. Qualitative interviews were conducted with staff and consumers at two time points between 2008–2010 (n = 108). At baseline, staff and some consumers focused on the stability of consumers to undertake representative roles. At post-implementation, the focus was on the stability of the organisation as frequent staffing changes and lack of adequate handover affected the progress of the projects. These issues combined with the perceived 'non-core' status of consumer participation resulted in none of the projects achieving all of their agreed goals.

Innocent fun or guilty pleasure? Depictions of people who use drugs and access treatments by service providers

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There have recently been instances of service providers and organisations that represent them depicting service users in stereotypically negative ways both across national publications and during public presentations.

A curious phenomenon developed around one recent instance. Strong user criticism of stereotyped depictions of themselves was met with more criticism and greater responses from the sector than the original depictions were met with, at least publicly. The original depictions were characterised as humorous and a bit of fun whereas the user responses were characterised as vicious attacks on allies.

AIVL's (Australian Injecting and Illicit Drug Users League) recently published report "Why wouldn't I discriminate against all of them?" highlights that discrimination against people who use illicit drugs is not only endemic across society but that those who discriminate are often not aware they are doing it and are ignorant to their own behaviour's impact. The coincidence of the publication of this report and the incidences of discriminatory humour noted above offers an opportunity to explore these depictions in the context of societal discrimination.

This presentation explores the depiction and articulation of drug user behaviours in some areas of the Australian Harm Reduction and AoD sector and the dynamic of the responses to this articulation, which included a silencing of criticism.

2C Asian gay men

Chair: **Maheswar Satpathy**

'I can be a young gay boy in Sydney because I don't have to look after anything or care about': being Thai and gay in Sydney

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Background: The data for this presentation are from a study about Thai gay men and HIV risk in Sydney. One aim of this project was to explore how Thai gay men, as an ethnic minority, engaged with the predominantly Anglo-Australian gay community.

Methods: As this was an exploratory study, qualitative research methods were used. Data were collected in focus groups and in semi-structured in-depth interviews with 27 men.

Results: Participants appreciated the openness towards homosexuality in Sydney, including protection from discrimination by the law. They also felt that in Sydney they could identify as men who had sex with men rather than being perceived as katoi or ladyboy (transgender females), and they could be openly gay without having to consider the family's reputation. However, they were also ambivalent about their relationship with gay community in Sydney. Some felt being excluded and being looked down upon. For some, rebuilding their careers after migration and focusing on relationships and family life were more important than participating in gay community. And some felt that gay community did not represent them. Thai cultural values were important where a son's responsibilities towards his family were concerned. A further issue relating to culture was the lack of gay role models in Thailand.

Conclusion: Thai gay men in Sydney are a heterogeneous group. They connect with the mainstream Australian gay community to varying degrees, or not at all. Thai cultural values are still important where the family is concerned.

Behind the mask: Asian gay men and HIV prevention

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In response to national MSM HIV notification rates, Asian MSM/gay men constitute a priority group within ACON's HIV prevention work through the Asian Gay Men's Project. However, multiple challenges exist in this work as issues of stigma, migration, isolation and sociocultural homelessness, in addition to racism and homophobia within the gay and ethnic community respectively, complicate the life-challenges facing Asian MSM/gay men. Negotiating these multiple marginalisation puts a great demand on the individual, often drowning out importance of HIV awareness and prevention. This paper seeks to discuss how HIV health promotion can be engaged in the context of broader exploration of gay/MSM individual's wellbeing. Moving beyond the health belief model, a holistic approach to HIV prevention needs to address issues of self-worth, social connectedness and family ties and actively engage with these as protective factors. These person-centric approaches seek to create a space for visibility and voice of Asian MSM/gay men as agents of behaviour change through role modelling and social learning. Additionally, working in this framework also enables a nuanced understanding and incorporation of cultural values and factors that can affect broader HIV prevention initiatives, making effective HIV prevention work resonate with a diverse cross section of the community. This paper will seek to address HIV prevention work through a contextualised approach by presenting initiatives of the Asian project in peer education, focus group research and community building projects as points of discussion, with an aim to generate a richer dialogue on HIV prevention work in a CALD setting.

Minority among minority? profile of gay Asian men in Australian Gay Community Periodic Surveys, 2000–2009

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Although gay Asian men (GAM) constitute a significant and growing minority in Australia, there is a dearth of research on their sexual behaviour and practices.

We examined social and behavioural differences over time of self-identified GAM with the purpose of investigating any changes that may be useful in designing prevention interventions for this population. Trends in social and behavioural characteristics were analysed using data from the Gay Community Periodic Surveys (GCPS) during the period 2000–2009.

Univariate differences between Asian gay men and non-Asian gay men were investigated using Pearson's chi square tests of association for categorical variables. Where there was a significant difference between GAM and non-GAM, these variables were included in multivariate logistic regression analysis to assess independent changes over time within each group.

Compared to non-GAM, GAM were significantly younger, more likely to have a university education, had fewer male partners in the past six months, were less likely to be tested for HIV and less likely to report unprotected anal intercourse with casual partners. During the reporting year period (2000–2009), GAM are significantly less likely to disclose their HIV status to their casual partner ($p < .001$). Similarly, GAM were less likely to be told by casual partner of the HIV status ($p < .001$).

These findings suggest although that the majority of GAM continue to avoid practices which are risky for HIV transmission, a growing proportion of them do so and therefore they should be included in HIV prevention programs.

Proffered papers

HIV in international settings 2D

Chair: **Limin Mao**

Revealing and concealing: public silences about AIDS in the South African lowveld

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In spite of massive investments to 'break the silence' surrounding the AIDS epidemic, concealment and secrecy continues to characterise the public response. This has significant implications for prevention, support and care. This paper explores reasons for the concealment of HIV infection, AIDS illness and deaths in a rural settlement in north eastern South Africa. My anthropological research suggests that concealment and secrecy are strategies employed to avoid the danger and harm associated with revealing the AIDS body and talking about the disease. Yet concealment and secrecy are also ways of revealing and communicating about AIDS. These conclusions expose weaknesses in public health discourse that insists on the beneficial effects of open disclosure of AIDS.

Human rights and public health in the international HIV response: issues of contested control

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From its earliest formulation, the international HIV response has attempted to harness human rights as a central element of public health practice. Policy initiatives aimed at eliminating stigma and discrimination of affected people would enable them to access health and social services, practice safe behaviours and thereby protect public health. However, this response was characterised by tensions between differing perceptions of public health and human rights and, with the advent of effective treatments, between those who regarded behavioural and biomedical interventions as competing, if not mutually exclusive, approaches.

A central theme in all of these elements has been control; control of the virus, control of the behaviours of people affected, control of policy and control of rights. HIV infection is both a cause and a consequence of human rights abuses, but for many people these two aspects are compounded into the same lived predicament; a predicament over which many feel they should have control. The test-and-treat debates at the 2010 IAS Conference demonstrated this as presenters and participants openly clashed over proposals to implement what many see as coercive measures in settings where viral transmission and the public health/human rights collaboration might both be regarded as now ‘out of control’.

This paper will explore issues of control in the international HIV response and how authority, in the forms of law and justice, is contested in that response.

Identities, practices and understandings of sexuality and gender among men who have sex with men and transgender people in the Fiji Islands

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Aims: Little research has explored sexuality and gender identities among men who have sex with men (MSM) and transgender people (TG) in Fiji. We explored sexual practices, identities and experiences within a sample of MSM and TG.

Approach: A community-based cross-sectional study was implemented with 212 MSM/TG in two locations, involving interviewer-administered questionnaires and group interviews.

Findings: There were distinct but overlapping groups of MSM/TG in Fiji: feminine-identified gays/TGs, straight-identified MSM, and an emerging group of masculine-identified gay men. Many participants understood the category of TG as a non-traditional gender identity rather than specifically involving feminine gender expression. Feminine gays/TGs and straight-identified men sought sexual partners from the "opposite" group, expressing more local/traditional understandings of sexuality and gender. Gender and sexuality were viewed as a single combined concept; masculinity and femininity as dichotomous and opposing. Those with feminine gender expression typically took the receptive role in sex, and the masculine partner's sexual pleasure was paramount. The gay men tended to find their partners from within their group, expressing more "globalised" gay male identities, similar to international gay cultures. These respondents identified as male, viewed sexuality and gender as distinct concepts, did not see one's position in anal sex as contingent upon identity, and viewed pleasure as reciprocal. Vulnerabilities around HIV infection were linked to gender expression.

Conclusions: Traditional and globalised understandings of gender and sexuality intersected among MSM/TG in Fiji, producing diverse articulations of identity, expression and behaviour. HIV prevention activities need to recognise diverse groups and target them appropriately.

Translating research to action: pilot results of anti-stigma training for healthcare providers and people with HIV/AIDS in Shanghai, China

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Introduction: As an urban centre with 23 million people, Shanghai's HIV cases have more than doubled since 2006. Its diverse PLWHA populations face many unique challenges in accessing healthcare. An international research partnership was developed to involve affected stakeholders to assess the needs and identify strategies for improvement.

Methods/approach: Individual interviews and focus groups were conducted with 50 PLWHAs and 46 healthcare providers to explore barriers and strategies for change. Research results were analysed and presented to stakeholders for collaborative recommendations development. Targeted interventions were developed to address key challenges identified that includes an anti-stigma training workshop for both clinicians and PLWHAs.

Results: Both PLWHA and healthcare provider participants identified HIV stigma and discrimination within the healthcare system as a key challenge that created a vicious cycle of non-disclosure, delayed testing and diagnosis, poor treatment and adverse health outcomes. To address this, the research team developed a training intervention: "Let's Talk: a communication skill building workshop for PLWHA and health care providers" that combined anti-stigma education for clinicians and disclosure skill development for PLWHAs. The workshop was piloted in May 2011 with 13 PLWHA peer leaders and 15 healthcare providers and received extremely positive evaluation from all participants.

Conclusions/implications: The research pilot intervention provided a safe environment to facilitate participants' self reflection and strategy development. Evaluation indicated high level of receptiveness to intervention and preparedness for change in practice. Plan is currently underway to explore opportunities to integrate training into healthcare providers' core education curriculum.

3A HIV prevention in Australia I

Chair: **Dean Murphy**

Enacting gay men, risk and HIV prevention knowledge: the looping effects of behavioural HIV surveillance in Australia

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My subject is a specific type of public health surveillance, namely the routine behavioural surveillance of gay men through the Gay Community Periodic Surveys (GCPS) across Australia. The GCPS inform the response to HIV in Australia by monitoring HIV-related sexual practices, drug use and health service utilisation among Australia's primary affected population: gay men. I currently manage the surveys in collaboration with researchers, policy-makers and community organisations. I have become increasingly interested in the effects of this surveillance on the actors who produce it, particularly the 8000 men who voluntarily divulge explicit information about their personal lives every year, but also the 'experts' like myself who consume the resultant survey data. This is an initial attempt to sketch out the 'looping effects' (following Ian Hacking) that link researchers, other stakeholders and the researched. Behavioural surveillance 'makes up' its subjects (in this case, gay men) in particular ways by focusing on practices such as sex, risk-taking and health care usage. The surveys offer an imaginary of gay men that can be taken up, rejected or reworked by those men, affecting their subjectivity and the practices the surveys seek to monitor. As the surveillance team adapts to changing practices in the target population, survey questions and priorities are modified, sustaining the looping effect by reflecting new priorities back to gay men in an altered imaginary. I suggest that HIV prevention could be better informed by behavioural surveillance if we reflect on how the surveillance assemblage and its subjects are enacted.

Acceptability of risk reduction strategies in gay men's networks in three Australian cities

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Introduction: HIV/STI risk reduction (RR) is more likely to occur if community norms regarding RR are supportive and are shared in the community. The CONNECT Study investigated norms and acceptability of RR strategies in Australian gay communities.

Methods: Participants were recruited using respondent-driven sampling (RDS). Men were asked about their personal networks and what they find acceptable to prevent HIV transmission. Questions about acceptability of RR strategies referred to specific circumstances and HIV serostatus of network members and sexual partners. Analyses used RDS analytical methods and regression estimation of the associations, on individual and pair-wise levels.

Results: Gay friends and regular partners played an important role in RR. Serosorting in casual sexual encounters was considered the most effective RR strategy reported by 65% of men with 69% of dyads of sex partners agreeing that this is the most effective strategy. Withdrawal was considered the least effective strategy. Acceptability of condoms depended on the type of relationship with partners: 46% of men would always use condoms with regular partners compared to 34% with fuckbuddies and 73% with new casual partners.

Conclusion: Our findings confirmed the complexity of gay men's approaches to RR. Many men continue using condoms; yet many rely on RR strategies other than condom use. Choice of RR often depends on the type of partner and serosorting appears the most popular strategy. These findings support the development and refinement of HIV prevention programs targeting the influence that gay men's peer networks can have on RR opinions and beliefs.

The effect of age difference on condom use in Australian gay men

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Background: Overall trends in HIV incidence suggest sufficient age mixing occurs across age groups to sustain HIV incidence in Australian gay men.

Methods: We explored age difference between sex partners and the likelihood to use condoms among men in the Pleasure and Sexual Health Study. We used Pearson's and McNemar's chi-square analyses to test for correlated proportions.

Results: The average age in years of participants with a regular partner was 34.8, 33.9 for men reporting protected anal intercourse with casual partners (PAIC) and 34.9 for men reporting unprotected anal intercourse with casual partners (UAIC) in the previous six months. Of the men reporting PAIC in the previous six months, 11.0% had a partner more than ten years older and 21.7% had a partner more than ten years younger. 10.7% of men reporting UAIC in the previous six months had a partner more than ten years older while 23.0% reported a partner of more than ten years younger. Age difference had no effect on the likelihood to use condoms with a regular partner [χ^2 (8, $N = 893$) = 3.46, $p = 0.90$] nor for men reporting both PAIC and UAIC in the previous six months and a partner more than ten years younger [$N = 543$; $p = 0.17$] or more than ten years older [$N = 543$; $p = 1.00$].

Conclusion: Age difference does not affect condom use in Australian gay men.

Perceptions of HIV transmission risk, range of sexual practices and self-reported HIV status: how do they align with each other?

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Background: We aim to explore how gay men's perceptions of HIV transmission risk vary by a) engagement in unprotected anal intercourse (UAI); and b) self-reported HIV status.

Methods: In the 2010 August Sydney Gay Community Periodic Survey, HIV risk perceptions were measured by participants' evaluation of hypothetical engagement in a range of anal intercourse with a stranger, whose

HIV status was known as either negative, positive with an undetectable or detectable viral load. Factor analyses were used to differentiate key items of risk perceptions by participants' HIV status. A mean risk perception score was calculated and men were dichotomised into those with low versus high risk perception groups. Multinomial logistic regressions were conducted to assess risk perceptions in relation to UAI and HIV status.

Results: Of the 1,692 participants, 16.0% reported as HIV-positive, 71.6% HIV-negative, and 12.4% HIV-unknown. HIV risk was perceived differently by the three groups in terms of seroconcordance and modes of anal intercourse. Among those who scored high in risk perception, the majority of HIV-positive men had no UAI or seroconcordant UAI-R; the majority of HIV-negative men had consistent condom use or seroconcordant UAI-R, and the majority of HIV-unknown men had no anal intercourse. Different characteristics including self-reported HIV status were independently associated with men who had: no UAI, any UAI but low risk perceptions, and any UAI and also high risk perceptions.

Implications: Gay men's perceptions of HIV transmission risk are shaped by a multitude of factors, including personal experiences, networks and behavioural contexts.

Characteristics and structure of networks in Sydney, Melbourne and Perth

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Introduction: Gay community comprises different groups and networks. HIV/STI prevention programs are likely to be more effective if they are able to reach these different groups and networks of the community. We investigated the structure of gay community networks to inform prevention services and better target HIV/STI prevention programs.

Methods: We used data from the ongoing CONNECT Study which is conducted in three Australian cities (Sydney, Melbourne and Perth). It recruits gay men using respondent-driven sampling (RDS). The recruitment started in December 2010. Data was analysed using RDS analytical methods.

Results: By November 2011, 569 participants were recruited. The mean age of respondents was 36 years for Sydney, and 39 years for Melbourne and Perth. Men reported mean personal network sizes of 12.1 (range 1–500) in Sydney, 15.9 in Melbourne (range 1–300) and 12.2 in Perth (range 1-100). Most men associated with more than one gay community group or network. More than half of all men were referred by their close friends and acquaintances and around 20% by their sex partners. Most men reported a close relationship with their referrer. In Sydney 60% men saw themselves involved in the local gay community (64% in Melbourne and 47% in Perth). Internet was an important means of communication in gay community: over 50% of respondents reported visiting gay cruising/dating websites and 20% accessed gay community social websites.

Conclusion: We discuss the comparative characteristics and structure of gay community groups and networks in the three Australian cities and their importance for HIV prevention work.

Hepatitis C treatment 3B

Chair: **Max Hopwood**

Silences and signals: the politics of 'medical progress' on hepatitis C

Suzanne Fraser

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Introduction: Hepatitis C is often described as a silent epidemic. In this presentation I consider the implications of this idea of silence, exploring its operation in medical journal articles and examining the way it frames a range of key concepts in the domain of hepatitis C: medicine, people who inject drugs, and scientific progress.

Methods: The paper is based on 29 medical journal articles published between 1989 and 2010. These were chosen to allow analysis of the ways knowledge creation about the disease is characterised in this domain. Sourced via searches of three databases (Medline, PubMed and Google Scholar), using the following keywords: 'review', 'overview', 'history', 'knowledge', 'progress', 'evolution', 'current perspectives', 'new', 'to date' and 'what we know', the articles cover a range of medical specialities including hepatology, virology and immunology.

Results: According to John Law, all knowledge-making processes (2004: 107) 'make silences and non-realities as well as signals and realities', but only some makers of knowledge admit this. Scientific knowledge makers, he says, generally do not. Drawing on Law's work, the paper traces the way ideas of silence are mobilised in this material to distribute responsibility and agency for transmission strategically across actors.

Conclusion: I argue that characterising the disease as intrinsically silent serves medicine's image of itself as oriented toward progress when, following Law, we might instead say that scientific methods have generated certain silences, amplified other, sometimes unhelpful, signals, then freighted the responsibility for this process over to the disease itself and to those who have it.

Centre and periphery: exploring the ethics and politics of treatment for people living with hepatitis C

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Aims: Around 3000 people commence treatment for hepatitis C in Australia annually (Hopwood, 2009). Despite concerns about treatment efficacy and its side effects, there are calls for the uptake rate to be trebled (see Treloar and Rhodes, 2009). This is partly because the treatment of individuals is seen to have the potential to help realise public health objectives—to reduce future transmissions—albeit at a significant personal cost. The aim of this study was to examine pathways into, and lived experiences of, hepatitis C treatment.

Method: Qualitative analysis of in-depth interviews conducted with thirty people living with hepatitis C. Participants were from Melbourne. Interview material was examined using Mol (2002) and Law (2004), among others. The study was funded by an ARC discovery grant.

Results: Hepatitis C treatment produces medicine and its subjects in normative, largely familiar ways. For instance, hepatitis C treatment produces its subjects as 'ordered', 'chaotic', 'successful' and/or 'failed', and invokes existential crises through the 'despair' associated with treatment. Here, hepatitis C treatment (re)produces the subject as a 'non-citizen'—a familiar and narrow form of subjecthood traditionally associated with injecting drug use and addiction. In turn, medicine (re)produces itself as counter-point to, and saviour of, the 'non-citizen'.

Conclusions: Hepatitis C treatment is politics, acting upon, performing and transforming it subjects and medicine. It reproduces its subjects in ways that are stigmatising and marginalising, enacting them in highly stereotyped ways. We consider the ethics and politics of these dimensions of treatment and the implications for policy and practice.

'There's only win-win-win': stories of hepatitis C treatment and transformative possibility from opiate substitution clinics

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Introduction: Australian initiatives to expand hepatitis C (HCV) treatment provision are focussed on opiate substitution therapy (OST) settings where HCV prevalence is high. Our previous work questioned the appropriateness of this proposed co-location, arguing that the context of OST actively participates in the socio-spatial segregation and stigmatisation of service users. Nonetheless, there are alternative treatment stories and identities emerging from within these sites which need to be articulated. Taking up de Certeau's idea that the 'practice of place produces space', this paper will explore the production of these alternative 'spatial stories'.

Approach: This paper will draw upon qualitative data collected from four pilot HCV treatment services established within the NSW OST program as part of the NSW ETHOS project, 2011–2012.

Findings: The introduction of HCV treatment within select NSW OST clinics has provided some service users living with hepatitis C increased access to treatment, allowing for alternative spatial stories and identities to emerge from a clinical setting where the stigmatising figure of 'the drug user' commonly prevails.

Conclusion: We conclude that despite the stigmatisation frequently embedded in the everyday institutional practices and culture of OST the introduction of HCV treatment may signal transformative possibilities for service users of drug dependence treatment. These transformations are realised through new experiences of care and place; through the creation of new connections, relations and performative possibilities for the production of self as articulated through the 'spatial stories' of treatment experience.

Evaluation of an integrated care service facility for the treatment of hepatitis C in New Zealand

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Introduction: People who inject drugs and are living with hepatitis C are a highly marginalised population who may not readily access healthcare. We evaluated the patient experience of a model of hepatitis C care introduced in Christchurch offering shared-care service delivery to provide continuum of care.

Method: Surveys were completed by 120 clients and comprised questions relating to changes in lifestyle habits since attending the clinic, hepatitis C knowledge, hepatitis C treatment and experiences with healthcare staff at the clinic.

Results: The majority of respondents indicated that attendance at the clinic has provided them with the information to better manage their hepatitis C and given them confidence to make changes in their lives to better manage their condition. Over 70% of respondents indicated that they had either reduced or cut out alcohol, and had regular hepatitis C check-ups since attending the clinic. Participants demonstrated a very high knowledge of hepatitis C and reported experiencing a less discriminatory and more accepting environment as compared to other health care settings. Respondents who had been attending the clinic for more than 6 months were also significantly more likely to indicate a desire to commence hepatitis C treatment over the next 5 years.

Discussion: The clinic was found to be effective in providing clinic clients with a positive and holistic experience of health care, which appears to increase their motivation to make positive changes in lifestyle for management of hepatitis C and to consider future treatment.

What's trust got to do with it? building, maintaining and brokering trust as a key issue for service planning and delivery

Paul Ward[1] and Carla Treloar[2] (presenter)

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Trust in health professionals and systems has been associated with a range of positive health outcomes and has been widely document as essential to effective therapeutic encounters. Trust affects many important health-related behaviours/attitudes including to: increase patient's willingness to seek care and use health services; encourage uptake and adherence to treatment and enhance quality of interaction between patients and doctors, facilitate disclosure by patients, enable providers to encourage necessary behavioural change, and may grant patients more autonomy in decision making about treatment.

Despite this evidence, trust is rarely present in health policies or service guidelines as an issue to be addressed in designing and providing services, particularly for people who experience marginalisation from mainstream society. This seems particularly problematic given the centrality of trust for developing, maintaining, brokering and improving inter-personal relationships.

This presentation will provide outline of sociological theories of trust (in particular Niklas Luhmann and Anthony Giddens) and highlight how trust has been operationalised in other areas of health service planning and delivery. In doing this, we will attempt to reveal how trust could be considered in services for people affected by or at risk of viral hepatitis and HIV, in order to increase the equity of access, acceptability and outcomes.

3C Sexuality and sexual health

Chair: **Philippe Adam**

Deciphering the anal monologues: why anal sex is so attractive; why anal health is not

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People have eternally engaged in several forms of sexual practices for deriving pleasure, and anal sex is one of them. Increasingly, recent years have seen profound engagement of several agents with anal sex as a means of deriving pleasure, partly influenced by explicit representations in media and pornography. This has probably led to an increased adoption and consumption of anal sex by people of all sexual orientations. Ironically, media discussions are replete with an illusory correlation of anal sex with sexual minorities.

This problematic association with diverse sexual minorities is based on the premise of risk-taking e.g. unprotected anal intercourse and barebacking. However, this risk discourse has unfortunately gained currency at the cost of ignoring a positive health promotion message for anal health. Moreover, this limited representation of anal sex as a means of pleasure or risk factor has blinkered the intricate dynamics of anal health being registered in popular discourse. Ironically, one of the major reasons for under-reporting anal health related issues is anxiety and fear of social ridicule. In this context, the following needs consideration: i) is there an adequate interest and effort to understand the concerns of people who engage in anal sex?; ii) how anal health issues are being approached, responded to and dealt with in popular media and healthcare scenarios; iii) why a risk model dominates our common understanding while a positive model is ignored; iv) how is this issue being responded to in developing countries?; and v) what are the emergent responses for healthcare research and policy?

Human Papillomavirus (HPV): are HPV vaccines a safe and effective management strategy for cervical cancer disease in Australia?

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Objective: Did the risk of cervical cancer to Australian women prior to the introduction of a vaccine justify the risk of introducing this medical procedure? In 2007 cervical cancer was not considered a significant risk to the majority of Australian women. The mortality rate at this time was 1.9 women/100,000 and it is a disease which is almost 100% curable with early detection from Pap smear screening.

Method: This is a literature review of the science used to suggest an HPV vaccine would prevent cervical cancer and of the aggressive marketing campaign used to sell the vaccine. The marketing campaign was funded by the manufacturing company and presented by doctors using company slides. It led to Merck being awarded the title of ‘Pharmaceutical Company of the Year’ for creating a ‘market out of thin air’.

Results: HPV infection is a necessary factor in most cervical cancer but is not sufficient to initiate cancer. Environmental and lifestyle co-factors are necessary in cervical cancer development. There are 20 HPV viruses associated with cancer and the HPV vaccine only protects against two.

Testing this vaccine in women aged 16–26 years was not an appropriate surrogate because pre-cancerous lesions in this age group rarely lead to cancer.

Conclusions: The benefits of this vaccine have not been established and there are side-effects from the vaccine in an unknown number of women. The inadequacies in the science used to promote this vaccine have serious implications for the health of women.

Do young gay men have specific sexual health needs? results from the online survey How Much Do You Care?

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Objective: To compare sexual risk-taking, testing for HIV/STIs, HIV/STI knowledge, and exposure to sexual health campaigns in younger versus older gay men.

Method: Between April and October 2011, the online survey recruited 920 sexually active HIV-negative men (95% gay identified; 95% originated from NSW/ACT). The sample was divided into 'younger' (459 participants aged 16–26 years) and 'older' men (461 participants aged 27 years and over). All participants answered questions on unprotected anal sex with regular (UAIR) and casual (UAIC) partners in the previous six months, testing for HIV/STIs, HIV/STI knowledge (40-item scale, range 0–10), and exposure to sexual health campaigns.

Results: Younger and older men did not significantly differ in UAIR (40.1% vs. 38.0%) or UAIC (22.7% vs. 25.4%), but younger men were less tested for HIV/STIs (71.7% vs. 95.0%, $p < .001$) and reported lower HIV/STI knowledge (Mean = 5.00 vs. 5.71, $p < .001$). Men who were less knowledgeable were also less likely to have tested (OR = .72, $p < .001$). Knowledge was lower among men less exposed to campaigns promoting either HIV testing (r =. 24, $p < .001$), STI testing (r = .24, $p < .001$) or condom use (r = .16, p <. 05). Significantly, almost a quarter of younger men had not been exposed to campaigns promoting HIV (23.5%) or STI testing (20.5%) compared to lower proportions in older men (15.1% and 14.1% respectively).

Conclusion: Younger gay men reported similar rates of UAI as older men, but their HIV/STI knowledge was lower, and 28.3% of younger men had never tested for HIV/STIs. Increasing the coverage of sexual health promotion among younger gay men may be required.

HIV/STI testing as a sexual health routine among gay men in NSW: results from the online survey How Much Do You Care?

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Objective: To assess the extent to which HIV/STI testing has become routine for gay men and explore characteristics of routine and non-routine testers.

Method: Between April and October 2011, this online survey recruited 920 sexually active HIV-negative or status unknown men (95% gay identified; 64% live in capital city). The sample was divided into 'younger' (459 participants aged 16–26 years) and 'older' men (461 participants aged

27 years and older). Three questions assessed whether men regularly tested for HIV and STIs and had a routine of regular sexual health check-ups.

Results: Almost half of the men (46.1%) tested for HIV and STIs on a regular basis and had routine sexual health check-ups. These routine testers were significantly more likely than non-routine testers to have tested in the last six and 12 months and had done so more frequently. In multivariate analysis, routine testing was significantly associated with older age, having a non-Anglo Australian background, having regular or casual partners and higher numbers of partners. Routine testing was not associated with unprotected anal intercourse with regular or casual partners. It was also not associated with sexual identity, education or living in or outside of capital cities.

Conclusion: Current guidelines recommend more frequent HIV/STI testing for men with higher numbers of partners and for men who engage in unprotected anal sex. However, while findings suggest that men who are more sexual active are more likely to routinely test for HIV/STI, no association was found between routine testing and sexual risk-taking.

Facilitating youth empowerment in youth sexual health promotion

Alischa Ross and Felix Scholz (co-presenters)

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Facilitating the meaningful participation of young people in the development and delivery of STI and HIV prevention interventions is an emerging area of sexual health policy and programs supported by the WHO and the United Nations' frameworks for best practice.

In the past 3 years Australia has seen a 20% increase in the rate of STIs diagnosed amongst people aged 15–29 years. With more than three quarters of nationally reported STIs occurring amongst young people we must find new ways to effectively communicate and articulate in a meaningful way with young people, many of whom have limited or inaccurate knowledge of sexual health risks and how to prevent poor sexual health outcomes.

This project investigates the effectiveness of people aged 17–29 trained in HIV/STI peer-education, to deliver sexual health promotion activities at a national regional music festival to determine if there is an evidence base for scaling-up youth-led sexual health promotion.

Using peer education and social marketing activities, the project facilitated the promotion of positive sexual health messages to 85,000 young people in five regional centres. Using qualitative analysis of the perceptions and experiences of participants, it's argued that methods involving young people are more likely to be effective in directly impacting young people's behaviour.

The analysis contributes to understanding best practices to empower young people to take control of their sexual health. The findings support increased investment in policy and peer-based programs that put young people's leadership at the centre of national responses to youth sexual health.

Immigrant and CALD communities and HIV 3D

Chair: **Shih-Chi Kao**

HIV and sub-Saharan African communities in Australia: questions unanswered

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Since 2005 the number of HIV diagnoses in Australian residents who were born in sub-Saharan Africa has been increasing and in 2010 this group constituted 11.3% of all HIV diagnoses in Australia. In late 2009, the Australian Federation of AIDS Organisations began a series of consultations nationwide with sub-Saharan African communities in order to investigate why this rise might be occurring and identify key care, support, HIV prevention and policy issues. The consultations, which culminated in a national forum in May 2011, involved community leaders, people living with HIV, multicultural HIV/BBV services, and HIV services. They identified that key challenges faced by African PLHIV in Australia include late diagnosis, racism, stigma and discrimination; and immigration-related problems such as financial hardship and difficulty accessing treatment.

Key issues in HIV prevention work are the stigma attached to HIV, mythologies around HIV transmission and illness, and cultural sensitivities around talking about sex. Key policy issues relate to immigration, Medicare ineligibility and the disproportionate representation of African men among people who are prosecuted for the knowing transmission of HIV.

The consultations also identified gaps in our knowledge and raised a number of questions, such as where and why people are becoming infected, how to best address stigma, how to enhance social research in this population without exhausting small communities, and why African men are over-represented in criminal cases. This presentation will explore these questions, with reference to the experience of the African diaspora in other developed countries.

HIV among CALD communities in Australia: articulating ways to frame the ‘problem’

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HIV among immigrants from low- and middle-income countries is increasing in many high-income countries around the world, including Australia. Over the past 10 years the HIV situation among CALD communities in Australia has gained traction in response to an upward trend in notifications. In 2010, people born in Asia and sub-Saharan Africa accounted for 26.2% of HIV notifications nationally. Despite some progress in addressing HIV among CALD communities, we still lack a clear articulation of the ‘problem’ and this hampers our efforts to build our response to HIV with these populations. This paper argues that there are a number of areas where our framing of the HIV situation among CALD communities lacks clarity including how we define the term CALD in an HIV context, the place of ethnicity in targeting our health promotion efforts, the significant changes to Australia’s immigration program, and the challenge which HIV among CALD communities poses for existing paradigms of programmatic work to address HIV. The paper concludes with recommendations for a clearer articulation of the HIV situation among CALD communities as one of the steps needed to make progress in addressing HIV among these communities.

Endangering life

Barbara Baird[1] and Anne Bourne[2] (co-presenters)

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This paper examines a recent, prominently reported South Australian case of the imprisonment of an HIV-positive man of African background for ‘endangering life’. The case sits against the background of the uneven prosecution of HIV-positive people who transmit the virus and the calls for reconsideration and reform of the use of the law in the case of transmission of HIV (AFAO, 2011; NAPWA, 2009). Arguably this case sits outside the boundaries of those considered previously because in this case there was no transmission of HIV. Nevertheless it included many of the features that have been elsewhere documented as part of the criminalisation of HIV transmission, including significant ignorance in the court of the nature of HIV and its transmission. The case dealt with the claim that the man put three women’s lives at risk. Our account of the case brings together the story of this man’s life in Africa and as a refugee, the cultural context of his HIV diagnosis and the gendered and racialised discourses through which sexual lives in contemporary Australia are understood. It pays particular attention to those stories which were silenced and contrasts the simplistic accounts of guilt and innocence that characterised the court and media pursuit of the case with a more complex account of subjectivity and local and global sexual politics.

We argue that careful attention to the intersecting discourses of sexuality, gender and race in this case sheds light on the broader canvass of contemporary sexual politics in Australia.

Lest we beget: HIV, immigration and national protection

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Introduction: In 2007, two criminal cases involving allegations of HIV exposure received nationwide media coverage. Simultaneously, comments by then PM John Howard regarding the case sparked a national debate about immigration to Australia of PLHA.

Methods: A search of newspaper databases and online versions of all major Australian newspapers for the period January to October 2007 was conducted and articles, letters, online comments and blog posts in relation to the Neal and McDonald cases and the issue of HIV and immigration were identified. Media monitors for the period May to August were also reviewed for coverage of the immigration debate. Material was analysed for key themes and relative weight of coverage for each issue.

Results: Despite the intense media fascination with the Neal and McDonald cases, public interest appeared low. In contrast, the HIV and immigration debate elicited widespread comment and debate, much of it hostile, and an internationally reported ‘germ panic’. The form of the debate suggests that HIV in the Australian popular imagination has been discursively quarantined to the ‘territories’ of ‘gay community’ and ‘Africa’, producing a heterosexual complacency about HIV which was deeply shaken by the prospect of HIV-positive immigrants being allowed into the country.

Implications: ‘Rational’ public policy stances in relation to HIV and immigration stand in contrast to popular anxieties about contagion, contamination and territorial integrity. Opposition to immigration of PLHA is by no mean universal, however, and may be able to be reduced through social marketing and media strategies.

Plenary

The politics of establishing the Medically Supervised Injecting Centre

4

Chair: **Bill Bowtell**

The Hon. John Della Bosca has been invited to give his personal perspective on the establishment of the Medically Supervised Injecting Centre (MSIC) in Kings Cross.

By the late 1990s, Sydney was witnessing an unprecedented number of heroin-related overdose deaths. Highly visible, street-based injecting around inner-city Sydney and the risks associated with this practice had become a daily reality for local residents. The establishment of an MSIC was one solution to this growing problem. However, the idea of an MSIC was politically charged. The saga that evolved included representatives from the Vatican to State and Federal political leaders and local Kings Cross constituents. Something had to be done.

John Della Bosca

Former Special Minister of State for NSW

Campaign Director, National Disability Insurance Scheme

5 Plenary

Chair: **Peter Aggleton**

Privileging researchers: knowledge brokerage, policy processes and implications for other voices in the illicit drug policy landscape

Alison Ritter

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The notion of 'knowledge broker' has been used to describe activities that link decision-makers with researchers. This paper will explore current understandings of knowledge brokers in the context of the evidence-informed policy movement, with reference to illicit drugs policy. The role of research is central to evidence-informed policy but how research is translated and taken up in policy decision-making is highly variable. In this paper I will describe aspects of research translation, discuss the many modalities for dissemination and influence, and consider what works in relation to effective research translation. A crucial aspect of the knowledge broker conceptualisation is the reliance on relationships and interactions between the parties.

The knowledge broker approach, however, does presume that we understand who is knowledgeable and about what. Certain types of evidence are privileged within the framework of evidence-based policy and knowledge brokerage. In addition, it assumes a particular model of policy processes that is largely technical and rational. While illicit drug policy in Australia is formally articulated within successive National Drug Strategies that suggest a largely technical approach, in reality there are complex decision-making processes, structures of governance and numerous actors within illicit drug policy including the state, international regulatory bodies, interest groups, researchers, the third sector, and the affected community. In this paper, I consider more fulsome models of policy making that supersede a technical rational understanding. Finally, it is important to consider where the knowledge broker model and evidence-based movement positions the other voices in drug policy such as interest groups, the third sector and the general public.

Power, rights and citizenship in the age of biomedical prevention

John Godwin

HIV, law and development consultant
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Biomedical prevention approaches are commanding unprecedented attention, with language evolving to articulate new strategies: TasP, PrEP, MPTs and Treatment 2.0 are being assimilated into the vernacular of the HIV sector. Human rights advocates also need to expand our conceptual vocabulary. A medicalised response to HIV prevention potentially silences agendas that focus on social context, rights and empowerment. This paper will respond to this challenge by reflecting on the utility of embedding concepts of legal empowerment and moral citizenship in our thinking—concepts that can assist in articulating a law reform and policy agenda that keeps pace with and potentially optimises biomedical advances.

Legal empowerment requires a process of systemic change through which socially excluded populations are enabled to use legal systems to advance their rights. Legal empowerment is a public good: it renders governments more accountable. However, unlike public health, states may have an incentive to obstruct legal empowerment, because it challenges state power.

Moral citizenship describes individuals' sense of their right to full and equal participation as members of society; a sense of positive entitlement produced by eliminating criminal penalties and structurally entrenched discrimination.

This paper will illustrate the application of these concepts to advancing human rights and public health outcomes. Systemic discrimination and legal marginalisation of people living with HIV, sex workers, people who use drugs, refugees, MSM and transgender people are experienced across the Asia Pacific region. Recently, a submission was presented to the Commonwealth to define a law reform agenda in the context of Australia's national strategies on HIV, STIs and blood-borne viruses. The UN is also seeking to define a new agenda for action on human rights and HIV in Asia and the Pacific. While the strategic deployment of biomedical prevention approaches holds great promise, their full potential will not be realised until community mobilisation, human rights and legal empowerment, critical enablers of the HIV response, are also addressed.

SESSION 6 Parallel presentations

FRIDAY: 10.45–12.30

Proffered papers

6A Sex work

Chair: **Elena Jeffreys**

How moral pressures and flawed implementation of decriminalisation reintroduced risks to the sex industry in NSW

Rigmor Berg[1] and Julie Bates[2]

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Australian experiences have shown that decriminalisation reduces HIV/STI risk in the sex industry (LASH Report), but there is evidence in NSW that flawed implementation and pressure from community groups with “morality” objectives have created new reasons for risks.

Drawing on findings of a services gap analysis conducted for the HARP (HIV and Related Programs) Unit of South Eastern Sydney and Illawarra Area Health Service, ICAC findings and observations as consultants providing advice in relation to development applications for SSPs and expert evidence in the NSW Land & Environment Court, we conclude that:

- In NSW, decriminalisation was legislated with the objectives of breaking the link with organised crime, removing opportunity for corruption of police and improvement of the sexual health of sex workers
- Local government was given substantial regulatory responsibility, but the best practice guidelines developed to support this role were never implemented
- Local government Councils, particularly elected Councillors, are sensitive to community lobby groups that oppose all sex services premises development applications
- The low success rate and high costs of getting development approval (DA) for sex services premises (SSPs) results in many operating with inappropriate DA (massage) or no DA, which in turn creates disincentive to have condoms on the premises (evidence of sex work), creates opportunity for corruption of Council Compliance Officers and makes access to SW by health promotion workers and WorkCover difficult
- Prohibiting home occupation SSPs and restricting SSPs to industrial areas both increase risk of harassment, coercion, violence, rape and robbery.

Adult/Asian Cam Models (ACMs) in the Philippines: health implications and advocacy

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Objective: To describe the working conditions of ACMs, a new industry of which we know almost nothing, and the sexual behaviour of ACMs. To assess the effects of this work on ACMs’ health.

Method: Long-term ethnographic study of 50 ACMs, interviews, and three case studies.

Results: ACMs sit for 8–12 hours in front of a PC, 6 days a week at various times of the day/week. They suffer from a lack of exercise, obesity, poor diets and sleep patterns, eye strain, headaches, etc. Many are single mothers who limit breastfeeding of their children to maintain their sexual appeal, and respond to frequent salacious and denigrating comments. Although not susceptible to STIs from virtual clients, they can be infected with thrush etc. by sharing sex toys. ACMing is also a means of meeting clients in real with the intention of non-virtual sex. As with other sex-workers in Asia, few are aware of or able to enforce safe sex practices.

Conclusions: We know very little about this industry, its conditions, the girls' sexual behaviour, how these impact on the physical and mental health of the girls, or lead to real-time sexual encounters for which they may be unprepared. For several reasons, the ACMs are unable to organise or advocate for better conditions and education; and because the activity is illegal and stigmatised, it is difficult to obtain information about their industry and experiences to enable advocacy or promote safe sex practices.

Long-term clients who access commercial sexual services in Australia

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The aim of this qualitative study was to present the long-term client's experiences of buying sex. The study further investigated the motivations to buy sex, the risks and benefits, and the self-identity of clients, their feelings about sex workers and their perceptions of other sex industry clients.

Online advertising for recruitment prefaced participants answering a semi-structured questionnaire and writing a narrative, within a guided framework, to allow them to identify the important issues. An online survey site was used to offer participants anonymity. Data was analysed using an interpretive phenomenological approach.

The results highlighted men's motivations to buy sex as seeking intimacy, sexual variety and convenience. Their strategies to distances themselves from deviant stereotypes were illustrated by their behaviour in regards to money, sexual etiquette, their feelings and treatment of sex workers, fear of STIs, and through the expression of their opinions about other clients of sex workers. The results include men's feelings of gratitude and respect toward sex workers and their social and political beliefs about the sex industry.

This study is an overview of how paying for sex affects consumers and provides a better understanding of the phenomenon of men who buy sex. Due to stigma and discrimination, sex industry clients are reluctant to present themselves to challenge current stereotypes, which are fuelled by moral philosophies that are not supported by peer reviewed published research. It has political significance which may affect sex industry laws and regulations, and may influence sexual health practitioners who service these clients.

Maintaining sex workers as HIV leaders = "same old bold targets"

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The Australian experience in HIV prevention among sex workers is a success story, with HIV and STI rates below that of the general population. However, while the National HIV Strategy recognises the need to maintain this success in 2012 we question where this goal will sit alongside the bold new targets of the UN Political Declaration on HIV/AIDS 2011 including a 50% reduction in new HIV transmissions and the appeal of 'treatment as prevention'.

Maintaining low rates of HIV and STIs amongst sex workers relies not on new targets, but on more than a decade old bold targets: full decriminalisation; funded peer education and peer-led programs; human rights; and national indicators to demonstrate the success of this work against the National Strategies. These components will ensure the continued success of HIV prevention amongst sex workers in Australia.

While these targets that are self-determined by sex workers are widely accepted as best practice, they are far from achieved. In fact 2012 finds us with a potential back slide as laws, proposed laws, and policies across Australia threaten to leave large sections of sex workers in Australia criminalised. Instead of supporting sex workers, policies, are being introduced to further stigmatise and criminalise us. As the evidence shows, this type of disabling policy environment increases vulnerabilities to HIV.

So Australian sex workers do not have “bold new targets”; we have the “same old bold targets” that have yet to be achieved anywhere and new threats which are likely to risk rather than protect and maintain our success.

Proffered papers

6B Hepatitis C health promotion and prevention

Chair: **Hannah Wilson**

The shaping of hepatitis C prevention messages in Australian educational print resources

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Introduction: The provision of prevention information to people who inject drugs is a key component of the Australian hepatitis C response. However, the substance of prevention messages and how they are produced and targeted is an area that has not undergone much detailed analysis. We aimed to review the types of messages included in existing print resources and identify factors contributing to the shaping of these messages.

Method: 159 print resources, produced between 1990 and 2010, featuring information relating to hepatitis C prevention in the context of injecting drug use were collected from community organisations. Key prevention messages were documented and analysed to identify factors which contributed to their shaping, paying attention to elements such as language, tone, imagery, absences, assumptions, presentation, audience inclusions or exclusions and contextualisation.

Findings: Messages primarily directed readers to not share injecting equipment and be conscious of blood transference. Commonly utilised concepts such as ‘blood awareness’ lacked explanation. Responsibility for prevention was framed individually; this combined with the addressing of an individual reader served to ignore the often social nature of drug consumption. Further, the influence of social, structural and environmental factors was rarely considered.

Conclusion: Hepatitis C prevention messages should seek to avoid blame and consider the social, structural and environmental contributions to transmission and injectors’ experience. Contextualising messages within the diversity of injectors’ experience and reframing prevention responsibility may aid in renewing relevance to specific sub-groups.

“10 pack please, and can you have a look at my…..?”

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Despite having a range of sexual health needs, people who inject drugs are under-represented in sexual health clinics.

A research project was commissioned by South Eastern Sydney and Illawarra Area Health Service (SESIAHS) to identify those factors that acted as barriers for people with a history of injecting drug use (IDU) when accessing HIV/AIDS and sexual health services in the area health service.

The IDU gap analysis explored the characteristics and needs of people who inject drugs, in order to identify the reasons why they may not be utilising local HIV and sexual health services. It also assessed their levels of knowledge and understanding around HIV/AIDS and sexually transmitted infections (STIs) as well as the services available in SESIAHS for information and treatment.

The recommendations from the analysis covered the following areas:

- To increase peer involvement
- To establishing innovative models of service delivery
- To reorientate current service delivery
- To promote sexual health services within IDU networks
- To foster cross agency workforce development

A number of key agencies within the Central Hospital Network (CHN) came together to oversee the implementation of the research recommendations. The aim of the working group was to develop a local action plan that addressed the key action areas above and to establish cross agency coordination through a project working group.

The project has led to increased access to HIV/STI services for people who inject drugs, the strengthening of partnerships across the CHN sector, outreach sexual health clinics in NSPs, workforce development and social marketing strategies.

The Jailbreak Radio Project develops innovative health promotion strategies for radio

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Although radio is not unusual as a tool for health promotion in the general community, the Jailbreak Radio Project has a unique opportunity in a national role in reaching isolated and vulnerable high-risk populations. Australia’s Community Radio Network (CRN) enables delivery of information about harm and exposure minimising practices around blood-borne viruses (BBVs) and sexually transmitted infections (STIs) for prisoners without access to Needle Syringe Programs (NSPs). Jailbreak strives to navigate the physical and the philosophical barriers and challenges facing people in Australian prison systems.

The challenge for Jailbreak is developing health promotion for radio which is therapeutic, credible, relevant and culturally appropriate and strives to overcome the social obstacles of shame, stigma and societal prejudice. Prisoners often experience social, health or economic disadvantage or have linguistically or culturally diverse backgrounds. Jailbreak therefore seeks to look beyond what is said by the community, bureaucrats, custodians, politicians and professionals and explores what's often not said by people (and what is or may need to be said) with lived experiences of both injecting drugs and incarceration.

The Jailbreak Radio Project uses innovative strategies in partnership with relevant communities and individuals to produce culturally appropriate, autonomous messages for radio and voices who tell their stories and lived experiences. Research in the development of a national current updated information service is recommended to guide health promotion development, particularly related to harm and exposure minimising practices in HIV and hepatitis C transmission in the prison environment across the states and territories of Australia.

How to make your website more accessible and socially inclusive

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Governments, businesses, educational and other organisations in Australia use the web to provide the public with access to information and other services in a timely and cost-effective way. Providing information and services via the web has the potential to provide access more broadly, more cheaply and more quickly than is possible using other formats. However, the presence of a document or service on the web does not guarantee accessibility nor make it inclusive of marginalised populations.

In 2008, the MHAHS conducted a usability study of its website to understand its visitors' perceptions of the site as well as identify ways to improve its virtual environment.

This paper will highlight some of the key challenges in implementing the study's findings to develop a more accessible and inclusive website. It emphasises why organisations should adopt the creation of inclusive web content as an integral part of their overall web design and urges considered inclusion of marginalised populations in designing organisational websites. It advocates online social responsibility and highlights the fact that designing accessible and inclusive websites is as much a strategic issue as a purely technical one.

In custody: do I disclose or not?

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Screening for blood-borne viruses (BBV) and sexually transmissible infections (STI) is not mandatory in NSW Correctional Centres. Despite years of education around such things as transmission risks, prevention measures, rights to health care and confidentiality there remains a great deal of ignorance or fear around the subject. Some will choose not to disclose status, particularly HIV, in the belief they will be the target of differential treatment by staff and other prisoners. Public Sexual Health Nurses, employed by Justice Health, offer screening for BBV and STI. The nature of the pre-test discussion allows the patient to choose whether or not to openly discuss current drug use or sexual practices or disclose status (HIV, HCV, HBV). The challenge for nurses is to ensure the patient is appropriately counselled and advised of their options so they can make well-informed decisions. If patients disclose that they are engaging in unsafe practices nurses must work with them to ensure they are fully aware of their responsibilities around not putting others at risk while still protecting their rights to confidentiality.

When situations occur where there is evidence, or a strong belief, that unsafe practices are occurring, decisions have to be made about when to more actively intervene to prevent patients from knowingly putting others at risk. Active intervention, with partner agencies, is a final course of action and must be considered carefully, with staff weighing up the public health risks against the patients' rights in determining if intervention is necessary

Gay men, HIV, health issues 6C

Chair: **Toby Lea**

Experiences of being gay: data from the Health in Men Study

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To determine the differences in the ages of first homosexual contact, first anal sex, and 'coming out' in men born in different time periods, and to explore whether there is a difference in the number of lifetime sexual partners.

The Health in Men study recruited 1,427 men from June 2001 to December 2004. Differences were compared in men who were born before 1955, 1955–1959, 1960–1964, 1965–1969, 1970–1974, and those who were born after 1975. The lifetime number of sexual partners was compared among these birth cohorts adjusted for the duration of their sexual careers.

The age of having first homosexual contact did not differ at around 17 years in men of all birth cohorts. However, the age of first anal sex decreased significantly from 24 years in men born before 1955 to 18 years in those born after 1975 ($p < 0.001$), as did the age of coming out, from 25 years to 17 years across the birth cohorts ($p < 0.001$). Not surprisingly, the lifetime number of sexual partners increased with the duration since first sex. Nonetheless, after adjustment for duration of their sexual careers, there was little difference in lifetime partner number among men born in different time periods.

Differences in the experience of being gay for men born in different time periods might be a reflection of attitudinal changes towards homosexuality in society. Regardless, men commenced homosexual contact at a similar age over time and reported similar numbers of lifetime sexual partners for the relative length of their sexual careers.

Exploring professional and layperson perspectives on the needs and service engagement of HIV-positive South Australians

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Introduction: The grassroots community movement is considered an important part of Australia's successful HIV response. The modern context for HIV has changed since the advent of antiretroviral therapy. This raises questions unanswered in Australian literature about how HIV-positive people engage with and experience services at community organisations, and how contemporary need is met. Positive Life South Australia approached Flinders University to develop a client survey tool with the aim of addressing these questions.

Methods: A sequential mixed methods study was undertaken. In depth qualitative interviews were conducted with HIV community service providers and Positive Life SA members. Themes from the qualitative data informed the construction of a valid questionnaire tool. Bradshaw's taxonomy of need was a conceptual framework used to guide the comparison of both lay person and professional views on need.

Findings: Need was identified and discussed by participants in three main areas:

1) Wider social environment and policy need: stigma and discrimination, ageing, and mainstreaming of services

2) Basic human needs: housing, financial insecurity, and transport

3) Service gaps related to particular groups: cultural barriers, logistical barriers, and the needs of minority groups

Conclusion: The research gave valuable insight into the complex and individual nature of the HIV experience. Need cannot be adequately explored without considering the historical context of HIV. Health promotion can be an abstract concept for lay people and professionals. This can present a barrier to HIV-positive people accessing organisations when they are more familiar with direct service delivery.

Prudent homosexuals

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Many of the technologies with which gay men engage to find sex presume a predictive subject who knows what he wants and when and how he will get it. The internet is an obvious case in point, with its invitation to pre-specify in meticulous detail precisely the pleasures one is seeking or in which one will even consider participating. The point could be extended to other techniques and technologies that have taken shape in the context of HIV risks inter alia: from the complex regimes of preparation engaged in by the partying subject, which turn partying into a form of administration, to the foresight presumed of the intermittent doser who is currently the subject of international PrEP trials. This paper asks initially what such technologies presume of the sexual subject and the sexual encounter, and whether such presumptions are fitting. It considers alternative ways of conceiving the encounter that take some of the weight off notions of intentionality, sovereignty, prediction, and control that otherwise overburden the subject of pleasure/risk. How can we conceive of practices of preparation in the vicinity of risk that do not revert to the sovereign subject? Are there other ways of approaching 'the encounter' that predispose the subject more adequately to the pleasures and risks of indeterminacy? The answer to these questions, this paper suggests, involves further thinking about notions of 'articulation', 'event' and 'encounter'.

Gay men: personal, community and health services barriers to sexual health testing

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Introduction/objective: In 2010, Queensland recorded the highest number of people newly acquiring HIV since it became notifiable in 1984. With the current National HIV Strategy 2010–2013 placing a strong emphasis on promoting sexual health testing, the Queensland Association for Healthy Communities, alongside other key stakeholders, has been engaged in a number of projects to investigate specific determinates of testing for gay men and other MSM. As well as trialling the validity of incentive-based promotion for testing within Sex On Premises Venues (SOPVs).

Methods/approach: Key approaches include the implementation of an HIV/STI testing promotion aimed at encouraging test-naïve or infrequent testing SOPV patrons to access mainstream clinical services in the Brisbane area. Additionally, a statewide survey recruited 390 men online and at gay venues to gather behavioural data around motivators and barriers to gay men's testing.

Results/findings: While SOPV Testing Project is due to conclude at the end of March 2012, initial findings from the project and survey results indicate that the strongest motivation to testing remains engaging in a risky event.

Conclusion/implications: In order to increase STI testing among gay and other MSM and to slow the rates of new cases of HIV and other STIs, new interventions must be implemented that can overcome the impediments to testing. The presentation will cover the range of motivators explored as well as some of the personal, community and health service barriers to gay men's testing.

What is PrEP for gay men? exploring HIV-negative gay men's understandings of pre-exposure prophylaxis

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Introduction: In 2010 an international trial reported that pre-exposure prophylaxis (PrEP) significantly reduced the risk of HIV infection among men who have sex with men. The Centers for Disease Control and Prevention in the USA has produced interim guidelines for its use. Despite these developments the response to PrEP in Australia has been relatively muted.

Approach: Interviews were conducted with 15 HIV-negative gay men in Sydney. The interviews explored their understandings of PrEP, current risk reduction strategies, attitudes to condoms and biomedicine. This paper focuses on how PrEP is constituted by the research participants and therefore what PrEP might do within the current HIV prevention milieu.

Findings: The majority of participants had very little knowledge of PrEP. Many of the men were interested in PrEP but indicated that factors such as effectiveness, cost, mode of delivery, and the sexual contexts in which it could be used would influence their future decisions about use. Participants believed it should be made available and that cost should not be a barrier. Only a minority of participants believed that PrEP would lead to an increase in HIV risk behaviours or make it more difficult to negotiate sex, including condom use.

Conclusion: PrEP is currently an abstract concept for gay men in Australia, understood as in the future rather than as an already 'present' biomedical technology. These findings highlight the need for greater openness and discussion about PrEP with gay men as well as a consideration of the ways in which PrEP could be successfully integrated into the Australian HIV prevention landscape.

6D Critical reflections on drug treatment policy in Australia and the UK: addiction and recovery

Chair:
Carla Treloar

Presenters:
David Moore
Jo Neale

Discussants:
Marianne Jauncey
Sione Crawford
User of drug treatment services

Drug treatment policy is a complex interplay of many competing forces. However, frequently policy (and its language of implementation) is fore-shortened to provide focus on specific issues. The implications of this narrow focus can be unanticipated consequences. In this symposium the nature of consequences experienced at individual, worker and systemic levels will be explored through a focus on two phenomenon of Australian and UK drug treatment policy. In Australia, the structure of health care delivery drives treatment and care in specific ways to ensure services receive funding. What is addiction and who is addicted under these structures requires careful examination to understand the cascade of implications, particularly for those who seek such services. In the UK, a new drug and alcohol recovery agenda has emerged with proponents urging others to get close to it, catch it and pass it on. This begs the question, what is recovery and what will be the implications if recovery contagion reaches Australia?

In this session, two keynote presentations will be delivered. These will be followed by responses from a clinician, a drug user advocate and a user of drug treatment services. There will also be opportunity for delegates to engage with the panel in a discussion of the issues relevant to the Australian drug treatment sector.

Episodes of care and the production of 'addiction': alcohol and other drug treatment provision in Victoria

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Introduction: Health service provision in all areas including dependence is generally understood in the following way: identify a health problem, mobilise medical knowledge, design treatment services, treat 'sufferers' and ameliorate the problem. Contrary to this view, we argue that the 'problem' of addiction emerges as both the precursor to, and the effect of, treatment service provision.

Approach: This paper draws on the work of Marrati (2006) and Deleuze (1994) on the constitution of 'social problems', and on 20 in-depth interviews with health policy makers and practitioners in Victoria, Australia.

Findings: The interviews suggest that the 'episode of care' system governing service activity, outcomes and funding relies on certain notions of 'addiction', 'treatment' and 'progress' that compel service providers to designate service users as 'addicts' in order to receive funding. Addiction is treated in policy as a serious problem, so people seeking help for cognate but less well serviced issues, such as depression or other mental health problems where substance use is evident, are often assigned addiction labels to facilitate access to treatment. Their problem becomes that of 'addiction', and they enter into record-keeping and epidemiological systems of measurement in these terms.

Conclusion: Rather than merely treating pre-existing 'addicts', the system works to produce 'addicts' as an effect of policy imperatives. Individuals enrolled in this service provision regime come to be labelled, and counted, as addicts. As 'addiction' comes to be produced by the very system designed to treat it, the scale of the problem appears to grow rather than shrink.

The rise of the UK recovery agenda: strengths, weaknesses, opportunities and threats

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The emergence of the recovery agenda in the UK is evident in policy documents, changes to service delivery and a strong recovery movement led by drug users themselves. Terms such as ‘recovery capital’, ‘recovery communities’, ‘recovery champions’, ‘recovery activities’, and ‘recovery care plans’ are now routinely used, although there is still confusion over what the term ‘recovery’ actually means. For example, some use it interchangeably with ‘abstinence’. Others argue that recovery is not simply about taking or not taking drugs: it is instead about drug users achieving benefits in a wide range of life areas. Furthermore, recovery means enabling individuals to have aspirations, feel that they are part of society, and lead more fulfilling lives. This presentation will review some key strengths and weaknesses of recovery as it has evolved in the UK. It will also consider some of the opportunities it offers alongside the threats it poses, particularly in relation to harm reduction services. To conclude, some thoughts on how we might benefit more from the inclusive principles of the recovery agenda if we reject the word ‘recovery’ are suggested.

Proffered papers

(Re)emerging issues in the gay community 6E

Chair: **Asha Persson**

Intensive sex partying associated with risk of hepatitis C

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Background: Sexual transmission of hepatitis C (HCV) is believed to be responsible for emerging epidemics of HCV infection within networks of HIV-positive gay men.

Methods: We conducted semi-structured interviews with 18 HIV-positive gay men diagnosed with acute HCV co-infection in Sydney and Melbourne. Interview topics included: men’s sexual and drug-using practices; structural and subcultural contexts in which risk behaviour occurs; and attitudes toward risk.

Results: Commonly, men’s accounts of their HCV acquisition involved intensive sex partying including: frequent sex with multiple partners (mostly of the same HIV-positive status) usually involving unprotected anal intercourse, and adventurous sex practices. As HIV acquisition was no longer an issue for these men, they often pursued a heightened, more intense sexual experience, usually unaware of the risk of HCV, or the implications of co-infection.

Conclusions: A lack of community awareness of the potential for HCV to be transmitted through sexual contact appears to be contributing to its ongoing transmission within some networks of gay men. Further, although men who engage in intensive sex partying may often be equipped with tools to reduce the risk of transmission of HIV to their partners, this may not apply in the case of HCV. In the absence of relevant and appropriate information, the men's pleasure-seeking activities may often place them and their partners at high risk of HCV infection. For men engaged in intensive sex partying, the relative balance between risk and pleasure may make any decisions about risk reduction in relation to HCV very difficult.

At the intersection of two marginalised identities: lesbian, gay, bisexual and transgender people's experiences of injecting drug use and hepatitis C seroconversion

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Introduction: Although international research shows higher levels of injecting drug use and hepatitis C virus (HCV) infection among lesbian, gay, bisexual and transgender (LGBT) populations, there is limited social research on the experiences of LGBT people who inject drugs or live with HCV.

Approach: An Australian qualitative study of understandings and experiences of HCV in people provided an unexpected data set of 8 LGBT injectors living with hepatitis C. This paper presents findings of an opportunistic thematic analysis of these data.

Findings: We argue that same-sex relationships as a social context for injecting has important implications for health promotion and health provision around risk reduction practices, understanding initiation to injecting, injecting as a relationship practice in creating intimacy, and relationships as a source of support during HCV or drug treatment. Many of our participants described tensions around their place in two communities, an LGBT community and a community of people who injects drugs. The loss of connection to a chosen community means the absence of vital support networks which may place additional stressors on those considering HCV or drug treatment.

Implications: We argue that meeting the needs of this population involves health professionals developing relationships with LGBT community health organisations, and developing capacity in providing LGBT health care, while LGBT community organisations must raise awareness of hepatitis C in LGBT communities. It is vital that we reduce stigma and potentially negative consequences for people whose experiences exist at the intersection of these two marginalised identities.

What moves a general practitioner to specialise in HIV? Interviews with 'key informants' from government, non-government and professional organisations

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Introduction: HIV care is provided in a range of settings in Australia, but advances in HIV treatment and demographic and geographic changes in the affected population and general practitioner (GP) workforce are testing the sustainability of the special role for GPs.

Methods: We conducted semi-structured interviews with 24 professionals holding senior positions in government, non-government and professional organisations that influence Australian HIV care policy to explore their perceptions of contemporary issues facing the HIV general practice workforce in Australia.

Findings: These key informants characterised GPs as being 'moved' to take on or maintain the role of HIV general practice doctor by a distinct set of clinical, professional and political factors. Each of these dimensions was represented as essential to the engagement of GPs in HIV as an area of special interest, although the political dimensions were often described as the most distinctive compared to other areas of general practice medicine.

Implications: Understanding the factors which contribute to shaping the contemporary 'culture of HIV medicine' may also be useful for understanding how health professionals become engaged in other under-served areas of medical work.

Attitudes towards hepatitis C and perceptions of hepatitis C risk practices amongst gay men

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In Australia, hepatitis C (HCV) is most commonly transmitted through injecting drug use. Less clear are the primary causes of transmission specific to gay and bisexual men. Shifting notions of safe sex, HIV transmission risk and the sexual cultures of some gay men further complicate these issues. Because of the relationship between drug use and high-risk sexual practices, it can be hard to determine the factors responsible for transmission of HCV. Nonetheless there is emerging evidence of increases in the sexual transmission of HCV among gay men, particularly among men who are HIV-positive. Five hundred and ninety participants completed an online survey assessing a range of variables including perceptions of HCV risk, HCV knowledge and attitudes towards people with HCV. Overall the findings of this study show that gay men have relatively good knowledge and awareness of HCV transmission including the risk of sexual transmission. The sample was divided into three groups, HIV-positive ($n = 106$), HIV-negative ($n = 366$) and never tested ($n = 101$) with 17 who had been tested but did not know their status removed from the sample. Comparisons across the groups reveal differences on a range of items. The HIV-positive group was the most socially inclusive of and least likely to stigmatise people with HCV. They were also most likely to engage in sexual practices that put them at risk of contracting HCV. These findings are discussed in light of the significant health issues and more rapid disease progression which may be associated with HIV and HCV co-infection.

Negotiating invisible boundaries: re-positioning the positive voice in HIV health promotion and prevention

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Introduction: HIV is articulated in a number of contexts (in government health initiatives, health-communication, research and popular culture) and has taken on a cultural life that is quite complex. These cultural constructions not only frame the way people understand HIV or experience their diagnosis, they also produce a narrative story line of what it is to be living with HIV.

Over time the experiences of HIV-positive people have been reduced to clinical markers, risk practices and disease statistics. HIV prevention and health promotion must continually re-negotiate the privileging of certain lines of enquiry (what is emphasised and what is muted) in order to be effective.

There are now new challenges for HIV-positive people to maintain their position at the centre of contemporary discourses on HIV.

Approach: Drawing on the health promotion and prevention programs of Positive Life NSW (2008–2012) this paper will investigate the cultural practices produced by HIV-positive people to respond to and manage (over time) an HIV-positive diagnosis. It will also describe the narratives and silences that shape these practices.

Findings: By opening up for discussion the social, institutional and subjective spaces which they occupy daily HIV-positive people not only make explicit the invisible workings of culture (what has been emphasised, excluded or sidelined), but also, reaffirm the positive voice in health promotion and prevention.

Implications: This analysis mobilises alternative practices (cultural, political and social) to articulate the shifting priorities of an HIV diagnosis and to negotiate the silences at play in health promotion, prevention and policy.

Heterosexuality, HIV, serodiscordance 7A

Chair: **Pene Manolas**

‘Straight’ men and ‘gay’ clinics: the changing cultural politics of Australian HIV health services

Christy Newman, Asha Persson and Dana Paquette

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Introduction: HIV has mostly affected gay men in Australia, and so the general practice (GP) and sexual health clinics which hold the most expertise in HIV medicine have typically developed as ‘gay friendly’ environments. Increasing rates of heterosexual transmission mean these services need to also be accessed by heterosexual men and women, but little research is available on how HIV health services are perceived to target (or potentially exclude) different client groups.

Methods: We conducted a secondary analysis of qualitative interviews with GPs who provide HIV care, key informants who shape HIV care policy, gay men who access care from high HIV-caseload GP clinics, and HIV-positive heterosexual men, focusing on the various meanings that these participants attribute to HIV health services in terms of who they are perceived to serve.

Findings: Whether involved in their planning, provision or use, participants shared a belief that Australian HIV health services can often be culturally ‘branded’ as exclusively addressing gay men. Particular narratives dominate, including that heterosexual men are fearful of being seen as gay if attending a high HIV-caseload clinic. However, a more complex range of perceptions were actually evident here, which tend to be obscured by certain assumptions on all sides.

Implications: While HIV care was originally mobilised through the energies of the gay men’s health movement, the changing epidemiology of HIV demands that closer attention now be paid to understanding tensions and differences in the perceptions of whom HIV health services are for.

“There’s really no community group that deals to heterosexuals who play blood sports, or heterosexuals/bisexuals who engage in promiscuous activity”: listening to NSW non-gay-and-lesbian identified sex/play partiers

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Introduction/objective: This paper draws on research conducted with non-gay-and-lesbian identified sex partiers in NSW, as part of an ARC Linkage partnership with Family Planning NSW (LP0669619). The project aimed to map existing subcultural practices and beliefs in relation to safer sex, in order to inform targeted health promotion resources.

Methods/approach: Researchers conducted 10 key-informant interviews with Sydney-based BDSM and sex party promoters, (including hosts of non-commercial house parties), and surveyed 105 BDSM/sex party guests via an online instrument. Postcodes indicated respondents from Sydney, Queanbeyan, the Blue Mountains, the Illawarra, the Southern Highlands, Orange, Lithgow, Taree and Port Macquarie.

Results/findings: Key-informants revealed high levels of engagement with 'safer sex' as an idea and practice, but also raised concerns regarding stigma, invisibility vs privacy; lack of access to relevant health information; and barriers in both accessing and disposing of condoms, dams, gloves and sharps.

Conclusion/implications: Interviewees and survey respondents experienced tensions between sexual identity and sexual practice. These tensions were most evident at the community level, where party hosts in particular expressed frustration at the lack of relevant sexual health information and material support. Consequently, I suggest that government and non-government services aiming to promote prevention of STIs and BBVs in the 'broader population' should take account of diversity of non-gay and -lesbian sexual practices, given that heterosexual identity does not preclude same-sex practices, 'esoteric' sex, or sex with multiple and/or concurrent partners.

The impact of HIV on meanings of health and wellbeing for heterosexual people with HIV

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Objective: To describe the impact of living with HIV on the health and wellbeing of heterosexual people in NSW.

Method: In 2010 HHAS conducted a needs analysis of heterosexual people with HIV in NSW.

The survey was available online via the HHAS website and was sent to known clients of the service. The needs assessment asked respondents to consider various facets of life including: HIV, health and wellbeing, HIV and health information, HIV services, and participation in service activities.

Results: This paper will focus on meanings of HIV and the impact of HIV on health and wellbeing among the respondents. A total of 37 questionnaires were returned by clients of HHAS or other heterosexual people with HIV in NSW. Meanings of HIV were categorised into three main themes that emerged from the surveys—HIV was a negative experience, HIV had a favourable impact on life, or the 'medicalisation' of HIV. The reported impact of HIV on life was reflective of the meanings associated with HIV, with positive and negative associations. Despite the reported negative meanings and impact of HIV, ratings of health were primarily positive (77%). However, when asked specifically about physical, mental and social health, a different picture emerged with undercurrents of issues related to discrimination, secrecy, stigma and mental health problems apparent among respondents.

Conclusions: While reporting good health, heterosexual people with HIV in NSW do experience negative impacts of HIV on health and wellbeing.

Critical reflections on the concept of risk in serodiscordant couples

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Serodiscordant relationships are increasingly recognised as a key context for the transmission of HIV globally. Yet insights into the dynamics of serodiscordance remain relatively limited. In this presentation, I argue that to understand what makes serodiscordant couples engage in sexual practices that increase the chance of transmission, we need to rethink the idea that HIV "risk" is a universal concept that can be applied across diverse contexts and cultures. The prevailing definition of "risk" in HIV prevention discourse rests on the assumption that HIV plays out in predictable ways in serodiscordant couples and that the couple members always perceive their respective HIV status in terms of their "difference" from one another, a difference which they recognise as posing a distinct kind of "risk", which they are deemed to manage competently or not. This assumption predetermines serodiscordance and thereby obscures its many and complex enactments. I draw on research literature to consider how serodiscordance is shaped in different ways by local practices, priorities, and meanings. It is within these lived contexts that perceptions and negotiations of "risk" arise and, thus, where couples' sexual practices need to be situated and understood. This rethinking is timely as HIV research and prevention grapples with emerging scientific data that challenge long-standing understandings about HIV transmission risk.

Proffered papers

Drugs, addiction, harm reduction 7B

Chair: **Jake Rance**

Substance use among same-sex attracted young people: associations with minority stress and the 'scene'

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The liberalisation of social attitudes towards sexual minorities in Western societies has led some commentators to claim that same-sex attracted people are experiencing reduced minority stress and diminished interest in the lesbian and gay "scene" of bars and nightclubs. Higher rates of substance use in same-sex attracted people compared to heterosexuals are often thought to be a consequence of minority stress and participation in the scene. For young people coming of age in an era of greater social acceptance, minority stress and scene participation may be less compelling explanations for elevated rates of substance use.

The aim of this paper is to examine the associations between alcohol and other drug use, minority stress, and the scene among same-sex attracted young adults in Sydney.

In 2010, an online survey was conducted with 572 young adults aged 18–25 (including 254 women and 318 men). Respondents were a drug-experienced group (34% had used drugs in the past month). Recent drug use and risky drinking were associated with participation in the scene as well as attendance at straight or mixed licensed venues. However, many drugs were more commonly used on the scene compared to other venues, which may suggest that drug use is more normalised on the scene. Homophobic physical abuse was the only indicator of minority stress associated with substance use. The limited support for the minority stress hypothesis suggests that alternative explanations for high rates of substance use in same-sex attracted young people are needed.

Articulating bodies: addiction and representation

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This paper will consider the conflict between production and consumption values in late capitalist forms of governance, and support the argument that the deviant label of addiction is one method by which this tension is resolved socially. One such outcome of this labelling process is the stigmatisation of those consumers who do not practice normalised patterns of consumption. The example of how the injecting drug user, frequently conflated with the idea of the drug addict, is represented in popular culture as a grotesque, will be argued to be a negative consequence of the normalising and pathologising potential of conflating the cultural with the medical and leaving consumption values unexamined. If these representations are the primary semiotic resources the lay public can employ to discuss and conceptualise issues around illicit drug use, public health, and preventing the spread of blood borne viruses through interventions such as needle and syringe programs, it makes the practical implementation of research and the work of advocacy all the more difficult. When the meanings and value judgments circulating through the public sphere are informed by representations that are both sweeping generalisations and simplistic if not outright incorrect, negotiating through these discourses to achieve desired social and political change is made all the more problematic.

Occupy harm reduction: a story of silence and articulation

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This presentation uses the phenomenon of the Occupy movement as a metaphor for the ongoing social struggle against the monolith of global prohibition and for overcoming the limitations inherent to the medical model of harm reduction. Originally, harm reduction was a grass-roots human rights movement that aspired to effect significant social and political change for users of illicit drugs. It has become a medical model of injecting-related HIV risk reduction. While medical harm reduction has had considerable international success in reducing injecting-related HIV infection rates it is a paradigm that has little relevance to a majority of illicit drug users worldwide. This presentation discusses an evolving discontent with medical harm reduction's priorities, policies and practices by drawing on the work of several theorists from sociology and commentators from the field. It highlights the role of silent resistance in the everyday practice of peer-workers and healthcare professionals as many quietly go about 'occupying' official harm reduction. To its detriment, modern harm reduction policy articulates the fears of the State in regards to blood-borne virus epidemics through injecting drug use while remaining silent about the impact of social inequality and prohibitionist drug policy on the production of drug risk and drug dependence.

Drugs, addiction, harm reduction 7C

Chair: **John de Wit**

“I always disclose. Not explicitly, but it’s certainly implied”: exploring post diagnosis HIV-positive status disclosure to sex partners

Ian Down[1,2], Jeanne Ellard[3], Graham Brown[2] and Garrett Prestage[1,2]

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Background: Disclosure of HIV status between sexual partners is critical to negotiating non-condom-based risk reduction. HIV-negative gay men are less likely to disclose their status to sex partners than HIV-positive men, while most HIV-negative men believe that HIV-positive men should disclose their status to sex partners. How do these perspectives change after HIV diagnosis?

Methods: The HIV Seroconversion Study collects both quantitative and qualitative data from people in Australia who have recently been diagnosed with HIV. Participants are asked about disclosure of HIV status with sex partners, both prior to their HIV diagnosis and since receiving their diagnosis.

Results: Many men reported that the experience of being diagnosed with HIV had challenged their previously held beliefs about the nature of disclosure and responsibility. Overwhelmingly, men expressed a determination not to transmit HIV to their partners. However, this was applied in various ways: while some men chose to be open about their status others remained hesitant, concealing their status to avoid the possibility of rejection and preferring to modify their behaviour to protect their partners. Some men recently diagnosed were still challenged by their new situation and chose to abstain from sex until they felt more comfortable negotiating sex.

Conclusions: Men recently diagnosed with HIV face a challenge in deciding if, how and when to disclose their status to sex partners. They therefore make very different decisions about disclosing their status to sex partners, reflecting their own levels of personal comfort and acceptance of their changed circumstance.

Confidence in HIV-negative status

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Background: To investigate confidence in avoiding HIV among HIV-negative gay men.

Methods: The Pleasure and Sexual Health study was an online survey of 2306 Australian gay men recruited during mid–2009.

Results: 2082 respondents indicated that they believed they were HIV-negative although 16.5% of them had never been tested. Most (85.0%) indicated they were very confident of being HIV-negative, regardless of their testing history, and 66.2% felt it was unlikely they would ever be infected. Almost all men (97.0%) said they very much wanted to avoid infection, regardless of their risk behaviour. Greater confidence in being HIV-negative was associated with not having engaged in unprotected anal intercourse with casual partners (UAIC) in the previous six months (AOR 0.357; $p < 0.001$, having a stronger commitment to avoiding HIV infection (AOR 1.991; $p = 0.002$), being less likely to indicate that they would feel relieved if they were infected (AOR 0.662; $p = 0.001$), and not having engaged in group sex (AOR 0.524; $p < 0.001$).

Conclusion: Mostly, men who had not tested HIV-positive were confident they did not have HIV. However, those who were less confident of being HIV-negative had engaged in sexual risk behaviour, were more sexually adventurous and were less concerned about the possibility of HIV infection. Some HIV-negative men who engage in sexual risk behaviour are also fairly realistic in their assessment of their own risk of infection. Often this risk assessment is tempered by their lack of personal concern about HIV infection.

Making wellness

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Delivery on NSW HIV partnership commitment to ambitious prevention targets requires a reinvention of the prevalent treatments discourse, which is still significantly framed in the mid-90s narrative of toxic treatment and corrosive side effects. This, in turn, positions treatment initiation as ‘descent into disease’ rather than as wellness generating and hence, ideally delayed for as long as possible.

Presenting a persuasive case to HIV+ gay men (GMHIV) requires an effective interactive engagement and I argue that achieving this will require a radical rethinking of our current HIV+ health promotion response.

I identify a key challenge existing in the very different perceptions of wellness, or “living well”, enshrined in the publicly sanctioned provider/client understanding of that term and the much broader range of understandings that exist for the majority of GMHIV whose lives shape at a calculated distance from the community-based program delivery, ostensibly in place to engage them.

I interrogate wellness from the perspectives of service providers like me and HIV-positive gay men like me, discuss the meaning of that pretty standard HIV sector bipolarity and the pervasive silence that surrounds it.

I examine what living well might mean in this context, on whose terms, through what agency, how it’s delivered and under what circumstances and offer some thoughts on prevention/health promotion program potential. I conclude with a brief examination of the under-valued and over-pathologised health promoting benefits of sex.

Semen play: hidden risky pleasures?

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Background: To investigate receptive semen play (RSP) among HIV-negative gay men

Methods: The Pleasure and Sexual Health study was an online survey of 2306 Australian gay men recruited during mid-2009.

Results: 1155 HIV-negative men reported a recent occasion when they used a condom during anal intercourse with a casual partner, of whom 17% reported having engaged in any RSP on this same occasion: Ejaculation over anus (4.4%); rubbing partner's semen over anus (4.0%); and masturbating with partner's semen (12.9%). 51.6% of those reporting RSP, also reported recent unprotected anal intercourse with a casual partner. Men who engaged in RSP were less likely to initiate condom use ($p = 0.009$) or to indicate that they always used condoms ($p < 0.001$). They were more likely to trust that their partner was also HIV-negative, yet were also more likely to believe that they might seroconvert at some time (not necessarily on this occasion). Nearly half (43.4%) found sharing semen to be 'very exciting'.

Conclusion: A sizeable minority of HIV-negative men engage in RSP with casual partners, even on occasions when they use condoms for anal intercourse, often because RSP was exciting for them. These men often only used condoms because their partner wanted to, and they tended to trust that their partners were HIV-negative. Some men appear to be less committed to avoiding risk and playing 'safe' all the time, in favour of acting on their desires, while trusting in their knowledge of their partner's HIV status. Nonetheless, many acknowledge that they are at increased risk.

Symposium

Articulating and enacting biomedical HIV prevention 7D

Chair:
Martin Holt

Presenters:
Jonathan Stadler
Marsha Rosengarten

Discussants:
Bridget Haire
Alan Brotherton

This session will consider how knowledge about biomedical HIV prevention —what it is, how it is used, who it is for, what it will do—continues to emerge from a complex web of scientific trial data, observational studies, advocacy and community debate. The perspectives of researchers, policy makers, activists, clinicians and affected communities may cohere or clash, with some perspectives emphasised and others overlooked. Debate and uncertainty are typical features of knowledge production but at stake is agreement over what HIV prevention is and how it might best be encouraged. The speakers and discussants will consider how different forms of biomedical prevention are understood by different actors, how these definitions correspond or compete, and whether the unfolding or enactment of new prevention technologies is privileging some forms of knowledge while silencing others.

Unanticipated outcomes of a microbicide trial: the case of the MDP301 trial, South Africa

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Introduction: Microbicides are medical technologies that are assumed to empower; tools to support female autonomy in HIV prevention, a microbicide gel can in theory be used without the tacit knowledge of a sexual partner. The MDP 301 trial tested the efficacy of Pro2000 in four African countries. Whilst the results of the trial were flat, women participants narrated the gel as a substance that transformed their bodies and their sexual relations, but not in the ways anticipated by trial design.

Methods: Using anthropological and qualitative research methods, the paper draws on 401 interviews with 179 female trial participants and 28 interviews with 18 male partners, 42 focus groups and participant observation in Johannesburg.

Findings: Participants were aware that the efficacy of the microbicide was unproven. Yet, in narratives about gel and condom use, participants ascribed improvements to their reproductive health and intimate relationships with men to gel use. Discussion: We argue that women enrolled in the trial broadened the meaning of the gel beyond its primary intended effect of preventing HIV. Through their accounts of gel use, women ‘reinvented’ the gel as a substance that transformed their bodies and sexual relations. This has implications for understanding how local knowledge of health and illness intersects with biomedical knowledge. These findings also have significant implications for creating a demand for, and marketing of, microbicide gels.

Inventiveness in the face-off with a ‘biomedical fix’

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Recent randomised control trial (RCT) results for oral pre-exposure prophylaxis (PrEP) with MSM and transgender women call for a review of existing approaches to prevention. In the immediate context, they pose the question of whether and, if so, how PrEP might be implemented? In this paper, we tackle the PrEP challenge by examining the process by which it comes to appear as a ‘biomedical fix’. Drawing on our research, we show how the promise of a ‘fix’ is an achievement of technologies of quantification: initially efficacy testing by the RCT and then, in the face of new forms of resulting uncertainty (e.g. ‘will new infections in the presence of PrEP result in an pool of drug resistant virus?’), statistical modelling. These technologies—what we refer to as performative devices—enact PrEP as a stable distinct entity for the purposes of generalisation. Yet interviews with PrEP’s trial investigators and bench scientists offer peculiarly contrary accounts of PrEP—as both stable and processual. In doing so, these accounts unwittingly expose something of the fallacy of any sort of ‘fix’ and potentially align themselves with recent developments in the social sciences attentive to the ever emergent and hence dynamic relations between humans and technology. It is in the highly contingent and evolving effects of PrEP-with-human/s that we propose answers to questions on PrEP implementation may be sought, utilising what is already known of the extraordinary inventiveness amongst those affected by HIV.

How do silence and articulation operate in communities that are less prominent in discussions about HIV, viral hepatitis, drug use and sex? 8

Panellists in this plenary panel discussion work with communities whose voices are less often heard in discussions about HIV, viral hepatitis, drug use and sex. They have been invited to think about how certain ideas about their communities (and within their communities) are emphasised and authorised, while others are excluded or sidelined because they are deemed incorrect, unhelpful, or dangerous.

Panel members will discuss:

- What can and can't be said about their community (or within their community) in relation to HIV, hepatitis C, drug use and sexual practices; what is seen as acceptable and unacceptable; and what such silences and articulations achieve and why.
- How are these communities portrayed in popular thought in relation to HIV, hepatitis C, drugs and sex?
- What doesn't get portrayed about these communities and why?
- What issues in relation to HIV, hepatitis C, drugs and sex are difficult to talk about within these communities and why?

Facilitator:

Norman Booker
ntb consulting, Sydney

Panel members:

Brandon Bear
Health Projects Manager
Yfoundations, Sydney

Pene Manolas
Manager, Community HIV Services, Heterosexual HIV/AIDS Service and Positive Central, Sydney Local Health District

Monique McEwan
Harm Minimisation Project Officer, Aboriginal Health and Medical Research Council, Sydney

Daniel Reeders
Senior Project Worker, Multicultural Health and Support Service, Centre for Culture, Ethnicity and Health, Melbourne

David Riddell
Client Services Manager, The Bobby Goldsmith Foundation, Sydney

Launches

Report

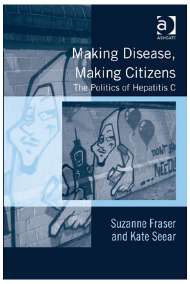
download at
www.ashm.org.au/publications

Stigma and Discrimination around HIV and HCV in Healthcare Settings Research Project (ASHM and NCHSR)

Nikki Woolley Viral Hepatitis Program Manager, ASHM

Stigma and discrimination towards people with HIV or hepatitis C (HCV) has been associated with negative health outcomes. This NSW report, produced by ASHM and NCHSR and funded by NSW Health, reviews the existing evidence on HIV- and HCV-related stigma and discrimination in the healthcare sector with specific emphasis on analysing the experiences and implications of this for people living with either HIV or HCV. The report includes: a review of related peer reviewed and grey literature with specific focus on patient experiences in the healthcare sector; interviews with key stakeholders from various relevant sectors; and recommendations for interventions to reduce stigma and discrimination within the NSW healthcare sector.

Book



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Making disease, making citizens: The politics of hepatitis C by Suzanne Fraser and Kate Seear (Ashgate)

Carla Treloar, Deputy Director, National Centre in HIV Social Research

Since the naming of hepatitis C in 1989, knowledge about the disease has grown exponentially. So too, however, has the stigma with which it is linked. Associated with injecting drug use and tainted blood scandals, hepatitis C inspires fear and blame. Making Disease, Making Citizens takes a timely look at the disease, those affected by it and its social and cultural implications. Drawing on personal interviews and a range of textual sources, the book presents a scholarly and engaging analysis of a newly identified and highly controversial disease and its relationship to philosophies of health, risk and harm in the West. It maps the social and medical negotiations taking place around the disease, shedding light on the ways these negotiations are also co-producing new selves.

DVD

view at
www.wdp.org.au

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C Me, Hear Me:
Hepatitis C: in our own words

Carla Treloar, Deputy Director, National Centre in HIV Social Research

This DVD was produced by the ASHM Workforce Development Program for the community and health workforces. The stories on this DVD can be used to become familiar with what it is like to live with hepatitis C.

Hepatitis C is one of the most commonly reported diseases in Australia. There have been, and continue to be, improvements in treatments, although the number of people commencing therapy remains low. The stigma and discrimination associated with hepatitis C creates significant barriers to individuals accessing education, care and support and treatment services. It is hoped the personal stories related here will increase awareness and understanding of hepatitis C, dealing with symptoms, considering and managing treatment, and stigma and discrimination.

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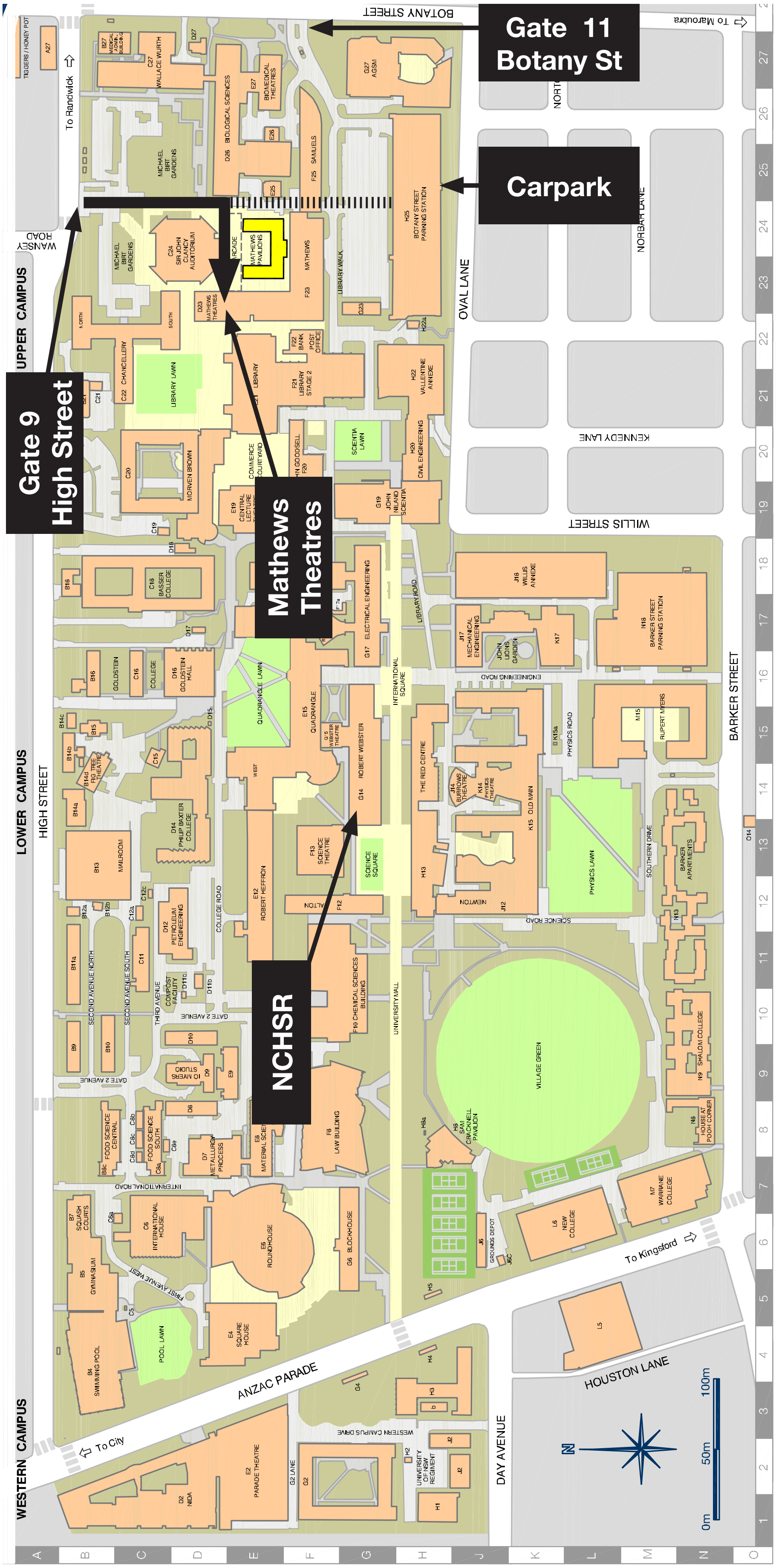
Map of UNSW kensington campus



Getting to and around the venue

Conference registration desk in Mathews Theatres

From bus/taxi: From Gate 9 on High Street, walk south down the Chancellery Walk until you reach the stairway to the Mathews Pavilions, on your right. Walk west along the front of the Pavilions and enter the lobby of the Mathews Theatres (D23) through the glass sliding doors.

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Mathews Theatre B

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Rooms 102, 104 and 107

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