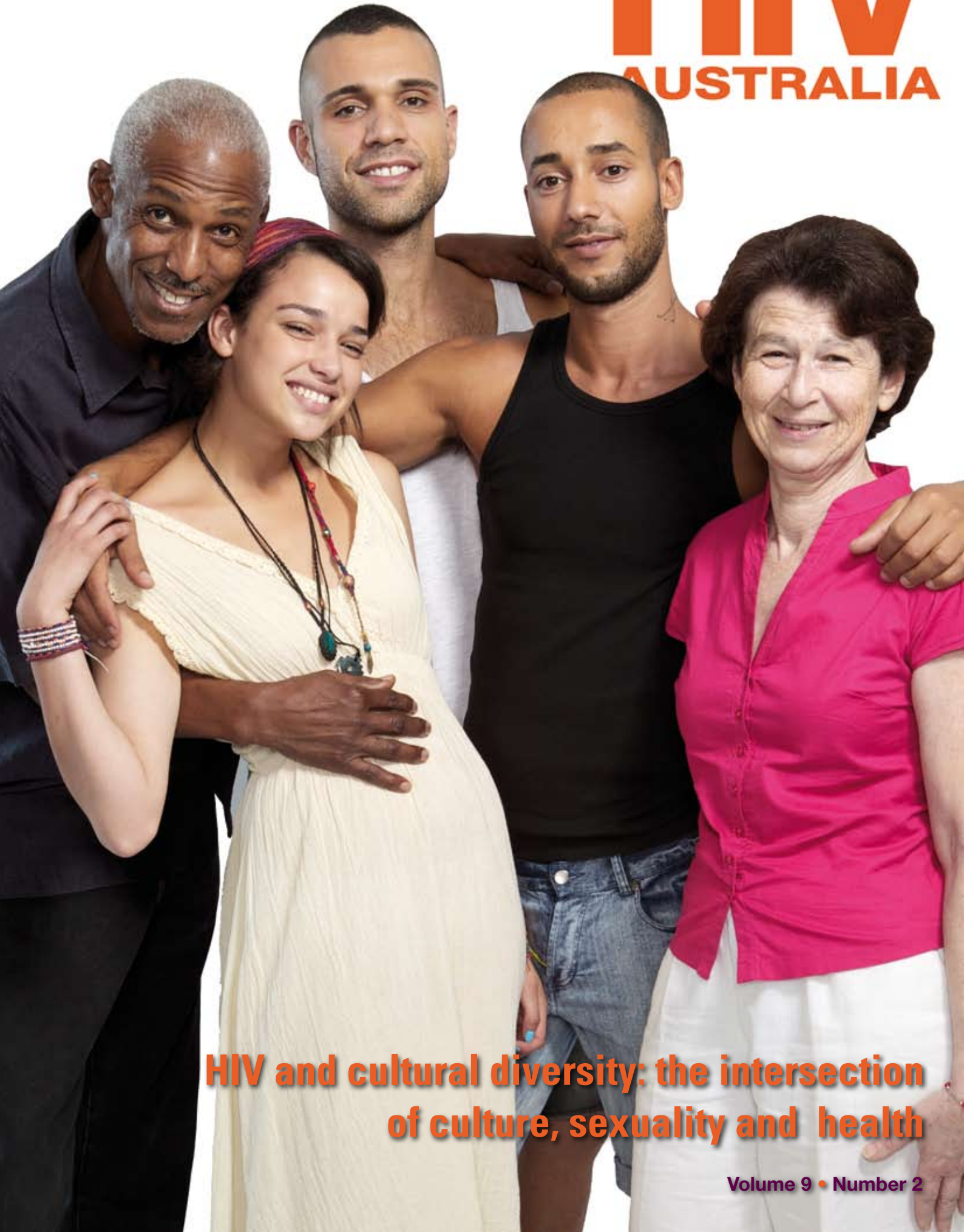


HIV AUSTRALIA



**HIV and cultural diversity: the intersection
of culture, sexuality and health**

Volume 9 • Number 2

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AFAO is the national federation for the HIV community response, providing leadership, coordination and support to the Australian policy, advocacy and health promotion response to HIV/AIDS. Internationally, AFAO contributes to the development of effective policy and programmatic responses to HIV/AIDS at the global level, particularly in the Asia Pacific region.

AFAO's aims are to:

- Advocate on behalf of its members at the federal level, thereby providing the HIV community with a national voice;
- Stop the transmission of HIV by educating the community about HIV/AIDS, especially those whose behaviour may place them at high risk;
- Assist its members to provide material, emotional and social support to people living with HIV;
- Develop and formulate policy on HIV issues;
- Collect and disseminate information for its members;
- Represent its members at national and international forums; and
- Promote medical, scientific and social research into HIV and its effects.

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This edition of *HIV Australia* focuses on HIV and culturally diverse communities. Authors explore the impact of cultural norms and values on perceptions and experiences of HIV, sexuality and health, and discuss the myriad other challenges faced by people living with HIV from culturally diverse backgrounds. Contributors also outline a range of available services and resources targeting culturally and linguistically diverse communities in Australia.

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NEWS

AUSTRALIA

Hepatitis C increase seen in HIV-positive men in Victoria

The Victorian Department of Health has reported an increase in cases of newly acquired hepatitis C in HIV-positive men over the past few months. Investigations are continuing, but it appears that these infections may be sexually transmitted. The Department has advised doctors to consider hepatitis C in any HIV-positive person presenting with symptoms consistent with hepatitis, but without conventional risk factors for hepatitis C, and has advised that hepatitis C testing should form part of the clinical assessment of newly diagnosed HIV-positive persons. It has also recommended annual screening of HIV-positive men who have sex with men for hepatitis C as well as looking for symptomatic disease and checking liver function tests.

New Australian research on commencing HIV treatment

Starting HIV therapy with a CD4 cell count above 500 cells/mm³ has only minimal additional benefits compared to initiating therapy with a CD4 cell count in the region of 350–500 cells/mm³, Australian investigators report in the online edition of the *Journal of Acquired Immune Deficiency Syndromes*.¹

As reported by *aidsmap*, the study was restricted to patients who started antiretroviral treatment when their CD4 cell count was above 350 cells/mm³. Patients with CD4 cell counts between 350–500 cells/mm³ rapidly achieved increases to above 500 cells/mm³. Moreover, 72 months after the commencement of treatment, patients had broadly comparable CD4 cell counts, regardless of their immune status at baseline.

Starting treatment at higher CD4 cell counts had clinical benefits, but overall these were modest. The study will inform the ongoing debate about the best time to start antiretroviral therapy. The investigators conclude, 'our analysis suggests that patients who start cART at CD4 counts >650 cells/mm³ have better preserved immune function, but only to a relatively modest degree ... furthermore the extent to which this might be expected to result in better clinical outcomes we show to be uncertain.'

Reference

- 1 *J Acquir Immune Defic Syndr*, online edition, doi: 10.1097/QAI.0b013e318225ba62

Heptagon Study to examine gay men's attitudes towards hepatitis C

AFAO is working with the National Centre in HIV Social Research (NCHSR) to conduct an online survey of gay men's knowledge and attitudes towards hepatitis C. In Australia, hepatitis C is most commonly transmitted through injecting drug use, however there have been recent reports of increased diagnoses of hepatitis C among gay men in Australia, including a number of cases believed to be due to sexual transmission. Hepatitis C infection is a significant health issue, particularly among individuals with HIV.

The study, called Heptagon, is exploring seven key areas: knowledge of hepatitis C transmission; perceptions of hepatitis C vulnerability/susceptibility; attitudes towards hepatitis C; attitudes towards injecting drug use; hepatitis-C-related stigma; testing for hepatitis C and HIV; and sexual and injecting practices. This study will inform public health and community prevention responses to hepatitis C among gay and bisexual men. The survey will take about 15 minutes to complete and all gay and bisexual men living in Australia are invited to take part. The survey can be found at www.heptagonstudy.net.au

Senate Inquiry into listing medicines on the PBS

The Federal Cabinet decision to delay the listing of medicines

referred by the Pharmaceutical Benefits Advisory Committee (PBAC) on the Pharmaceutical Benefits Scheme (PBS), prompted a Senate Inquiry in July into the process of listing medicines on the PBS.

Many HIV-sector community organisations raised concerns with the Inquiry. Key concerns included how deferral of listing pharmaceuticals for the PBS undermines community confidence in the integrity of the system and the serious medical consequences that people living with HIV may experience if they do not have access to the most efficacious pharmaceuticals.

African migrants fear donor discrimination

African migrants in Australia believe they're discriminated against in our society and as a result, don't donate blood, according to a study by the Australian Red Cross Blood Service and Professor Michael Polonsky from Melbourne's Deakin University. Feelings of exclusion by mainstream Australian society and a general mistrust of the health system also influence migrants' attitudes to donating.

'Our study participants felt that we view them negatively and wouldn't want their blood,' says Dr David Irving, the Blood Service's Executive Director, Research and Development. 'Whether this is accurate or not, is not the point, it's their perception that matters and this influences their decision to donate blood. African people have a higher prevalence of rare blood types not seen in the general population, so we need them to give blood,' Dr Irving said.

ASIA-PACIFIC

India Health Minister's comments spark international outrage

During a two-day meeting on HIV prevention, held in India in July, India Union Health Minister Ghulam Nabi Azad sparked international outrage over his comments that that homosexuality was 'unnatural' and a 'disease'.

Deccan Herald reports that during his address to the convention, Azad stated: 'The disease of MSM is unnatural and not good for India. We are not able to identify where it is happening as it is less reported also.'

Mr Azad's statements are at odds with a Delhi high court ruling from 2009 decriminalising homosexual sex between consenting adults. His views were strongly condemned by international human rights organisations including UNAIDS, whose officials were among the delegation attending the event.

In an official statement criticising the comments, Michel Sidibé, executive director of UN AIDS, noted that 'India's successful AIDS response has been possible due to the strong participation of communities of men who have sex with men, sex workers, people who inject drugs and transgender people backed by a strong and progressive National AIDS policy.'

Mr Azad has since apologised for the offence caused by his comments, saying they were taken out of context.

India pledges continued availability of generic drugs

India's Commerce Minister, Mr Anand Sharma, has given assurance that India will reject any efforts to include 'data exclusivity' clauses in bilateral trade agreements. This assurance came at a recent meeting between Mr Sharma and UNAIDS Executive Director Michel Sidibé. 'We reject data exclusivity clauses in free trade agreements,' said Mr Sharma. Welcoming the Minister's assurance, Mr Sidibé said: 'Millions of people will die if India cannot produce generic antiretroviral drugs, and Africa will be the most affected. For me, it is an issue of life or death.'

India's pharmaceutical industry produces more than 85% of the first-line antiretroviral drugs used to treat people living with HIV. The cost of the least expensive first generation treatment regimen has dropped to less than US\$86 per patient annually. However, as increasing numbers of people move towards more efficacious and tolerable first-line treatment, drug prices could double compared to first-generation regimens. In addition, as patients develop drug resistance and require more expensive and patent-protected second- and third-line antiretroviral medicines, some estimates indicate treatment costs could escalate by as much as 20%.

Controversy over Gilead licensing agreement

UNAIDS has welcomed a new license agreement between the Medicines Patent Pool and the pharmaceutical company Gilead which will see increasing access to antiretroviral therapy in some developing countries. This is the first time a pharmaceutical company has signed an agreement with the Medicines Patent Pool, marking a turning point for future private sector collaboration in sharing innovation to advance the response to HIV. Under the agreement, Gilead will share intellectual property on a range of medicines to treat HIV. Companies interested in producing generic versions of the medicines for developing countries will be able to approach the Patent Pool to negotiate licensing terms.

However, this agreement has not met with universal approval. The International Treatment Preparedness Coalition (ITPC) in North Africa has denounced this as a deeply concerning agreement that automatically excludes many developing countries from accessing the

pool, ultimately preventing millions of people living with HIV to access life-saving medicines.

The ITPC in North Africa highlights the restrictive aspects of the agreement between Gilead and UNITAID, particularly the exclusion of five of the six countries in the sub-region: Morocco, Algeria, Tunisia, Libya and Egypt.

INTERNATIONAL

Ground-breaking international resolutions and declarations

In June 2011, three highly significant international resolutions relating to HIV and protection of human rights for GLBTI people were agreed to.

The 2011 United Nations Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV/AIDS, was adopted by the UN General Assembly at a High Level Meeting on AIDS in New York on 10 June. The Declaration, issued as a consensus statement with support anticipated from all UN member states, is the first General Assembly statement on AIDS to explicitly include men who have sex with men (MSM) alongside other key populations affected by HIV, creating unprecedented opportunities for advocacy to promote MSM health and human rights.

On June 21, new public health recommendations were released by the World Health Organization (WHO) – the first global public health guidelines to focus on MSM and transgender people. The guidelines recommend the development of 'anti-discrimination laws and measures to protect human

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rights and to establish more inclusive services for [MSM] and transgender people based on their right to health'. The guidelines also aim to assist policy makers and health professionals scale up access to HIV treatment and prevention services for MSM and transgender people.

On Friday 17 June, the United Nations Human Rights Council passed a historic resolution on the rights of gay, lesbian and transgender people that 'seeks equal rights for everyone regardless of their sexual orientation.' The resolution was passed following a tense debate and narrow vote, in which some African states accused South Africa of breaking ranks with the region following its introduction of the resolution. The resolution has been hailed as an historic step towards ending discrimination and stopping human rights abuses against gay and lesbian individuals. Rights activists called the resolution an important shift on an issue that has divided the 'global body for decades.'

The Commonwealth calls on members to address GLBTI discrimination

Commonwealth Law Ministers met in Sydney on 12–14 July, with the Commonwealth HIV/AIDS Action Group (CHAAG) in attendance as observers. Commonwealth countries account for 30% of the world's population, yet they account for 60% of the world's people with HIV. 43 of the 54 Commonwealth countries still criminalise homosexuality, with varying penalties.

Despite a request by the Commonwealth Lawyers Association at a meeting in October 2010 of the Senior (Law) Officers, neither HIV nor discriminatory laws were on the agenda for the meeting. However, the Commonwealth Secretary General, His Excellency Mr Kamallesh Sharma, made reference to sexuality in his opening address, stating that 'vilification and targeting on grounds of sexual orientation are at odds with the

values of the Commonwealth'. During the meeting, a question about the work of the Commonwealth Secretariat regarding LGBT issues was asked – but silence on HIV and the human rights of those most at risk prevailed in terms of the formal agenda.

CHAAG and AFAO will continue to push Commonwealth governments to acknowledge and respond to these issues in the period leading up to the meeting of Commonwealth Heads of Government in Perth in October 2011.

Treatment reduces transmission by 96%

Men and women infected with HIV reduced the risk of transmitting the virus to their sexual partners by taking antiretrovirals, according to findings from a large-scale clinical study. The clinical trial, known as HPTN 052, was scheduled to end in 2015 but the findings were released early due to an overwhelming result.

The study included 1,763 HIV-serodiscordant couples, the vast majority of which (97%) were heterosexual. The study was conducted at 13 sites across Africa, Asia and the Americas. Couples were randomly allocated to one of two groups: immediate treatment with antiretrovirals by the HIV-positive partner; or deferred treatment when CD4 count fell below 250 cells/mm³ or the development of an AIDS-related illness. Among the 877 couples in the delayed treatment group, 27 HIV transmissions occurred compared to only one transmission in the immediate treatment group. This difference was statistically significant and equated to a 96% reduction in risk.

There are two observational studies of HIV transmission in gay serodiscordant couples: one is an ongoing European study (the PARTNERS study). The other is the upcoming Australian study (to be conducted by the Kirby Institute). Both these studies focus on treatment, viral load and transmission.

Heterosexual PrEP trials success

Results of two studies released on 13 July demonstrate that

taking antiretrovirals as pre-exposure prophylaxis (PrEP) reduces transmission of HIV by up to 73% among heterosexual couples. The trials, which were both conducted in Africa, are the first to show efficacy among heterosexuals.

The results of the Partners PrEP study of 4,758 in Kenya and Uganda were released early because the study endpoints had already been reached. In this study of heterosexual serodiscordant couples the HIV-negative partners were assigned to one of three groups: tenofovir; Truvada (tenofovir plus emtricitabine); or placebo. There were 47 infections people on placebo, compared to only 18 in those taking tenofovir (a 62% reduction) and 13 in those taking Truvada (a 73% reduction). There was no statistically significant difference between the two intervention arms. Women and men were equally protected. The study will now continue. All participants receiving tenofovir only or Truvada will remain on those medications, and those receiving placebo will start receiving tenofovir or Truvada.

In the other study (CDC TDF2) in Botswana, 1,219 men and women were assigned to take either Truvada or placebo. Nine participants taking Truvada became infected compared to 24 taking placebo – a 63% reduction.

Armenia lifts travel ban for people living with HIV

On July 14, the government of Armenia lifted travel restrictions for people living with HIV. The reform aligns the country's legislation with a growing number of other countries that have also removed HIV-related travel restrictions in line with international public health standards.

Following Armenia's repeal of the restrictions, UNAIDS counts 48 countries, territories, and areas that continue to impose some form of restriction on the entry, stay and residence of people living with HIV based on HIV status. Five countries deny visas even for short-term stays and 22 countries deport individuals once their HIV-positive status is discovered.



Facing up to reality: the United Nations adopts a new global plan to end AIDS

By **Bill Whittaker**

Last week the United Nations General Assembly held a special session (UNGASS) to review progress in the fight against AIDS and to decide on a new global plan of action to tackle the epidemic. This historic meeting brought together government leaders from all countries as well as advocates from medical, scientific and community sectors and people living with HIV from all parts of the world.

Australia played a key role in this UN meeting, with our Ambassador to the UN, Gary Quinlan, accorded the honour of co-facilitating the event with his counterpart from Botswana, Ambassador Charles Ntwaagae. Their work included weeks of intense negotiations to get all countries to adopt a new *UN Declaration on AIDS* – not an easy thing to do in the intricacies of the UN system. Foreign Affairs Minister Kevin Rudd led the Australian representation at the event and spoke

eloquently of the need for the United Nations to commit to bold new measures to fight AIDS. Australia was also well served by the efforts of Don Baxter, former Executive Director of AFAO, who worked tirelessly to help coordinate civil society input in the UNGASS meeting.

This special General Assembly meeting coincided with the 30th anniversary of the first public report of AIDS in June 1981 – a brief report noting a peculiar cluster of unusual pneumonia cases in five otherwise healthy gay men. Today the epidemic affects every part of the world and has claimed more than 30 million lives. Another 33 million people are living with HIV and there are some 7000 new infections every day, mostly among young people. Some 16 million children have been orphaned because of AIDS.

Even though powerful new HIV treatments are making a tremendous impact in reducing illness and AIDS

related deaths, the sustainability of providing HIV treatment – especially in low to middle income countries – is threatened by the reality that for every one person put on treatment, another two people become infected. Costs must be brought down and the pace of the epidemic slowed if we are to make providing HIV treatment sustainable for the millions of people who will need it.

The answer to reducing new infections is prevention, prevention and more prevention. In fact Michel Sidibé, the Director of the UN's HIV Agency, UNAIDS, has called for a prevention revolution that makes every person aware of HIV, tackles stigma and discrimination about HIV and makes condoms and clean needles and syringes widely available. Sidibé notes that future prevention efforts must

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also capitalise on the latest scientific findings, including that using HIV treatments earlier not only helps the individual living with HIV, but also reduces infectiousness, resulting in less new HIV infections. Other measures that need to be scaled up include making HIV testing much more accessible and actively promoted.

Ten years ago the United Nations adopted its first *Declaration of Commitment on AIDS*, a comprehensive global plan for fighting HIV. While the plan contained excellent elements and has been important in helping guide the global HIV response, it was fatally flawed in one area – it didn't name the three groups who are universally at higher risk of acquiring HIV, namely, men who have sex with men, people who inject drugs and sex workers. A group of countries adamantly refused to allow these groups to be listed in the first Declaration and instead insisted that they be obliquely referred to as 'vulnerable groups'. This decision to deny the reality of who is at higher risk has arguably cost many new HIV infections and lives. It has hindered HIV prevention efforts, misdirected many millions of dollars in targeting populations at low risk to HIV, instead of directing money and effort where it would have the greatest impact.

This time, finally, and against all the odds, the UN was able to agree for the first time to list in their new Declaration the three key groups along with targeting other populations at risk, depending on the pattern of each country's HIV epidemic. If countries implement this much more strategic approach to HIV prevention, there is the potential to dramatically slow the rate of new HIV infections.

AFAO welcomes the *Political Declaration on HIV/AIDS*, agreed to last month by the 192 member countries of the United Nations

Thirty years after HIV was first identified, the UN has finally named and included the rights and interests of some of the most at risk populations in the fight to prevent, diagnose and treat HIV. Sex workers, men who have sex with men and people who inject drugs are all explicitly named in the new Declaration.

The Declaration includes a renewed commitment to increased treatment access by 2015, attention to the human rights of people with HIV and a strong commitment to HIV prevention, calling for a 50% reduction in sexual transmission by 2015. In Australia, this would mean a reduction to 500 diagnoses by 2015.

The adoption of the new Declaration is a momentous achievement with ramifications for decades down the track – as long as we diligently build on the ground that it has broken. The challenge for AFAO, its member organisations and Australian governments is to consider what resources and strategies will be needed to ensure its impact in Australia, South East Asia and the Pacific.

As well as calling for HIV prevention to be better targeted and scientifically based, the new UN Declaration contains an extensive list of new commitments and targets. Bold targets have been endorsed to reduce rates of new HIV infections from sexual transmission and injecting drug use by 50% by 2015. Countries have also agreed that HIV transmission from mother to child must be eliminated by 2015 as a response to the appalling statistic that around 370,000 babies are infected with HIV annually.

While the UN Plan reiterates that prevention must be the mainstay of the global HIV response, the urgency of expanding HIV treatment is acknowledged through a commitment to ensure that another 14 million people are able to start HIV treatment by 2015, as part of a goal of providing universal access to HIV treatment for all in need.

Other important commitments in the plan include calling for better

coordination and monitoring of HIV programs, measures to help strengthen health systems and a call for all countries, not just donor countries, to assume greater ownership and funding of their HIV responses.

At the end of the day, the new *United Nations Declaration on HIV* will stand or fall on the willingness of governments to implement it. This will require political leadership, scientific guidance and forceful advocacy. However, the willingness of all countries to adopt a new Declaration on HIV, with its important new commitments, goals and targets, is a truly hopeful sign that the global response to HIV can be revitalised and that a world without AIDS can be a reality.

A version of this article was originally published in *New Matilda* June 2011 (www.newmatilda.com)

Bill Whittaker attended the United Nations Special Session on HIV/AIDS in 2001 and 2006 and provided technical advice to the Australian Government delegation for the 2011 UNGASS meeting. He is a Commissioner with the UNAIDS High Level Commission on HIV Prevention. He is also a special representative of the National Association of People with HIV/AIDS (Australia) (NAPWA), Board Member of Pacific Friends of the Global Fund to Fight AIDS, TB and Malaria, and former President of AFAO.

As well as calling for HIV prevention to be better targeted and scientifically based, the new UN Declaration contains an extensive list of new commitments and targets.



LEGAL UPDATE
CASE NOTES:
NEAL v THE QUEEN

BY **MICHAEL WILLIAMS**

In 2009, Michael Neal received a 19-year prison term with a non-parole period of 14 years for a catalogue of serious offences such as attempting to infect with HIV; reckless endangerment; rape; and possession of child pornography. On 15 June 2011, the Victorian Court of Appeal handed down its decision in *Neal v The Queen*¹, upholding his appeal against various erroneous directions given to the jury at trial by Judge Parsons. It reduced Neal's term to 12 years with a non-parole period of 9 years. The Crown may in-turn appeal, in which case the matter will be decided by the High Court.² In their judgment, Justices Nettle, Redlich and Kyrou provided some clarity on the issues relevant to informed consent in the context of reckless endangerment and HIV. However, there is much in this area that remains uncertain. This case note focuses only on those aspects of the ruling relevant to the transmission of HIV, rather than the other grounds of appeal, such as against the jury directions relating to rape.

In relation to the charge of 'reckless endangerment', the Court held that 'informed consent' is capable of providing a defence to a charge of recklessly endangering a person with HIV through unprotected sexual intercourse, so long as the consent is communicated to the offender'.³ Thus, if prior to sex, an HIV-positive person clearly informs their sexual partner of their status and obtains their verbal consent to have intercourse knowing this information – or sincerely believes that they obtained such consent – they will be guilty of no offence.

However, what is 'informed consent' beyond this example? When is consent being 'communicated'? Arguably, a person can be informed of someone's status without being told. Communication does not always have to be verbal before a person is conveying to another their willingness to run a risk. The Court also said clearly that 'informed consent' could not be raised when the offence is intentional infection with HIV. As their Honours' discussion of the UK cases shows, the law will tolerate risk taking if the outcome is secondary to conduct that has some social utility (such as sexual pleasure), but it will not do so if one party's behaviour is for the purpose of 'cruelty', which cannot have any useful social purpose.⁴

There was nothing explicit in the judgment about condoms and their relevance to acceptable risk taking. However, because reckless endangerment through anal intercourse is only an issue where condoms are not used, it follows that condoms are unnecessary when informed consent is present. Their Honours did not say this but it is implicit in the notion that a complainant has consented to run the risk of infection (which they could only do logically if intercourse was unprotected). The Court also quoted from the New Zealand case of *Re Mwai*, in which it was ruled: '... the duty to use a condom would arise only if there were a failure to disclose'.⁵

The Court dismissed an argument by Neal's lawyers that 'the risk of

infection through unprotected anal sex was at most less than even, and thus should have been left to the jury to determine whether it met the test "of being immediately and not remotely connected with the commission of the offence".⁶

According to the Court, whether an act is 'connected' to a desired result is based on 'common sense' and it need not be likely to eventuate.⁷ Similarly, the Court rejected a submission that because of the small risk of transmission Neal did not expose his sexual partners to 'an appreciable risk'. Yet their Honours made an interesting observation, worth quoting at length:

As we apprehend the notion of an "appreciable risk" of infection in this context, it means a real and potential danger of being infected with HIV which exceeds the ordinary risks of contracting HIV from homosexual anal intercourse (my emphasis) ... Professor Grulich gave evidence that the risk of an HIV infected man transmitting HIV in a single sexual act of homosexual penile anal intercourse was between one in 200 and one in 33. Similarly, Associate Professor Mijch gave evidence that, although she did not 'feel comfortable' with the estimate of one in 33, apparently because she perceived it might have been based on too small a statistical sample, the estimate of one in 200 is what the Centre for Disease

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Thus, if prior to sex, an HIV-positive person clearly informs their sexual partner of their status and obtains their verbal consent to have intercourse knowing this information – or sincerely believes that they obtained such consent – they will be guilty of no offence. However, what is 'informed consent' beyond this example? When is consent being 'communicated'?

*Control in America consider to be reasonable. Professor Grulich also gave uncontested evidence that the risk of infection would increase, and could increase dramatically, with the number of occasions on which a couple have sexual intercourse. On any reasonable view of the matter, therefore, it was open to the jury to conclude that the risk was sufficient.*⁸

For a risk to be appreciable, must it go beyond the 'ordinary risks' inherent in an unprotected sexual intercourse? And what are examples of these 'appreciable risks': 'rough sex' (which may increase trauma to mucous membranes, leading to small tears or fissures in the mouth or anus, creating an increased risk of HIV-transmission), donning a Prince Albert (a genital piercing) prior to intercourse? Would a single act of unprotected sex mean that the risk was within the ordinary range of risk? Or by quoting the epidemiological evidence is the Court saying that even a single act of unprotected sex would be considered an 'appreciable' risk? The latter is probably the safer view, though we cannot be sure until the point is tested in the courts.

The judgment offered some insight into the relevance of undetectable viral load. The Court found that certain of the trial judge's directions to the jury on what Neal believed about his own HIV infectiousness were flawed. While the judge directed that, for a guilty

finding, Neal must have 'believed that he *may* be infectious'⁹ the Crown in fact had to show that Neal 'believed that he was capable of infecting others with HIV'¹⁰. On some counts, it was obvious through his words or conduct that he believed he was able to transmit the virus (and arguably that he intended to do so).¹¹ However, Neal's lawyers argued successfully that certain acts occurred when he 'had a low or undetectable viral load and, therefore, the Crown had not established that the applicant believed that he was capable of infecting others with HIV'.¹² Arguably, then, knowledge of an undetectable viral load may be evidence that a person did not believe that they were infectious. The Crown would then have to show that a different mental state was operating – through the defendant's words to, or conduct towards, the complainant – at the time the offences occurred. An individual's belief about non-infectiousness would probably be stronger if their doctor had said their viral load was undetectable, but did so without any of the corresponding disclaimers to their patient regarding appropriate precautions.

Neal v The Queen clarifies the principles somewhat on risk taking and consent. However, the facts of the case are highly particular. The case was not the appropriate vehicle to fully explore how the law would respond to a defendant whose conduct was not as extreme

as Neal's. We are left to ponder the criminality of someone whom, prior to sex, failed to disclose their status, in circumstances where the complainant asked no questions. To avoid liability, we should assume that the positive person in this instance must disclose and obtain full, verbal consent from the other person to 'run the risk'. This places the entire burden on people with HIV to protect the health of HIV-negative sexual partners. It is worth remembering that, while the law must be followed, it can always be criticised as being iniquitous.

Readers of HIV Australia may be interested to note that the appeal judgment also referenced the article 'HIV and consent: when yes means no' by HIV/AIDS Legal Centre (HALC) lawyer, Indraveer Chatterjee, published in HIV Australia Vol. 8 No. 4. A detailed briefing on the Neal v The Queen decision is also available at www.afao.org.au

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- 4 *ibid*, paras 64–73.
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- 7 *ibid*, para 49.
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Michael Williams is the President of the Victorian AIDS Council/Gay Men's Health Centre. The author would like to thank Associate Professor Matthew Groves of Monash University Law School for reading a draft and offering helpful comments. Any remaining errors are those of the author.

The Court found that certain of the trial judge's directions to the jury on what Neal believed about his own HIV infectiousness were flawed. While the judge directed that, for a guilty finding, Neal must have 'believed that he *may* be infectious' the Crown in fact had to show that Neal 'believed that he was capable of infecting others with HIV'.



What's the 'problem'? Current issues in defining HIV among people from culturally and linguistically diverse (CALD) backgrounds in Australia

By **Tadgh McMahon** and **Barbara Luisi**

Over the past 10 years, the HIV situation among CALD communities has gained traction in the HIV sector as we observe an upward trend in notifications among these communities. Steps to quantify this trend commenced in 2002 with the collection and reporting of 'country of birth' data in national HIV surveillance, and the collection of 'language spoken at home' data from 2004. Another significant milestone has been the identification of CALD communities as a priority population in the *National HIV/AIDS Strategy 2005–2008*.

Despite this progress, we still lack clarity in defining what the 'problem' of HIV among CALD communities is, and consequently, we are hampered in developing an effective response to address the emerging epidemic in this area.

Australia is not the only high-income country struggling to conceptualise and respond to HIV among immigrant and ethnic minority communities. Countries across Europe and North America are also witnessing rising diagnoses among these populations. This article explores some key issues relevant to the Australian context and attempts to synthesise these issues into a coherent, if still complex, narrative. The article argues that it is through greater sector-wide discussion of these conceptual and theoretical issues that we can develop more robust surveillance systems, and undertake social research to underpin targeted HIV prevention and initiatives and improve the health and well-being of people living with HIV from CALD backgrounds.

Surveillance data indicate significant shifts in notifications among people

from CALD backgrounds in Australia from 2002 (the year in which country of birth data was first reported), to 2009 (the most recent year of reporting). In 2002, people born overseas accounted for 31% of overall notifications, with Asia (8.5%), sub-Saharan Africa (5.5%), and Europe (excluding the UK/Ireland) (5.3%) the main regions of birth.¹ By 2009, people born overseas accounted for 44% of overall notifications in Australia, with most of this increase attributed to people born in Asia (13.8%), and sub-Saharan Africa (10.2%), while other regions of birth have remained largely stable.² Some of this increase can be attributed to inward migration from these two regions, which has greatly expanded in the past decade. However, during this

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time the age-standardised incidence rates for these two regions have also increased markedly, with the highest rates now among people born in sub-Saharan African (47.4) and Asian-born communities (8.8).³

One barrier to a clearer appraisal of the challenges we face arises from confusion over the term 'CALD', which is essentially an administrative term that is used in public policy to cover a whole range of culturally diverse communities. It can refer to immigrants, people born in English-speaking countries, people born in Australia of non-Anglo heritage, or people born in high prevalence countries (or indeed all of these), depending on the context in which it is being used. In the context of HIV, we can bring more clarity to the term, by identifying priority CALD communities. This can be informed by an assessment of ethnicity indicators (e.g. 'country of birth') in HIV notifications, the size of the CALD population as measured by the census, the prevalence of HIV in the country of origin, consultations with CALD communities and by examining service utilisation patterns.⁴

In addition, a recent analysis of NSW HIV notifications suggests that the income group of the country of birth (as defined by the World Bank⁵) can also be a useful proxy measure to determine priority CALD communities affected by HIV.⁶ The analysis found that immigrants from low and middle-income countries

were similar to each other across a range of indicators including: exposure category (more heterosexual acquisition); gender (more women); age (younger); and stage of diagnosis (diagnosed later).⁷ Immigrants from high-income countries were more similar to Australian-born cases of HIV across these indicators compared to their fellow immigrants born in low and middle-income countries.⁸ The analysis also confirmed that because HIV is reported across multiple CALD communities, it is imperative to prioritise our efforts to those CALD communities most affected by HIV.

In the past we have tended to conceptualise the HIV 'problem' among CALD communities along the lines of language proficiency (i.e. non-English speaking), or even the category of migrant (i.e. refugees), or at times, immigration status, in the case of people ineligible for Medicare. A more useful way to conceptualise how we need to respond is ethnicity. Ethnicity is a relatively new term that only became widely used in the 1970s and shares much ground with terms such as race and nation to describe 'people of the same stock'.⁹ Common indicators of ethnicity in the public health field include country of birth, language spoken at home and year of arrival.¹⁰

Ethnicity does not 'cause' HIV, however, it can be harnessed to stratify and target populations as a basis for culturally appropriate health promotion initiatives. This targeted work can complement mainstream campaigns.

For example, interagency work to address HIV among Thai and Spanish-speaking background gay men in NSW over the past five years suggests that the messages of mainstream gay men's campaigns have relevance for CALD gay men. However, the execution of mainstream messages was often seen as culturally inappropriate. Therefore, tailored, in-language, culturally specific versions of those messages were developed for these niche audiences of Thai and Spanish-speaking background gay men. Similarly, using ethnicity indicators in heterosexually acquired HIV surveillance data offers a useful method to develop and deliver culturally appropriate health promotion messages to target heterosexuals, most at risk of, or living with HIV in Australia. Indeed, it is difficult to envisage why we would not use ethnicity as one of the ways to stratify and target our HIV response among heterosexuals alongside other more conventional risk behaviour measures.

Immigration patterns to Australia have shifted significantly since HIV first emerged 30 years ago. The most visible change has been the decrease in the proportion of immigrants from those European countries that dominated the immigration intake for decades during the post-War years. A less visible change has been the shift to various forms of temporary migration alongside a largely stable annual permanent immigration intake of about 170,000 settlers, including about 12,000 humanitarian entrants.¹¹ Some analysts have characterised this as the 'permanent shift to temporary migration'.¹²

This model of migration is an increasing reality in many high-income countries as a way to plug skills shortages in the labour market and bolster income for secondary and tertiary educational institutions. This reality occurs against a backdrop of a rapid expansion in the volume, speed and reach of bi-directional people flows in a globalised world.¹³

Ethnicity does not 'cause' HIV, however, it can be harnessed to stratify and target populations as a basis for culturally appropriate health promotion initiatives. This targeted work can complement mainstream campaigns.

Temporary entrants typically reside in Australia for periods of up to four years. In recent years, temporary migration accounted for an annual average of more than 600,000 people residing in Australia, dwarfing the permanent immigration intake.¹⁴ This pattern of temporary and permanent immigration raises important questions for our HIV response and focuses attention on issues including travel and mobility. This has sometimes led to an undue focus on travel to high prevalence countries as the key HIV risk environment for CALD communities. However, even in a context of rapid bi-directional travel there are other important risk contexts contributing to the emerging HIV situation among CALD communities. These include high levels of undiagnosed, and therefore untreated, HIV; perceptions among some CALD communities that Australia is 'HIV free' due to assumptions that all immigrants are tested for HIV (HIV screening is largely carried out in health checks for permanent residency); the inherent difficulties of condoms as the key HIV prevention tool for heterosexual couples who are planning to have children; the poor HIV health literacy of CALD communities; and the on-going stigma associated with HIV in these communities.

A final impediment to conceptualising a more effective response to HIV among CALD communities arises from a perception that HIV among people from CALD backgrounds is, in the main, a heterosexual issue. The rate of heterosexually acquired HIV among CALD communities is certainly high but the evidence, from NSW at least, points to a different reality. In NSW from 2002–2008, notifications among CALD communities drawn from low- and middle-income countries was almost equally divided between heterosexually acquired and homosexually acquired cases of HIV.¹⁵ This reality points to the flaws in conflating heterosexual transmission of HIV with CALD communities.

It also highlights the often neglected dimension of cultural and linguistic diversity among gay men at risk of, or living with, HIV in Australia. Historically in Australia our response to HIV has been stratified in terms of gay men, people who inject drugs and sex workers. This paradigm is challenged among CALD communities most at risk of HIV where male-to-male and heterosexual transmission share the territory for a programmatic response.

Conclusion

In the current Australian context, generating a more effective response to the emerging epidemic of HIV among CALD communities is paramount. Such a response will require the HIV sector to engage and hold the complexity and uncertainty that lie at the core of work with these culturally diverse communities. In part, we will need to challenge the dominant paradigm of how the HIV response has been stratified and targeted in Australia to date. This will engender a wider discussion of the complexity and challenges, and will lead to a greater clarity in defining the 'problem' of HIV among CALD communities in ways that are more amenable to timely, effective and appropriate interventions.

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A final impediment to conceptualising a more effective response to HIV among CALD communities arises from a perception that HIV among people from CALD backgrounds is, in the main, a heterosexual issue.



Myth-understandings: issues relating to HIV and cultural understanding

By **Zhihong Gu**

Australia is one of the most culturally diverse countries in the world. There are currently over 200 languages being spoken in the Australian community, and one in four individuals in the population is born overseas.¹ Immigrants account for nearly 70% of Australia's population growth in recent years.² This growing migrant population is having a direct impact on HIV service and prevention programs.

Cultural beliefs and cultural norms can strongly influence an individual's feelings and behaviours, particularly in relation to sensitive topics like sexual health. As health educators working with Australia's increasingly culturally diverse communities, awareness of and sensitivity to the influence of cultural understanding is a vital part of the work that we do, especially in relation to HIV prevention and care.

Health, disease and prevention

The Ethnic Communities Council of Queensland (ECCQ) HIV/AIDS, Hepatitis and Sexual health program focuses primarily on community health education. We routinely find that clients,

particularly those from high HIV prevalence countries, either don't know HIV exists in Australia or prefer to ignore the issue. 'We know AIDS' is the usual response we always receive.

On the one hand, this reluctance to engage with us about the issue of HIV may be partly due to the fact that in countries where rates of HIV are high, messages about HIV/AIDS are oversaturated by the mass-media and other channels and most people are likely to know someone who has been directly or indirectly affected by the virus. But on the other hand, this does not mean that the individuals that present to our service have all the necessary information they need about HIV. In fact, many may hold quite false, inaccurate information about the virus. For instance, there are lots of myths and misunderstandings about how HIV is transmitted.

Some of our clients have said they believe that divine punishment or curses can cause HIV/AIDS, virgins can cure HIV/AIDS, and some herbs in Africa can cure AIDS, and so on. In particular, many people still believe

that a positive HIV diagnosis is a death sentence.

In Australia, the messages and strategies for prevention and health promotion need to consider cultural understanding and beliefs, education levels, language barriers, as well as other social determinants that influence people's behaviour.

Most cultures strongly believe 'health' means good physical condition. Therefore, people think that if they show symptoms or signs of ill-health or feel unwell, they have diseases – otherwise they are healthy. The concept of 'preventative health' is unknown to many people. This can result in late diagnosis and treatment for infections that are typically asymptomatic for a long period of time, including HIV. People frequently express shock after they have been diagnosed with HIV, especially if they have lived for years without symptoms.

Stigma

Stigma surrounding HIV/AIDS is a huge issue in culturally and linguistically

diverse (CALD) communities; it exists in all cultures and plays a big role in preventing people from being tested, treated, or even being informed. Without fighting stigma, it is hard to defeat HIV in the population.

HIV/AIDS is a taboo subject, often associated with 'immoral' behaviour. Some of our clients have expressed the belief that those with HIV should be locked up and confined, a belief which stays with them after they move to Australia. We have been asked by communities about where HIV-positive people have been 'put' in Australia, or why the government allows people with HIV to walk freely in the community. People have also expressed a belief that community members should be notified about who has HIV infections.

Stigma is everywhere – it can come from community norms and values about sex and disease, from close friends or even a person's own family. As a result, many people don't want to be tested for HIV because they fear a positive result, and believe that this could mean the loss of their permanent visa, or Centrelink benefits.

Stigma can be combated by giving people accurate and current information about HIV which dispels myths around HIV transmission. This can be best achieved through face to face peer education with community members and individuals. Ethnic media can also play an active role in disseminating information, but its effect can be limited because of its unavailability in many priority CALD communities.

People living with HIV in the community can play a critical role in reducing stigma by speaking out about their positive experiences of living with HIV in Australia. These stories may be very different from people's experience of HIV in other countries. People need to hear that in Australia we have one of the best health care systems in the world, a system that provides the excellent care and treatment for people living with HIV. Australia also has effective anti-discrimination legislation in place to help protect people living with HIV. These either don't exist or are poorly available in many other

countries. Unfortunately, encouraging and engaging HIV-positive people from CALD communities to speak out about their experiences is not an easy task, especially for people whose first language is not English.

The Queensland Positive Speakers Bureau (QPSB) is a collaborative effort between Queensland Positive People, Hepatitis Council, the HIV and Hepatitis C Project at the University of Queensland and the ECCQ. The QPSB successfully recruited and trained a selection of people from CALD backgrounds to enable them to give public speeches. During World AIDS Day 2010, two CALD positive speakers were invited to speak at a World AIDS Day Forum organised by ECCQ. This forum attracted more than forty community members, mainly from African communities. Most people said that this was the first time they had seen HIV-positive people in Australia and they greatly appreciated the positive speakers' encouragement to share their stories. The images of living with HIV/AIDS in many CALD people's memories were of 'slim', 'weak' and 'dying' people – quite opposite to what they saw at the forum.

Risk – different perspective

The majority of HIV infections in many countries are among the heterosexual population. In many cultures, boys and men have more sexual partners than girls and women. In some cultures where the prevalence of HIV is high, multiple sexual partners, concurrent sexual partners, sexual violence or polygamy, are widely practised. Condoms, however, are not commonly used in some of these communities. People either don't like to use them or have barriers to accessing them (for example, they don't know where to buy them, or are too shy to buy them, or cannot afford them). Some people may not know what is meant by unsafe sex, or don't realise that having multiple sex partners is a high risk activity.

In addition, people normally don't want to disclose unsafe sex behaviours to service providers even when directly

asked. This is partly because of culture, and partly because of a lack of trust. Many people think that information disclosed to health care workers will be spread to others.

Quite often HIV health promotion messages focus only on sexual transmission. However, in many countries where the prevalence of HIV is high, other transmission routes also play an important role in HIV transmission. These include unsafe infection control in health care settings, and traditional or cultural practices involved in sharing equipment for skin penetrations (such as circumcision, excision, ritual scarification, sealing brotherhood through the mixing of blood, and sharing razors).

If our message only focuses on sexual transmission without raising issues of other transmission routes, or simply using terms such as 'blood transmission' without unpacking the term in a way that an individual can relate to their culture and life experiences, people will not get a full understanding of how HIV can be transmitted and therefore won't comprehend the risk. Focusing on a variety of transmission routes can also reduce stigma associated with sex.

It is our challenge, as health educators, to be flexible in our approach and to take the time to deliver the messages in a culturally-appropriate way that meets the individual needs of all our clients.

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'We didn't leave it in Africa': Okello's story

In 2010, AFAO conducted a series of interviews with HIV-positive African Australians, in the lead up to a forum by and for African communities to discuss issues related to living with HIV in Australia. All names and identifying details have been changed.

I was working in Australia about ten years ago, I'd just met someone new and we started dating. She was aware of the HIV/AIDS pandemic in Africa so she was a bit cautious and she asked me to go for a test, and that's how I found out I was HIV-positive.

Coming to Australia, I had tested for HIV and I was HIV-negative and because I always practised safe sex since the last time I'd been tested I was sure I was negative. So it was quite shocking, I can't even describe it. It made me think of a lot of things, the usual stereotypes – all these stories I grew up hearing about people who are HIV-positive, all the labels that went with HIV/AIDS.

At the time I didn't have enough knowledge or education about HIV/AIDS. I assumed that it was a sexually transmitted disease, or it was something that bad people get, or something that only gay people have, so it was a really

hard time because I wasn't any of these. I also had to deal with the fact that the person I'd been with, who's still my partner, I might have infected her with the virus, and it turned out to be the case.

So guilt came in, no matter what she said or did to make me realise that she didn't make anything of it. She genuinely understood that I didn't know that I was positive and it was as new and as shocking to me as it was to her. I guess coming from a western culture, she had a different understanding of HIV and probably dealt with it better than I did, even though I came from a place where there's HIV here, there and everywhere.

It wasn't easy, early days, it was hard. I wasn't even a permanent resident at the time. We had this secret we had to keep from a lot of people, simply because within the African community, my so-called friends didn't stand by me.

It became juicy gossip. I had told my friends I was positive. Not so much to get support and help, but I guess trying to say, 'This thing is real guys, we didn't leave it in Africa. It's not for gay people, it can happen to anyone like you and I.' But that's when friends started to shun me. Now I pick who I tell, and when.

These days I'm very positive about life. I'm going good with my meds, have two beautiful boys that I love very much. My relationship is better and stronger than ever. I'm working, looking after my family. I haven't lost hope; I'm looking forward to so much, to doing so much, not just for myself, but with and for my family.

Probably the most important thing for the African community to know is – there's nothing wrong with people who are positive, don't judge them.

And if you are HIV-positive – there's a lot happening with regards to medication. I started on 21 plus tablets a day and now I'm just on one tablet a day. So there's a lot of hope on the medical side. There's a lot of peer support. There's so much help out there, there's no need to be careless and reckless and give up hope. You can still live a normal healthy life.

Other stories from this series of interviews are available in the online edition of HIV Australia, available at www.afao.org.au



Building the capacity of the HIV sector in Australia: taking a culturally competent approach

By **Gai Stackpool** and **Barbara Luisi**

Australia is one of the most culturally diverse countries in the world. Forty-four (44) percent of Australians are born overseas or have at least one overseas-born parent and 17% speak a language other than English at home.¹ Nationally, almost one quarter of all new HIV notifications are among people from culturally and linguistically diverse (CALD) backgrounds.²

HIV among CALD populations is not new to Australia. However, changes in global migration patterns influence which populations we need to reach, and provide the impetus for re-orienting approaches to prevention, treatment and care to better meet the needs of emerging communities. Cultural competence, which will be explored in depth in this article, provides a framework to enhance the capacity of the HIV sector to meet this challenge across a range of cultural contexts.

The local impact of a global epidemic

At a global level, 95% of annual HIV notifications occur in low- and middle-income countries³, locations characterised by a range of demographic factors including low socio-economic status, low levels of employment and education, and high infant mortality. Factors such as poverty, social isolation, poor knowledge of HIV and AIDS, lower testing rates, late presentation and limited access to health services, may mean that people born in these countries are more socially vulnerable to HIV.⁴

In Australia, HIV among CALD communities reflects this global pattern, with the highest number of notifications concentrated in people born in low and middle-income countries. In 2006–2009 there was an increase in HIV notifications in

Australia among people born overseas, with a doubling of HIV rates found in those born in sub-Saharan Africa, Asia and South/Central America.⁵ Similar upward trends are also occurring among migrant and ethnic minority communities in other developed countries such as the USA^{6,7}, Canada⁸, and in the European Union⁹.

Prioritising different approaches: HIV and CALD communities in Australia

Approximately a quarter of Australians were born overseas.¹⁰ This cultural diversity is reflected in national HIV notifications; in the period 2006–2009, 45% of new HIV notifications were among people born overseas.¹¹ In response to this trend, national, state and local policy frameworks have recognised people from CALD

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backgrounds as a priority for both HIV health promotion, and treatment and care programs.

To date, HIV programs in Australia have successfully engaged with the most affected communities, including gay men, sex workers and injecting drug users. A similar targeted approach, sensitive to issues faced by priority CALD communities is now required.

The main modes of transmission among priority CALD communities in Australia tends to mirror the epidemic in their country of birth, producing different patterns of HIV infection in people born in low and middle income countries compared with those born in Australia and other high income countries.¹² These differences include a much higher proportion of heterosexual people with HIV – around 40% of cases in people from high prevalence countries in 2005–2009, with almost 60% of these among women.¹³

For people living with HIV from CALD backgrounds, experiences in their country of birth mean that HIV is often perceived as being synonymous with AIDS, and is therefore seen as a ‘death sentence’.^{14,15} In addition, people living with HIV may attempt to protect themselves and their family from stigma and discrimination by not disclosing their HIV status.^{16,17} This need to maintain privacy and confidentiality may also be a barrier to seeking treatment and support. This can contribute to late presentation and poorer health outcomes.^{18,19}

The experiences of HIV for people from CALD backgrounds is also often different because HIV testing, which is part of the migration health requirement for those applying for permanent residency²⁰, occurs against a backdrop of intense upheaval and uncertainty. Once in Australia, migrants are typically dealing with the multiple stresses of language and cultural barriers, the search for housing, employment and education.²¹

A culturally competent approach

Responding appropriately to cultural diversity has created new challenges

Cultural competence: models of operation

At a systemic level

In line with the National Health and Medical Research Council (NHMRC) framework, surveillance and service utilisation data informs service planning. Use of data to identify priority populations and allocate sufficient resources represents the application of cultural competence at the systematic level.²⁶ Another example of this approach undertaken in NSW, was a project targeting African-Australian communities to increase HIV testing and promote safe sex practices. Surveillance data indicated that a diverse range of African-Australian communities constituted a priority population and partnerships were formed with local African community organisations. An annual football tournament was identified as a culturally-appropriate event to reach these populations and disseminate health promotion messages.

At an organisational level

The organisational level focuses on integrating or embedding cultural competence into an agency through its policies and procedures, planning processes, and workforce development.²⁷ The need for this level of integration was reinforced by an analysis of the learning needs of the national HIV sector workforce conducted by the Multicultural HIV/AIDS and Hepatitis C Service (MHAHS).²⁸ It found that while staff had some understanding of the issues faced by people from CALD backgrounds, they lacked the capacity, skills and resources needed to work with them.²⁹ As a result, the MHAHS developed a cultural competence training program tailored to HIV sector agencies, which has been effective in assisting organisations to plan and implement sustained programs with priority CALD communities as part of their core business.³⁰

At the individual and professional levels

The model also focuses on enhancing the skills of individuals and professionals to work with people from a range of culturally diverse backgrounds.³¹ They include the ability to value, understand and manage cultural differences, so as to improve service delivery, and daily interactions and communication with clients. The development of these skills also requires support at the systemic and organisational levels. Agencies need to have systems and policies in place to ensure that workers are equipped with not only the skills, but also the resources required to work with people from a diverse range of communities.

This approach can be seen in work previously undertaken by the MHAHS in NSW promoting HIV testing for pregnant women from CALD backgrounds. Based on HIV notification data among CALD communities and birth register data, this included the development of written resources in priority languages, as well as targeted workforce development for midwives working in selected hospitals. The development of resources and training in cultural competence enhanced the midwives’ ability to provide appropriate information and care for women from priority CALD backgrounds.

and opportunities for the HIV sector. The previous focus on ‘cultural awareness’, ‘cultural sensitivity’ and ‘cultural responsiveness’, emphasised difference and implied a ‘recipe-type’ approach when working with CALD communities. The shifting epidemiological landscape requires a broader framework and the development of capacity and skills

to work with the dynamic nature of diversity in Australia.

Cultural competence is a way to work towards equitable access to services and ultimately better health outcomes, regardless of cultural background. It takes into account an understanding of issues specific to CALD communities along with an integrated, multi-level skills-based response.

The National Health and Medical Research Council (NHMRC) describes cultural competence as being more than just awareness of cultural differences.²² Its focus is to integrate culture into an organisation to improve the health and wellbeing²³ of individuals and populations. It is both a learned and ongoing process that applies not only to individual workers, but also to the agency and systems in which they work.²⁴

For agencies to improve their reach to CALD communities, the NHMRC provides a framework with four interrelated levels – systemic, organisational, professional and individual. It recognises that for individuals and professionals to work in a culturally competent way, commitment and support are also required at systemic and organisational levels.²⁵

Conclusion

Responding to HIV among CALD populations requires action at multiple levels across the sector that takes into account the cultural experiences, issues and needs of these communities. Enhancing the cultural competence of agencies and workers can improve community access to services, as well as the overall quality of care provided by building the capacity and skills of both agencies and workers to deliver culturally-appropriate services and programs.

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Responding appropriately to cultural diversity has created new challenges and opportunities for the HIV sector. The previous focus on 'cultural awareness', 'cultural sensitivity' and 'cultural responsiveness', emphasised difference and implied a 'recipe-type' approach when working with CALD communities.



Behind the mask: Asian gay men and challenges in HIV health promotion

By **Min Fuh Teh**

'Do you have girlfriend?' 'When are you getting married?' From both my own personal perspective as well as through interactions with other Asian gay men, it is not always easy being Asian and gay. Ask us whether it's hard dealing with cultural and family expectations you will get a definitive nod – these two topics complicate our already bumpy road towards self-acceptance.

Connections to family and community are our life raft but also keep many of us living behind a mask for fear of losing the support of friends and family – or worse still – the risk of reactive ostracism and homophobia from our whole community. We yearn to love and be loved, but upon reaching out to the other men, we commonly experience a sense of disconnect – coming up against a wall of covert discrimination based upon racial and cultural differences, and sometimes, our very own internalised states of homophobia.

Of course, this is in no way a justification of privileged status

of victimhood or heroism. Nor is it intended to be a blanket representation of the experience of being Asian and gay – that would be an oversimplification of the diversity of our lived experiences and the resilience and resourcefulness of individuals within the group. It is clear, however, that living as a minority and overcoming marginalisation and discrimination are major life challenges for most Asian gay men. Crucially, this presents us a starting point to unpack the barriers we face in addressing HIV prevention with Asian gay men.

A minority within a minority

A useful way of framing the challenges faced by Asian gay men is the concept of a minority within a minority.¹ On the one hand, Asian gay men exist as racial minorities within a predominantly Anglo-centric or Western-constructed gay community, where cultural marginalisation and racism are a constant challenge. On the

other hand, we are also a minority in our predominantly heterosexual ethnic community, tiptoeing between cultural norms and gender roles. We constantly navigate between racial discrimination from the gay community on the one side, and homophobia from the ethnic community on the other.

With all this in mind, one must then ask how can HIV health promotion respond to the needs of Asian gay men, when our lived experiences are so complex, with life challenges and demands on the individual to cope and survive being a priority often surpassing HIV awareness?

At the crossroads: HIV health promotion and the Asian Gay Men's Project

Annually, gay men account for 70–75% of new HIV notifications in NSW.² Data from 2005–2009 indicates that notifications from Asian men who have sex with men have steadily increased during this period, sitting at 13.8% for 2009.³ This makes gay Asian

men and other Asian men who have sex with men a priority population for HIV prevention.

The Asian Gay Men's Project works with Asian gay communities in HIV and sexually transmissible infection (STI) prevention. The project facilitates health capacity building through community development and peer education approaches and initiatives. Working through ACON's Community Development Unit, the project complements work done by other HIV health promotion projects that target gay men.

In particular, the Asian Gay Men's Project engages heavily with migrant and recently-arrived Asian gay men, as well as second generation individuals from over 10 different countries and cultures. It is at this crossroads of culture, sexuality and health that the Asian Gay Men's Project sits. In addressing HIV/STI prevention, the project engages with Asian gay men through community building and peer education in a culturally appropriate way.

It is crucial to acknowledge the general apprehension that exists within the Asian gay community about discussing HIV/STIs. The stigma surrounding this is compounded by the fact that HIV and/or health promotion initiatives that target a perceived health inequality within the community can pathologise the community's experience and foster a sense of victimisation.

As a result of the shaming and 'othering' of HIV, another barrier exists: the 'It does not affect me' attitude. This attitude can be fed by other life challenges such as work and money issues, attending university, finding accommodation, finding love, dealing with family expectations, and coping with other inequalities associated with marginalisation. All these issues take precedence over HIV. Therefore, effective health promotion needs to move beyond just talking about HIV/STIs; programs must deal with a wide range of personal experiences, life challenges and needs.

The Asian Tea Room project and culturally-appropriate HIV health promotion

The Asian Gay Men's Project runs a peer education group called the Asian Tea Room. This monthly social group is a continuation of nearly 20 years of peer education initiatives of the project. The social group seeks to create a space where Asian gay men can feel connected, and provides a platform for topical discussions and the sharing of ideas and experiences.

Providing an alternative socialising space to bars and clubs, the group is centred on an easily accessible and culturally appropriate bonding activity – tea drinking, which is accompanied by in-depth discussions. Using topics which are immediately palpable as a 'hook', a group conversation is facilitated that explores participants' thoughts, attitudes and experiences about a range of issues, alongside HIV education where appropriate.

While not everyone immediately warms up to the idea of talking about HIV and STIs (or health in general, for that matter), the moment we steer the topic towards love, sex and dating, the conversations take on a different life. These topics are personally relevant to the participants' daily lives and pave the way for discussions about safe sex, HIV/STIs and sexual negotiation.

ConversAsians⁴, a four-week closed group course, is a similar program for Asian gay men run by ACON, that also seeks to create a safe space for rapport building, experience-sharing and mutual learning integrated

with HIV/health education. Most importantly, these types of groups create opportunities for the formation of friendships and networks, supporting the individual in negotiating their lives. For many participants, this is their first experience of feeling connected within the gay community.

Un-masking further challenges

When I started my current role at ACON as Asian Gay Men's Health Promotion Officer, I faced the ongoing challenge of community engagement. How can a community which is so diverse, operating under unique norms and attitudes – especially around sex and sexuality, HIV and health – be effectively engaged?

Under the umbrella of 'Asian', we are not one homogenous group. Each community has a distinct culture and heritage, with specific norms and language around discussion of sexuality, sex and HIV. Asian cultures are often perceived to be conservative but it is a mistake to make such generalisations. For example, most Filipinos are Catholic, however, this descriptor can belie exposure to diverse sexual identities: *bakla* (or gay men) are popular in mainstream Filipino entertainment. Similarly, Buddhist Thai society embraces *katoey* (or 'ladyboys'), many of whom live openly and have everyday jobs without needing to hide this aspect of their identity. *Katoey* are accepted by the mainstream as potential partners, thus forming

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inroads to community engagement around a visible and socially relatable expression of sexual diversity and HIV awareness. In 2009, the Asian Gay Men's Project successfully partnered with a Thai organisation to host a beauty contest for Thai ladyboys – 'Miss Queen Sydney Thai' – garnering huge community support and engagement.

However, these identities are also perceived as 'feminine', and this is potentially alienating for those who do not identify with that description. The issue of living a 'double life', means that men in these societies who identify as 'straight' but who engage in sex with other men might miss out on health promotion messages specifically targeting gay communities.

Similarly, marginalisation can occur across many contexts and affect targeting by focusing on newly-migrated versus second-generation; language skills; education; religious affiliation; employment; or geography and living environment. It is important to keep in mind the complex intersections that exist, acknowledging that there is no 'one size fits all' approach. Effective initiatives need to validate and provide space for multiple identities to exist with respect for confidentiality, steering away from prescribing set ideas of being 'out' or 'being gay'.

While there are multiple differences in the 'Asian' identity, the importance we put on family is a unifying factor. Confucian values (values that privilege the nuclear family) are held by many regardless of geography or religion. Family expectations about marriage, continuation of the family line, and traditional male roles aside, it is our family that forms the bedrock of our support system. Coming out (or being outed) means risking alienation and rejection from the family, because it is seen as bringing shame and disrespect to the family and extended community.

This sudden estrangement could propel the individual into what Daniel Reeders from the Multicultural Health and Support Service at the Centre for

Culture, Ethnicity and Health termed 'time in crisis'⁵, where a combination of challenging life events and loss of family support create a setting for sexual risk-taking and unhealthy relationships to develop. Similarly, situations like this can also occur when family support is lost through migration for work, education or refugee status.

On one level, the challenge lies in engaging Asian communities, both in person and through the media, to de-stigmatise homosexuality. One such opportunity occurred when the SBS Mandarin channel partnered with the ACON Asian Gay Men's Project to run a story on Mardi Gras with a focus on Chinese gay men.⁶ This was a great partnership between ethnic media, gay community and participants' parents resulting in a non-biased portrayal of what it is to be Asian and gay. Importantly, such stories increase the visibility of same-sex-attracted individuals as well as their families, opening dialogue and de-mystifying gay identities.

A supportive environment – especially in a 'time in crisis' – is crucial. Groups such as Asian Tea Room and other community groups function to 'de-isolate' individuals, providing peer support and a sense of community. Importantly, social learning around integrating life and same sex attraction can occur, building resilience in the individual.⁷

Multiple masks

Asian gay men are frequently torn between multiple identities. Like chameleons, we adopt different roles in different situations, compartmentalising our identity and moving through life wearing different masks. A mask of a filial piety son upholding the family name, a mask of a proud gay man out and about in the weekends (but distancing association and identification from his ethnic community), a mask of a successful career man averting marriage questions with the response 'I'm concentrating on

my career'. Always present is a mask of invisibility, silencing our other multiple identities motivated by cultural expectations and familial obligations to hide our sexuality, or (gay) community expectations around 'outness' and 'being gay'.

It can feel like an uphill struggle for Asian gay men to find acceptance and belonging while negotiating these conflicting identities. The challenge then for HIV health promotion lies in validating and engaging with multiple identities, mindfully working with complexities of the individual, family, and community. We need to privilege personal narratives and alternative experiences of negotiating culture and sexuality as a tool for community engagement, instead of taking a one size fits all approach.

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HIV and the social exclusion of culturally and linguistically diverse men who have sex with men

By Daniel Reeders

Late one night, a young man messaged me on a chat site. I was tired and ready for bed; we had chatted before, and his complaint was familiar. 'I can't meet white guys, they don't want Asians.' He was afraid to post a face picture, and essentially hoped to find someone who would enter a long-term relationship with him, sight unseen. I suggested lightly, 'why not post up a shirtless picture? You don't have to show your face.'

Nearly a year passed before I noticed he'd taken my advice. We chatted and he told me he'd been meeting anonymous guys for bareback sex, and that he'd become HIV-positive. His was an exceptional case; I don't hold it out as the norm. Indeed, I only tell it because, after two years of looking, I still haven't found an HIV-positive international student willing to talk 'on

the record', and I think it's important to represent their experience, even if only second-hand.

The encounter brought two things home to me. One is how powerful intense loneliness can be. Had I owed him more in the way of friendship, or a better answer to his complaint? It also showed me what's at stake when international students return home with HIV. Even in developed Asian nations, there are less than ten antiretroviral medications available – mostly older ones that are no longer under patent, some no longer even prescribed here.

In 2009, the Multicultural Health and Support Service (MHSS) convened the 'Double Trouble' consultation forum looking at the health needs of culturally and linguistically diverse (CALD) men who have sex with men (MSM).¹ We wanted to find out 'what do we know,

and how do we know it' as a sector. On the day there was a strong attendance by interstate participants, which added considerable depth and breadth to the consultation and our findings.

At the consultation, following expert presentations, we held small group discussions about key topics – sexual practices and spaces; identity, discrimination and vulnerability; negotiations of identity, family and community; and navigating the health system – which we recorded, transcribed and thematically analysed. In our facilitation and analysis we assigned categories of 'known', 'assumed', and 'unknown' to allow for 'fuzziness' and uncertainty in the accounts we elicited.

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Rather than summarise all our findings, this article gives a broad overview of the relationship we found between discrimination/exclusion and HIV risk, before suggesting ways we can respond as a sector to the unmet health needs of CALD MSM.

The ‘double trouble’ of the report title refers to the way homophobia (or heterosexism) in ethnic communities, and ethnic prejudice (and ethnocentrism) in gay community services and spaces can separate CALD MSM from sources of information, support and social connection.

There has been a lot of research trying to show that discrimination ‘causes’ HIV infection risk-taking via ‘low self-esteem’.^{2,3} In groundbreaking Australian studies in 1999, 2002 and 2003, Asian MSM actually reported *lower* risk behaviour compared to Anglo-Australians and the Sydney periodic surveys^{4,5,6} (testing rates and unprotected sex in relationships were exceptions⁷). Yet surveillance in Victoria showed HIV diagnoses among South East Asian (SEA) MSM increased sharply from six to sixteen in the years 2006–2008.⁸

The rapid growth of Victoria’s international student population has no doubt contributed – but we can’t say to what extent, because our notification form doesn’t ask for visa status. In the separate project analysing Victorian international student needs, focus groups and literature search found the students receive little or no sex education in their countries of

origin, and most education providers in Australia don’t cover sexual health during student orientation sessions.

But international students are only one piece of the puzzle. Research on Asian MSM in Western countries suggests that social connectedness strongly predicts variance in risk-taking between individuals.

Talking to close friends and family about *anything* predicts lower risk-taking; the effect is not limited to conversations about HIV risk.⁹ Men who respond actively and socially to experiences of discrimination report less risk-taking than men who internalised and blamed themselves for their exclusion.¹⁰ In our analysis we also suggest risk-taking can occur during ‘time in crisis’, a time of anomie and quiet desperation arising when CALD MSM come to feel the gay community cannot replace what they gave up by coming out.

At the forum, many participants were keen to explore the inherent ‘identity conflict’ they perceived in someone who has overlapping ethnic and sexual identities. In fact, research shows that CALD MSM only choose between identities when compelled by external social pressures, such as prejudice or a lack of culturally competent service provision.¹¹

When looking at prejudice, it’s essential to look at both sides of the equation – including people who practice exclusion, the personal needs it serves, and the cultural process that sustains it.¹² Double Trouble

calls for ‘twin’ campaigns (including social media, social marketing and community development) to challenge sexual racism in gay community spaces and promote acceptance of same-sex-attraction in ethnic families and communities.

It also calls for strengthened peer education approaches, like Asian Tea Room (ACON) and Gay Asian Proud (VAC/GMHC), and resource development by and for CALD MSM to raise awareness of tacit, staged approaches to integrate same sex attraction into family life – ‘coming home’ instead of ‘coming out’¹³ – as well as negotiating cross-cultural differences in meanings and expectations around sex and relationships.

These strategies are simple to recommend, but there are significant hidden complexities in their implementation. A recent campaign by ACON and the City of Sydney asked ‘Would you wear it?’, with imagery featuring racial epithets (e.g. ‘Arabs are all the same’) printed on t-shirts.¹⁴ The campaign invited people who experience racism to ‘report incidents’ online or by phone, using a questionnaire adapted from one used to report street violence to the Gay and Lesbian Anti-Violence Project.¹⁵

There is no question that racism has a violent history and racist violence occurs every day. Prejudices evolve along with the cultures in which they circulate, and our response strategies need to keep up.¹⁶ ‘Modern racism’ is subtle and covert, consisting of everyday racial ‘microaggressions’ that are designed to fly beneath the radar.^{17,18} It has an insidious, undermining effect on recipients – unable to tell if it was ‘really’ racism, they are left forever questioning their reactions.

Modern racism frequently comes with an alibi. That staple of gay dating profiles, ‘No Asians’, is now frequently accompanied by ‘(not racist, just preference)’. Enraged by this glib statement, one might feel tempted to give chase, but it’s a circular debate that goes nowhere – and that’s the point.

When looking at prejudice, it’s essential to look at both sides of the equation – including people who practice exclusion, the personal needs it serves, and the cultural process that sustains it.

As we found, unfortunately, the HIV sector has immobilising questions of its own. As one clinical worker put it at the forum: ‘anecdotally, there’s no doubt there are barriers to CALD MSM accessing services – but how do you get *evidence* that it is due to internalised racism?’¹⁹

This question appeared linked in our analysis with limiting assumptions about evidence – that only published quantitative research counts; that risk and vulnerability can be ‘read off’ from numbers; and that numeric evidence is the only acceptable basis for action. In combination these assumptions can produce inertia – a reluctance to initiate change – and a continual questioning of the rationale behind program work for CALD MSM.

The rationale for working with these men is as much about human rights and social inclusion as HIV-related risk. Our report – *Double Trouble* – shows how discrimination/exclusion and lack of culturally responsive health promotion contribute to distress and risk-taking. It also acknowledges the strength, resilience, assets and protective factors of CALD MSM, and their diversity as a community.

It also calls for ‘social public health’ methods of enquiry.²⁰ Multicultural sexual health promotion works with newly-arrived communities which are small in size and fragmentary in their distribution and social connectedness. This challenges us to develop skills in community-based research and rapid assessment and community development approaches to health promotion and social change.

In closing, I want to return to the young man whose story opens this article. He won permanent residence in Australia, and connected with a community of people who share his sexual interests. His story is a disaster for HIV prevention but for him, life goes on. It’s a lesson against looking too closely at HIV and neglecting its context of friendships, relationships, and social connectedness.

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As one clinical worker put it at the forum:
‘anecdotally, there’s no doubt there are barriers to CALD MSM accessing services – but how do you get *evidence* that it is due to internalised racism?’

TOP TIPS

For Living Well with HIV

Top Tips: new booklets for HIV-positive people from culturally and linguistically diverse backgrounds

By **Ben Wilcock**

A new range of four booklets designed for people from culturally and linguistically diverse (CALD) backgrounds who are living with HIV will soon be released by the Australian Federation of AIDS Organisations (AFAO). The new booklets will be available in four languages – Arabic, Amharic, Thai, and Vietnamese – and will complement an existing set of resources titled *Top Tips For Living Well with HIV*.

The new booklets include tips for living with HIV, along with contact information for relevant organisations. Each tip is written in a relatively brief format for readers to refer to and to assist them in finding out more information about particular topics.

With increasing cultural and linguistic diversity among HIV-positive people in Australia, it is important that this kind of information reaches as many people as possible. These resources will enable people living with HIV to have access to accurate information about

HIV management and treatment in their own language. These booklets will also serve as an important tool to assist service providers to better meet the needs of an increasingly diverse client base.

AFAO President, Graham Brown explains why resources like these are particularly valuable: 'It is important for people living with HIV to keep up to date with the current information on the management of HIV. These resources help provide this information in a clear and simple way while still giving the opportunity to find out more about a particular topic if required.'

Robert Mitchell, President of the National Association of People Living with HIV/AIDS (NAPWA) commends the development of the four booklets as important resources for people living with HIV. 'Health and wellbeing tips are important for everyone, but these resources help explain why some of these issues are particularly significant for people living

with HIV. The availability of these booklets in different languages is also very valuable, as it is important for all people living with HIV have access to this information.'

The four languages for these booklets were selected using the available information on the languages other than English spoken by HIV-positive people in Australia. AFAO also consulted with HIV educators, multicultural HIV services, and people from the target communities and those who work with them. These consultations also helped form the content of the booklets.

In addition to the four new translated booklets in the *Top Tips* set of resources, there is also a booklet written in plain English called *Top Tips For Living Well with HIV: A Plain English Guide*. This booklet has been designed for people from CALD backgrounds, people of Aboriginal or Torres Strait Islander origin, or people with low literacy skills.

The other resource in the set is the *Top Tips For Living Well with HIV* website (www.hivtopstips.org.au) which is aimed at the broader HIV-positive population. Some of the tips in the website also provide links to other relevant websites.

Copies of the booklets will be available from state-based AIDS Councils and People Living with HIV organisations, as well as through multicultural HIV services. The plain English booklet is also available from these organisations.

The new booklets include tips for living with HIV, along with contact information for relevant organisations. Each tip is written in a relatively brief format for readers to refer to and to assist them in finding out more information about particular topics.



Perceptions of HIV risk and protection among people from CALD backgrounds in Sydney: findings from CALD periodic survey and the late diagnosis study

By **Augustine Asante** and **Henrike Körner**

The dynamics of the HIV epidemic in Australia are changing. The number of new infections attributed to heterosexual contact has increased, and people from culturally and linguistically diverse (CALD) backgrounds – especially those from high HIV prevalence countries – account for a significant proportion of these diagnoses: 37% of new diagnoses due to heterosexual transmission in 2000–2004 and 41% in 2005–2009 were people from high HIV prevalence countries, especially from sub-Saharan Africa and South East Asia.¹ A considerable proportion of HIV diagnoses in people from CALD backgrounds are late diagnoses. For best possible treatment outcomes, early diagnosis is essential.

Recent studies of HIV in migrant communities in Europe have suggested that limited perceptions of risk as well as restricted access to health services in the adopted countries of migrants are two factors that may contribute to a rise in the number of HIV diagnoses and increasing late diagnoses.^{2,3} Findings from two recent studies in Sydney^{4,5}

suggest that high levels of knowledge about HIV risk among people from CALD backgrounds in Australia (where access to health services is readily available) does not necessarily translate into greater personal protection from acquiring HIV and that HIV-related stigma among CALD communities is a major factor contributing to an increase in late diagnoses.

Two studies of Sydney CALD communities – *Periodic survey of HIV knowledge, perceptions and use of health services among people from culturally and linguistically diverse (CALD) backgrounds* (the CALD periodic survey)⁶ and *Understanding late HIV diagnosis among people from culturally and linguistically diverse (CALD) backgrounds* (the barriers to testing study)⁷ – both indicate a clear disconnection between knowledge of HIV risk and having unrestricted access to health services on the one hand, and implementing health-seeking behaviours to reduce personal risk of acquiring HIV on the other.

General knowledge about HIV/AIDS

The CALD periodic survey⁸ found that awareness of HIV was very high; over 90% of the respondents had heard about the disease and a very high proportion understood the modes of HIV transmission – including unprotected sex, sharing of needles and syringes, and mother-to-child transmission – and knew about modes of protection such as consistent use of condoms, abstinence from sex and avoidance of sharing of injecting equipment. For a good number of participants, knowledge about HIV was not just obtained through the media or from written sources but was grounded in first-hand experience of knowing somebody living with – or directly affected by – HIV. In one study community, nearly 57% of respondents said they knew a person living with HIV/AIDS; sometimes these people were relatives or friends of the respondents⁹. High knowledge of HIV was also evident in the barriers

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to testing study¹⁰, where almost all participants knew about the disease before their diagnosis, and about a third of the participants knew someone with HIV before they were diagnosed.

Access to health services

In both studies, almost all respondents held a Medicare card: about 92% of respondents in the CALD periodic survey and 79% of the CALD participants in the barriers to testing study. The majority (64%) of the respondents in the CALD periodic survey had a regular (personal or family) doctor. This was particularly common among older respondents. 80% of people aged between 45 and 54 years old, and 86% of those aged 55 and over, had a regular doctor. However, just over half (52%) of respondents aged under 25 had a regular doctor. Finally, respondents in both studies had positive views about routine health checks. 86% of the CALD periodic survey respondents thought that routine health checks were necessary for disease prevention generally and for timely diagnosis of HIV infection. General practitioners were usually an individual's first point of contact with health services; about 90% of the respondents in the barriers to testing study sought health care from GPs.

Use of health services

Despite the widespread access to free or subsidised Medicare services and the positive views about having a regular doctor and routine health checks, nearly 41% of respondents in the CALD periodic survey said they used health services only about once a

year or not at all, and around 47% had never seen a doctor for a routine check-up. Similarly, in the barriers to testing study, 69% of the CALD respondents had used health services less than once a year prior to being diagnosed as HIV-positive. Respondents in both studies gave varying reasons for this. In the CALD periodic survey, 55% said that a lack of time prevented them from seeking health care.

In the barriers to testing study, most respondents believed that they were healthy prior to their HIV diagnosis, and therefore did not need health services. One woman who was diagnosed during antenatal care explained: 'Normally I didn't get sick. I saw a doctor for the first time when I was pregnant with my second baby [in Australia]. When I had a cold I just took lemon juice.'

For those who saw a doctor because they experienced health problems, HIV was not always explored as a possible cause for the problems. For example, a heterosexual man who was diagnosed as HIV-positive at a CD4 count of just 80 explained: 'I was sick in hospital. It took a long time before my GP suggested an HIV test. I don't know why he didn't think about that early enough. I lost a lot of weight, I had diarrhoea, I lost appetite but he didn't figure out until it was almost too late for me. Any time I see him he tells me everything will be fine.'

HIV testing

In the CALD periodic survey, about 86% of respondents believed that testing for HIV was important.

However, nearly half (49.7%) of all respondents had never had an HIV test. Similarly, about 72% of the CALD respondents in the barriers to testing study never had an HIV test prior to their diagnosis. It should be noted that HIV testing among the participants in both studies was not significantly lower than HIV testing rates found in the general Australian population. In the Australian Study of Health and Relationships nearly 60% of heterosexual men aged 16 to 59 had never been tested for HIV.¹⁰ What was striking, however, was that in both the CALD studies, the majority of respondents who had tested for HIV at least once were tested either because they were sick in hospital, or for immigration or employment purposes, or through contact tracing. Voluntary HIV testing was rare.

Reasons for not getting tested or for delaying an HIV test had little to do with not understanding the Australian health care system or not knowing where to go for an HIV test. In fact, in both studies the majority of respondents had good knowledge of where and how to get an HIV test. What seemed to influence their decision to delay or not to seek a test was more related to individual perceptions of HIV risk, and to the stigma associated with HIV/AIDS.

Perception of HIV risk

While many participants had good knowledge about HIV transmission and prevention and acknowledged that anybody could be infected, many did not see themselves to be at risk. They saw HIV as a distant reality which affected others but which did not apply to them personally. Therefore, in the barriers to testing study, even when participants experienced possible HIV-related symptoms, they explained these in the context of their everyday lives and did not connect them to HIV: 'I had no idea I have HIV because I have not been getting sick. When I feel tired I thought it is just because I work hard and probably don't sleep

What seemed to influence their decision to delay or not to seek a test was more related to individual perceptions of HIV risk, and to the stigma associated with HIV/AIDS.

enough.’ Others thought they were not doing anything ‘risky’ as far as HIV was concerned, and consequently, an HIV-positive result often came as a shock: ‘I never thought the result could be positive because I thought I wasn’t doing anything stupid to put myself in danger. Although I used to play around a bit when I was quite young but I never thought it could lead to something like HIV.’

HIV stigma

In the CALD periodic survey, nearly 80% of respondents had positive views about people living with HIV (PLHIV), and most disapproved of discrimination against HIV-positive people. However, despite these positive views, about 43% thought HIV-positive people bring shame to themselves and their families. Such negative perceptions were a reason for not seeking an HIV test in the barriers to testing study. For nearly 61% of CALD respondents, the shame that an HIV-positive result would bring to them and their families was a major concern. ‘Other people finding out was my biggest worry. I had to move from my house to another area after the diagnosis because a nurse at the clinic which did the diagnosis happened to be my neighbour. I sold my property and moved out because of her. I knew she’ll definitely tell her family at least.’

Conclusion and recommendations

There is a gap between accurate knowledge of HIV transmission and competence to obtain health services on the one hand, and low perceptions of individual susceptibility to HIV infection on the other hand within culturally and linguistically diverse communities in Sydney. There is also substantial stigma and discrimination against people living with HIV. People in the two studies reviewed in this article have sufficient knowledge about HIV transmission and prevention in general, but many do not find the HIV epidemic in Australia and their home country personally relevant. To bridge this gap, we recommend firstly,

to encourage people from CALD backgrounds to make better use of existing health services. While holding a Medicare card ensures access to health services, people from CALD communities are often from countries where health services need to be paid for and are used only in times of seriously illness. There is a need for education about the benefits of routine health service use to encourage people from CALD backgrounds to engage with preventive health care.

Secondly, HIV prevention in CALD communities would benefit from improved sexual health education among GPs in these communities to increase their confidence in recognising and investigating HIV-related symptoms. Finally, social and cultural perceptions about HIV in CALD communities, including stigma and discrimination, continue to negatively affect individuals’ decisions to seek an HIV test. Mainstream education campaigns seem to have done little to reduce HIV stigma in these communities. There is the need for a new and targeted approach to addressing stigma within CALD communities if progress is to be made.

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There is a gap between accurate knowledge of HIV transmission and competence to obtain health services on the one hand, and low perceptions of individual susceptibility to HIV infection on the other hand within culturally and linguistically diverse communities in Sydney.



Making sexual health hip

By **Cara Brough, Chiedza Malunga and Dan Walls**

The Multicultural Health and Support Service (MHSS) is a program of the Centre for Culture, Ethnicity and Health (CEH). MHSS works with and empowers culturally and linguistically diverse (CALD) communities, individuals and groups to achieve better health outcomes in relation to the diversity of highly complex and culturally sensitive issues regarding blood-borne viruses (BBV) and sexually transmissible infections (STI).

MHSS currently works with individuals, families and communities from Africa and Asia, with a focus on newly arrived groups and refugees. MHSS also works with other target groups that include CALD and the broader communities, as well as relevant mainstream service providers in relation to access and culturally sensitive service provision.

Working in partnership with key community groups, MHSS developed two sexual health education projects designed to engage with newly arrived young people from Africa and the Middle East. Through a strategic combination of workshops, peer education and outreach support, MHSS was able to deliver two highly successful youth focussed projects – Hip Hop and Health (later referred by the young people as H3) and sister2sister.

Hip Hop & Health (H3)

Funded through the Victorian Department of Health, MHSS initially partnered with the Anti-Racism Action Band (ARAB) – a program of the Victorian Arabic Social Services – in undertaking the H3 project. The aim of this project was to reduce the

risk of transmission of HIV and STI amongst African and Arabic-speaking young people under the age of 25. There was particular focus on recent arrivals to Australia (a group defined by the Australian Government as having arrived within the previous five years¹), including both those who attended secondary school and those who had left the school system.

In order to increase their knowledge of these issues and promote preventative behaviour, H3 utilised both male and female MHSS Community Workers to facilitate interactive workshops and outreach support. These sessions covered basic information about blood borne viruses (BBVs) and sexually transmissible infections (STIs), how to practise safe sex, where to get tested and information on treatment. The sessions

were presented in a peer education framework communicated through hip hop performances and adult learning. Each session was accompanied by a performance by ARAB that included beat boxing and dancing.

During the first year of the H3 project, 13 workshops were conducted in metropolitan Melbourne, with 395 young people of Sudanese, Somali, Eritrean, Ethiopian, Iraqi and Afghani backgrounds attending. It was noted that once a few workshops had taken place, the target communities began to promote the program themselves through word of mouth. However, it took time for demand to build for H3. One community worker involved with the project noted it took approximately six months of sustained engagement to forge the networks required to build acceptance of the program within the relevant communities.

Another target set for the H3 project was outreach support for at least 15 young people in the first year. This goal was met and surpassed due to community workers meeting with many different groups in and outside the scope of the project to build rapport and circulate information on BBV/STI prevention, testing and treatment services. The workers also received phone calls from young people seeking information on BBV/STI and accompanied some young people to treatment services.

The evaluation process revealed that H3 had been particularly successful in engaging Sudanese young people, with more than half the workshop participants being of Sudanese background. This finding was not surprising, as the Sudanese participants were specifically targeted during the recruitment process for the project – the rationale being that the Sudanese community are a relatively new emerging community in Australia and, therefore, Sudanese young people are likely to have limited awareness of the service systems available and less exposure to information about BBV/STIs.

Another issue of representation highlighted by the program was that it was harder to engage with particular sub-groups within the

nominated populations, such as Muslim communities – although the program did deliver sessions to these sub-groups. Some community leaders and people working with these harder-to-engage subgroups expressed concerns regarding the cultural relevance of the program for their communities. As a result, the community workers engaging with these sub-communities negotiated content and material with community leaders and workers, a process which was successful on a number of occasions.

The ARAB project workers also needed to ensure that community elders and workers – who often facilitated youth programs – were comfortable with the workshop material and objectives. For example, community leaders were more comfortable with material that emphasised health rather than sex, was less sexually explicit, and treated abstinence and monogamy as viable preventative behaviours. The MHSS Community Workers and ARAB adapted the performances and workshops to be less sexually explicit and more sensitive to the values of the particular group in question. For example, where the female protagonist in a workshop performance would usually pull out a string of condoms from her pocket, the performance was altered so that she pulled out a single condom. This change was made to avoid the suggestion that ‘promiscuity was the norm’ among young people generally, and young women specifically.

Other examples used during the health education sessions needed to be tailored to a particular group’s cultural values. Some groups could

relate better to safe sex messages when they were discussed in the context of a long-term relationship, rather than relying on scenarios that assumed casual sex as the norm.

In one session observed by the independent project evaluator, participants told a MHSS community worker that the option of abstinence as a protective behaviour seemed to be under-explored. In this instance, the community worker was quick to respond to the values of the group and incorporated abstinence, as one option, within his examples.

Sister2sister – adopting an African tradition

Incorporating traditional values of the target group was also a tactic used to achieve success with the sister2sister program. In African cultures, sharing information from sister to sister is a traditional and effective way to talk about real life issues, share advice, and provide guidance. Therefore, the project adopted this traditional approach as its foundation to address low levels of awareness about sexual and reproductive health among young women from refugee and migrant backgrounds.

Sister2sister was developed through a collaboration between the Refugee Minor Program (RMP) of the Victorian Department of Human Services, the Centre for Multicultural Youth (CMY) and MHSS. An RMP case manager had developed a proposal for a sexual health education group

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for clients of her program. Workers from MHSS and CMY then met with RMP to develop a project to support the group, with roles allocated to the different partners based on their area of specialisation. It was decided that RMP and CMY would recruit the young people and provide social and logistical support, with MHSS developing and delivering the sexual health education program. The approach was to make use of the sisters in each organisation (female workers), to provide guidance and strategic direction for younger sisters (the participants), to enable their discovery of what it means to be a healthy woman.

To recruit participants, two flyers were designed to promote the program to both young women involved with RMP and CMY, and their guardians. Through these two agencies, 10 Sudanese and Ethiopian young women were recruited. Written consent was obtained from the guardians, and participants were supported by RMP and CMY workers to attend the group. Participants were picked up from their school or home, and then dropped off again after the session was over. This had the additional benefit of allowing the community workers to establish a rapport with the families of the participants.

Sister2sister group members took part in six after-school sessions that were approximately two hours each in duration. Each session encompassed relevant topics and hands-on activities, which included exploring the female reproductive system, negotiating sexual relationships and sexual rights, as well as learning about BBV/STI and visiting relevant health services.

MHSS has found that low levels of awareness among young people about

issues such as BBV/STI, unintended pregnancy, infertility, contraception and sexual dysfunction is common, particularly among young people from refugee and migrant backgrounds.

In a research study from 2009, Australian service providers expressed concerns about the incidence of teenage pregnancy, termination and STIs among refugee young people in Victoria.² The study found that the most common source of information and support for refugee young people was their friends, but also that young people had significant doubts about the reliability of the information they got. This finding is consistent with that of the sister2sister project, as one member of the group stated:

'Before this program, I feel like I knew everything but I actually didn't know anything about this girl stuff but I came and I really know much more now.'

These findings demonstrate a need for a peer education model that employs sexual health educators who can relate to young people and who are ideally also of a similar age to the participants.

The 2009 study found that group discussion about health promotion is often more effective than printed information.³ Literacy levels for young people who have recently migrated to Australia are lower than Australian born young people in many cases, as a result of extreme poverty and low levels of formal education in some countries. Interactive group-based learning caters for this difference in a way that printed material cannot. Young people who participated in the study also highlighted the need for programs that take a more holistic approach to issues of risk and protection in sexual health. They

wanted programs to not focus entirely on STIs but cover a range of topics including responsible decision making, communication and relationships.⁴

H3 and sister2sister – clearly showed how peer education and group work can be an effective strategy to encourage young people from CALD backgrounds to engage with sexual health and harm minimisation messages. Additionally, the knowledge gained from these two projects can contribute to research and the development of targeted programs and resources for CALD communities and relevant services. Other important learnings that need to be considered are that trust and acceptance from the community and its leaders are essential, and promotion and engagement take time, and that recruitment is most effective when spread organically through word of mouth. The most significant lesson from a health promotion perspective though, is that young people from a CALD background are more receptive to messages that are validated by their peers and communicated in a medium that is known and respected.

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... young people from a CALD background are more receptive to messages that are validated by their peers and communicated in a medium that is known and respected.

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'It feels like a second home.'

By James May

James May speaks with three HIV-positive people from culturally and linguistically diverse (CALD) backgrounds about their countries of origin, their HIV status and their experience of HIV service providers in Australia.

Emily

Emily came to Australia from Zimbabwe in 2009 on a student visa. She now studies social work in Melbourne and has been given permanent residency. She says that Australian citizenship was not difficult to obtain, despite her HIV status. Emily wanted to come to Australia to find a better life and the chance to build a career. She now has a partner and a daughter as well as two siblings in Melbourne.

Living with HIV in Zimbabwe is very challenging, according to Emily. Most people have no access to medication, while some only have access to basic treatment which cannot be tailored to suit the individual. Many people don't

have access to clean water or good nutrition, especially in the rural areas where Emily is from. Also, there are very few HIV services available across Zimbabwe, aside from a few non-government organisations (NGOs) that are not equipped to deal with the scale of the problem.

Emily says many people in Zimbabwe still lack basic education about what HIV is and how it's transmitted. As a result, there is a great deal of stigma and prejudice about HIV and AIDS. 'It's rarely spoken about unless it affects you personally, and there's a lot of fear and shame. [If you are HIV-positive] people think you're promiscuous.'

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Emily had no idea what her HIV diagnosis meant in the beginning. It was only when she came to Australia and met her current partner that she disclosed her status and made contact with medical services. Her CD4 count was then deemed to be low enough to commence antiretroviral therapy.

Emily says that keeping busy and active in the community takes the focus away from her health – although there have been times when she felt in need of support. That led her to contact Positive Women Victoria. She says it's been a big help to discuss things with other women who understand what she's going through. Emily says she also gained a lot of strength from her experience in Zimbabwe where she saw many people sick and dying. 'It drove me to keep going,' she says.

Emily hopes to play a role in HIV service provision in Africa one day. She says the virus has hit women and children the hardest. 'Women in Zimbabwe have very little power and are resigned to life at home. They often have no idea they're carrying the virus because they're infected by men who won't disclose their status or seek treatment.'

Wei

Wei Zhang is a Chinese artist. He came to Australia from Shanghai in

1996 and found out he was HIV-positive in 2000. He says it's very hard to be openly gay in China and he wanted to travel abroad to see what it was like to live in a democracy. According to Wei, there's a lot of pressure to marry in China and he's never told his parents about his sexuality. 'They still tell me there's time to marry when I visit them.' Wei was able to secure permanent residency as a political refugee and also as an HIV-positive gay man.

Although Wei doesn't spend a great deal of time in China anymore he understands that people are talking a lot more openly about HIV/AIDS these days. He believes that condoms and HIV treatments are now more widely available and that Chinese governments will actually subsidise antiviral therapy in some cases.

Wei says he did not trust HIV treatments for a long time because of the side effects he witnessed in others, although he is now taking combination therapy. He lived in Sydney for a long time and did not feel adequately supported by some HIV services there, but he now has a great support network at the Positive Living Centre (PLC) in Melbourne. He attends a peer support group where he can share his experience with other HIV-positive

men and he can also access meals and exercise groups. 'It feels like a second home,' he says.

In addition to being HIV-positive, Wei is also living with hepatitis C. He underwent antiviral therapy to eradicate the hepatitis C virus and says it was extremely debilitating and caused severe side effects such as depression, fatigue and low motivation. The virus was cleared after twelve months but it reappeared on blood tests seven months later. He is now considering his options.

Wei says his English was quite poor when he arrived in Australia and it was a barrier to learning more about his HIV and hepatitis C status. He'd like to see more language-specific material made available in HIV support services, although he says that people who work in the sector do a very good job. 'It's the individual's responsibility to learn English but more language-specific information could assist with HIV prevention,' he says.

Wei says he feels very fortunate to be HIV-positive in Australia, where there is good access to medication, support and information. 'I can't imagine how hard it must be in China.'

Kathy

Kathy is an eighteen year old student from Papua New Guinea (PNG). She now lives in Victoria with her parents. She was diagnosed HIV-positive when she was fifteen and was seriously ill at the time. Kathy is still struggling to come to terms with her HIV status and says it occupies her mind a lot. She was very angry and scared when she found out and her parents were sick with worry. 'I had no idea there was medicine. I just thought I was gonna die.' Kathy says it still causes her a great deal of anxiety and she has been suicidal at times. She also says that she was very annoyed with her doctor for informing her parents about her HIV status without her consent.

Kathy would love to have her own family one day and she'd prefer to have

Wei says his English was quite poor when he arrived in Australia and it was a barrier to learning more about his HIV and hepatitis C status.

He'd like to see more language-specific material made available in HIV support services, although he says that people who work in the sector do a very good job.

children while she's young. 'When I got HIV I thought this wouldn't be possible.' She finds it very difficult to disclose her HIV status to friends or potential partners. 'Guys my age are too immature,' she says. Although many people are HIV-positive in PNG, Kathy says there is little education and people tend to gossip about private matters. 'If people knew I had HIV they wouldn't sit near me. They'd think I was sleeping around,' she says. 'No one discloses their HIV status in PNG. They don't care about others.'

Kathy started antiretroviral therapy three months ago and although it's working she hates the thought of taking pills every day for the rest of her life. While her current medical service is adequate, Kathy says she didn't feel cared for when she began attending a major hospital service in Victoria.

She also says that counselling has not improved her emotional wellbeing. 'They just tell me things I already know. It doesn't help. Sometimes I feel sick from thinking so much.' She prefers talking to people who are living with HIV as they understand her experience and she has found some good mentors through Positive Women Victoria. However, as a young woman, she doesn't feel comfortable with other HIV services that are predominantly used by gay men.

Kathy is glad to be living in Australia. 'Women have more freedom here. They're stuck at home in PNG and there's a lot of violence against women.' She hopes to do a photography course at TAFE and would love to work in the media as a photographer one day.

Summary

Some people from CALD backgrounds wish to come to Australia to take control of their health, build careers and find a better life – and perhaps contribute to the health and wellbeing of HIV-positive people in their countries of origin. Living with HIV in many countries is still tough due to

widespread poverty, poor sanitation, lack of access to HIV services and medication, as well as poor education. The participants in these interviews each had vivid recollections of HIV-positive people from their home countries being gravely ill and dying in recent years.

A lack of education, cultural beliefs and gender inequality means that stigma and discrimination is deeply entrenched. People don't understand what the HIV virus means or how it's transmitted. There is a lack of open communication about sex and safe sex messages, leaving people vulnerable to infection. Women are particularly at risk and HIV-positive women are viewed as 'promiscuous', according to the women I spoke with.

Support groups are important for people from CALD backgrounds. The respondents take solace in the company of other people living with HIV who share their experience. However, it is essential that more women-specific groups are made available, as women do not always feel comfortable attending HIV services that are predominantly used by gay men.

While the participants agree that effective information and diverse staff representation is widely available in the HIV sector, there were examples where people felt unsupported by

particular services. Perhaps this is due to an inability of some staff to engage effectively with CALD groups. A knowledge of basic English makes it easier to navigate these services while poor language skills can be a barrier to understanding one's HIV and hepatitis C status and related issues around treatment access and adherence.

All respondents are very pleased to be living with HIV in Australia. This is largely due to the availability of better treatment, care and support. They would also be at a greater risk of stigma and discrimination in their countries of origin due to the ignorance surrounding the virus. The people I spoke to recall the suffering of people living with HIV in their birth countries with deep sorrow. As HIV-positive citizens of Australia, they now have a renewed sense of freedom and power over their future.

James May is a writer of short fiction, theatre and freelance journalism. His work has been published in various magazines and anthologies.

Some people from CALD backgrounds wish to come to Australia to take control of their health, build careers and find a better life – and perhaps contribute to the health and wellbeing of HIV-positive people in their countries of origin.



Returning to the homeland: a means of addressing heroin issues for Vietnamese-Australian young people and families

By Naomi C K Ngo

Almost all studies on Vietnamese-Australian heroin users have expressed concerns over their risk behaviours, particularly in relation to young people travelling to Vietnam for drug-related reasons. The latter were considered as a 'bridge population' in epidemiology because they were seen as liable for potentially transporting HIV from Asia into the Australian community^{1,2} and sustaining the current epidemic of hepatitis C among injecting drug users³. Although these studies have produced valuable findings on the profile and health risks of these young people, they have not focused on their experiences and motivations. As a result of this knowledge gap, my PhD study, summarised below, aimed to provide a description and understanding of the experiences of young Vietnamese-Australian heroin users who travelled to Vietnam to address their heroin related issues.

Methodology

Given the focus of the study, I adopted a qualitative methodology that was

influenced by a critical ethnographic approach. This was because I viewed the lives and experiences of these young people as being located within the political, economic, social and cultural context of Australian society.

The action of sending young people to Vietnam as a way of addressing their heroin related problems – an act that I refer to as *the option of return* – is largely a decision made by the young people's parents, and supported and assisted by their case-workers and other professionals ('workers'). Therefore, my research participants consisted of a range of workers (n=10), family members (n=5) and young people aged between 15 and 25 years (n=16).

Resorting to the homeland to address heroin issues in the family

Vietnamese Australian families whose children have heroin issues are not only dealing with the disruptions brought upon by the experiences of dislocation and resettlement, but they also find themselves battling with their children's illicit drug problems. When these

families turn to the Australian health system for support, they are confronted with ideologies and service models that are culturally and linguistically inappropriate and insensitive to their needs. The majority of health services are directed solely towards the individual and are based on a highly individualistic Western culture that inevitably discourages or excludes families and certain individuals from meaningful and effective access and participation.

The level of stress and hardship the young people and their families were confronted with in relation to illicit drug issues was further heightened by their limited personal resources and the absence of a supportive traditional extended family, which had disintegrated due to dislocation, migration and settlement. As a last resort, these families decided to send their children to Vietnam – a familiar society that has a familial support system, which has in the past effectively addressed the needs of the family. As one mother explains:

'Over here we've tried to detox them many times but they weren't successful because they can ring at any time for someone to bring it [heroin] to them ... That's the problem that we had ... so the family decided to send them to Vietnam. Vietnam is actually a gateway for the transport of narcotics. There's a lot of it and I'm afraid there's more of it than here. However, when we send them to Vietnam there are many family members who can come together to assist them. That's the first reason. The second reason is that we can remove them from the lifestyle that they were leading ... When they return to Vietnam it's like an unfamiliar world to them.'

— 40 year-old Vietnamese-Australian mother.

Returning to a collectivist tradition

Although Vietnam is rapidly changing, it still remains largely a traditional society that is collectivist or communal in nature, where the individual is defined and directed by others. In Vietnam the family is the fundamental unit of society. The actions of family members are guided by rules, morals and virtues that are in accordance with a Confucian heritage. The traditional and common form of communication is face to face interaction, with clear lines of communication within the family that are based on filial piety. Face to face interactions and oral traditions provide most people with a sense of the past and a social context for everyday life.

Many of the young people who participated in my study successfully met their own and their families' objectives in relation to drug detoxification and abstinence while they were in Vietnam. It appears that exposure to the traditional social, cultural and familial structures in Vietnamese society, which they lacked in Australia, helped provide most of these young people a renewed sense of identity and self respect, as well as a stronger sense of familial and social obligations and duties. This assisted them to appreciate the consequences of their actions on both their own family and the wider community, and gave them a greater appreciation for family and community.

'The community here is more loving, like everyone talk to each other not like over there, like I don't even know my next door neighbour ... Like people [here in Vietnam] they talk more, it's more community. Everything is close by. If you're hungry, people bring food to your door. Over there, if you want to go somewhere you have to like hop into a car ... [In Vietnam] Sometimes I can't keep up with it. I have to follow the rules, like don't lose the family name whatever, like I have to save face and that for the family ... It's a good thing but. [It] gives [you] something to believe in.'

— 19 year-old Vietnamese Australian young man.

In general, the option of return seems to be an effective strategy in addressing heroin issues for young Vietnamese Australians. However, the strategy also entails some risk because of the availability and affordability of heroin in Vietnam, and the lack of awareness among young people about the health risks involved in sharing injecting equipment. Furthermore, for a few young people, their experiences of Vietnam were negative because they could not identify and connect with the environment and the people around them.

Nevertheless, for the majority of the young people, the respect, support and love they received from their

family and the community in which they lived in Vietnam provided them with meaningful interactions and relationships with those around them. As well as a strong sense of belonging to the family and the community, most importantly, returning to Vietnam provided these youth with a very positive and fulfilling experience that ultimately gave them a sense of confidence and optimism about their life and future.

Returning to Australia

When the young people returned to Australia, almost all were healthy and hopeful about their future. They had clear plans for themselves that included abstinence, employment and education. However, within three months after returning to Australia, most relapsed into heroin addiction and subsequently returned to a situation where they were, again, highly at risk of dangerous heroin use and incarceration.

'I saw a good future, but then I start using again. So that wasn't really good. There were times I wanted to go back to studying, there were times where I wanted to go look for work, get a job, but then I started using again. There are things I want to do. I wanna just get a job, live a normal life like everyone else, be drug free. Eventually if I keep on using drugs

continued overleaf

The level of stress and hardship the young people and their families were confronted with in relation to illicit drug issues was further heightened by their limited personal resources and the absence of a supportive traditional extended family, which had disintegrated due to dislocation, migration and settlement.

you know, being around drugs, I'll be left with nothing. You know what I mean? There'll be no future.'

— 21 year-old Vietnamese Australian young man.

The factors identified as contributing to the young people's relapse are boredom and, most importantly, returning to an environment with limited support and a state of isolation and marginalisation. In Australia, they were part of a minority group, and for many of them their lives were characterised by socio economic disadvantage, racism and marginalisation. Whereas in Vietnam, they were part of a majority and held the elevated status of *Viet Kieu* (overseas Vietnamese). Almost all of them were well cared for and most felt respected, valued and loved in Vietnam. Consequently, the conditions of their lives in Australia ultimately drew them to seek comfort with their drug using friends and in heroin.

Despite relapsing, the majority of the young people believed that they had 'done better' than other young people in similar situations by going to Vietnam. They found that Vietnam provided them with an environment, space and

time to learn about themselves, their families and their homeland. More importantly, it provided them with the opportunity to get off heroin and start a new life. For these reasons, almost all of them recommended returning to Vietnam as an option to address young people's heroin issues.

Recommendations

The findings of my study have provided a cultural and socio economic dimension to the discourse and debates on drug dependency and drug treatment. As a result, I have recommended that cultural and socio-economic factors be incorporated into current understandings of heroin addiction at all times. We also need a holistic approach to ensure access and equity for all those affected by substance misuse.

To address the whole range of physiological and socio-cultural factors that cause ill-health, as well as those that sustain and create good health, I propose that we adopt the World Health Organisation's Primary Health Care (PHC) approach – a social model of health.⁴ It is important not

to confuse the PHC approach with primary care, which is based on a biomedical model and widely adopted by nursing and allied health. PHC is partially based on the understanding that in order for people to obtain good health, their basic needs must first be met. In practice, this translates to a whole of government approach that addresses the range of social determinants of health including income distribution, discrimination, and marginalisation based on factors such as race, gender, age, disability and so forth. Within this approach, PHC practitioners work to change the socio economic and political structures to address the social determinants of illness in order to produce healthy people and societies.

A copy of Dr Ngo's PhD thesis can be downloaded from <http://researchbank.rmit.edu.au/eserv/rmit:7537/Ngo.pdf>

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Dr Naomi Ngo is the Manager of the Multicultural Health and Support Service, a program of the Centre for Culture, Ethnicity & Health.

Despite relapsing, the majority of the young people believed that they had 'done better' than other young people in similar situations by going to Vietnam. They found that Vietnam provided them with an environment, space and time to learn about themselves, their families and their homeland. More importantly, it provided them with the opportunity to get off heroin and start a new life.



Regional feature: HIV and the law in Papua New Guinea

By **Tim Leach**

Papua New Guinea (PNG) is focusing on the role of law in combating HIV, but not everyone is happy. Tim Leach reports.

While not everyone may find the legal dimensions of the HIV epidemic compelling, few would deny the important link between combating HIV and having a legal framework that protects the rights of those individuals and communities most affected by the epidemic. Given this, a workshop about these issues that took place in PNG earlier this year is worth noting.

The workshop, held in Port Moresby March 22–25, examined how HIV law and policy might be used to help stem the country's HIV epidemic and how to better protect people living with HIV (PLHIV). The event was hosted by the Rome-based International Development Law Organisation (IDLO) and Sydney-based AIDS Projects Management Group (APMG). It was funded by AusAID and the OPEC Fund for International Development (OFID) and supported by the National AIDS Council Secretariat (the agency responsible for coordinating PNG's HIV response).

There were several really impressive aspects of the workshop. The first was that at least half the attendees were lawyers. To date, PNG has not seen much involvement from lawyers in the HIV response – and there are no stand-out judicial or legal champions advocating for a better legal response – so to have so many lawyers in the one place discussing HIV and the law was of itself an important development.

A second important aspect was that the workshop was well attended by representatives of marginalised groups in PNG. Even more noteworthy, these groups are clear about what their legal issues are and how they might be addressed. These community representatives had no difficulty at all identifying their most pressing legal problems. A short summary of these problems will follow. For those familiar with the legal response to HIV in Australia and elsewhere there won't be

continued overleaf

too many surprises – the same legal problems encountered by marginalised groups here in Australia are being experienced by groups in PNG. In this sense, the workshop included some depressingly familiar tales.

Obviously, there are some very important ways in which the HIV epidemic in PNG differs from the one in Australia, and these will help shape PNG law reform priorities. Firstly, and perhaps most obviously, PNG has a generalised epidemic and infection rates are, as far as we can tell with imperfect surveillance, no worse among men who have sex with men (MSM), transgendered people or sex workers than among other groups. Even so, it is important to note that the marginalised nature of these communities exacerbates their vulnerability to HIV, so there will need to be priority attention to their legal needs.

A second difference relates to the legal framework for tackling HIV in PNG. The country's constitution has much to say about the rights of its citizens, so there is already some invaluable support for a rights-based approach to HIV in PNG. PNG has also enacted the *HIV/AIDS Management and Prevention Act 2003*, a single piece of legislation which seeks to address all aspects of HIV from prevention to transmission to the prohibition on discrimination against people living with HIV.

A third big difference relates to the role of customary law in PNG and the activities of the village courts. While village courts have no jurisdiction in relation to the *HIV/AIDS Management*

and Prevention Act, it is clear that they are actively engaged in the resolution of HIV-related matters. Research conducted to date shows only a handful of *HIV/AIDS Management and Prevention Act*-related cases having been heard by the formal court system (without, as yet, a single judgement being handed down), while village courts have heard hundreds of matters involving HIV as an issue.

Further research is being conducted into what these village court cases involved. It will be fascinating to learn the details about the ways HIV has been raised in these cases and what the village court magistrates decided. Participants at the workshop reflected on the obvious dilemma – in order to generate a better legal response to HIV, should our actions focus on the formal court system and exploration of how the *HIV/AIDS Management and Prevention Act* might be better used, or should the focus be the village courts where the cases are already being considered in their hundreds (admittedly, without reference to the *HIV/AIDS Management and Prevention Act*)? Village courts have constitutionally protected jurisdiction, subject to the constitutional rights afforded all citizens of PNG. No doubt, some engaging arguments about how these matters might be reconciled lie ahead.

What are the legal issues for marginalised groups?

A presentation from Igat Hope, the national body for people living with HIV in PNG, presented research

done by the organisation in 2010. The organisation had discovered, through a workshop run by and for positive people in Port Moresby, that the primary legal issues for people living with HIV are¹:

- Mistreatment within the healthcare setting
- Decriminalisation of homosexuality
- Family issues
- Violence against women
- Abuse and discrimination
- Non-implementation of the *HIV/AIDS Management and Prevention Act*
- Police abuse and failure to protect PLHIV
- Discrimination in employment, and/or
- Breaches of confidentiality

A presentation from Friends Frangipani, the national peer-based sex worker advocacy group, named the key legal issues as:

- the need for decriminalisation of sex work
- sexual and other violence against sex workers
- police violence against sex workers, and/or
- harassment of sex workers by police – particularly in relation to possession of condoms, and discrimination against sex workers and their families.

Finally, a presentation from the Poro Sapot Project of Save the Children in PNG (the nation's leading authority on issues affecting men who have sex with men, but also respected for its programs with sex workers) identified the following legal issues for its constituencies:

- Abuse of sex workers and men who have sex with men
- Discrimination against sex workers and men who have sex with men, either based on involvement in the sex industry, sexuality or perceived HIV-status
- Blackmail
- Family and welfare issues (child custody, child support, abuse of children, family violence)

PNG has also enacted the *HIV/AIDS Management and Prevention Act 2003*, a single piece of legislation which seeks to address all aspects of HIV from prevention to transmission to the prohibition on discrimination against people living with HIV.

- Assault, sexual assault and rape
- Ignorance of legal rights
- Inaccessibility of the legal system and lack of free legal services
- Likelihood that cases will be settled out of court with outcomes that do not benefit the victim: 'customary justice' not equaling justice, and/or
- Shame of being a member of vulnerable and illegal groups makes accessing justice difficult.

There was agreement amongst presenters that there is a need for change in PNG. Most urgently:

- Laws criminalising homosexual behaviour between consenting adults and sex work need to be repealed
- Existing laws protecting Papua New Guineans – such as the *HIV/AIDS Management and Prevention Act*, laws prohibiting blackmail, laws against rape and laws protecting children – need to be enforced.

There is some preliminary research in PNG which backs up the claims made by these groups.

Almost half of sex workers interviewed for an important study into the sale and exchange of sex in PNG² reported physical abuse connected to the selling or exchange of sex in the last six months, and half reported being forced to have sex.

In another important study³, almost half of all people living with HIV interviewed reported having experienced some form of verbal abuse as a result of their status, and almost 15% reported physical abuse linked to being HIV-positive.

The workshop achieved some important outcomes – first and foremost it gave a voice to marginalised groups, allowing them to articulate the legal problems they want addressed. But it also brought lawyers, community representatives and others together in a positive way, paving the way for further legal advocacy – in fact advocacy strategies were developed during the workshop for four priority

goals: decriminalisation of sex work, decriminalisation of homosexuality, reduction of the incidence of ante-natal testing without consent and better implementation of the *HIV/AIDS Management and Prevention Act*.

This multi-sectoral support for reform will be critical, and it will be further strengthened by IDLO's establishment of a free legal service dedicated to addressing the challenges presented by HIV. IDLO has established this service with funding from AusAID and OFID. The service is working closely with Igat Hope, the Poro Sapot Project and Friends Frangipani, and is seeking advice and support from the HIV/AIDS Legal Centre (HALC) in Sydney.

Recent developments

In June, retired judge of the Australian High Court, and HIV legend, Michael Kirby travelled to PNG to address the first national dialogue on HIV, Human Rights and the Law. The Honourable Michael Kirby was invited by the National AIDS Council and AusAID, and further supported by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Development Programme (UNDP). He was joined by representatives of the sex work, men who have sex with men, transgender and HIV-positive communities in addressing the gathering on the legal dimensions of HIV. Among other factors, the workshop addressed the contentious issue of decriminalisation of homosexuality and sex work. It occurred against the backdrop of an ongoing campaign to achieve these reforms, the campaign being spearheaded by the Minister for Community Development Dame Carol Kidu (PNG's only woman parliamentarian). The campaign has been encountering ferocious opposition from a range of powerful groups, notably the media, many religious leaders and some particularly influential parliamentarians.⁴

At the conclusion of this important dialogue, all participants agreed to keep talking with each other. Surely, this is a step in the right direction, but more needs to occur. The government has already agreed to give a reference to the PNG Law Reform Commission so that it may explore decriminalisation in the context of the country's HIV response, although the reference has yet to be formally made by the Attorney-General.

In the meantime, IDLO's legal service has begun to take on clients and is planning its first test case – a case of HIV-related stigmatisation.

Watch this space.

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- 4 In an attempt to generate maximum benefit from Kirby's address, several lead-up workshops had been conducted for specific groups – the media, religious leaders, women and civil society – with varying levels of success.

Tim Leach is a development practitioner who works a lot in PNG. He used to be a lawyer. He was part of the International Development Law Organization/AIDS Projects Management Group team which facilitated the workshop, Using the law and legal policy in the response to HIV and AIDS.



WEB WATCH: MULTICULTURAL HIV/AIDS AND HEPATITIS C SERVICE (MHAHS)

[http://www.
multiculturalhivhepc.net.au](http://www.multiculturalhivhepc.net.au)

The Multicultural HIV/AIDS and Hepatitis C Service (MHAHS), based in NSW, works with culturally and linguistically diverse (CALD) communities. MHAHS provides a range of services, including support for people living with HIV and hepatitis C, clinical support, information and referrals. The MHAHS website targets more than 25 language groups, based on the principle that understanding culture and language is vital to providing individuals and communities from CALD backgrounds with equitable access to health information and support.¹ Given Australia's multicultural population, the MHAHS website, which provides HIV and hepatitis C information in plain English and 25 community languages, is a particularly important resource.

According to Sonam Paljor, media and education officer at MHAHS, there is a huge demand for multilingual health information online. He says the MHAHS website receives over 7000 unique visitors every month, both from Australia as well as overseas. Site visitors spend an average of 15 to 20 minutes per visit, which is a marker of the site's success.

Sonam recommends that more health organisations should be inclusive in their approach by disseminating multilingual information as part of their work. He suggests translating segments of websites, or translating key resources over time. Another way to increase CALD access to

information and services is to display web banners linking to MHAHS and other multilingual resources wherever important health information is displayed. He is keen to stress that even small steps towards providing multilingual access can speak volumes about an organisation's willingness to engage with CALD communities, who may otherwise be disadvantaged in accessing services.

The MHAHS website underwent major redevelopment in May 2011. Accessibility is a key feature of the redesign. The site now offers four separate entry points catering for different audiences: multilingual fact sheets, information for health care workers, a media centre and a password protected area for MHAHS staff. Information is available in multiple locations throughout the site to aid navigation and to help make key information easier to locate. A site map, an often under-utilised feature of many websites, is displayed prominently in two locations on every page to further assist user access. There is also a step by step 'how to use this site' guide.

The multilingual HIV and hepatitis C fact sheets section of the site provides resources in various languages, including basic information about HIV/AIDS and hepatitis C, information for those newly diagnosed, health and treatments information, information on the health system in Australia, a glossary of common terms and 'Living a positive life' – a selection of HTML and audio recordings of personal stories from members of various CALD communities. A notable feature of the fact sheets section is the use of HTML language scripts on all pages, meaning translated health information can be assessed directly within the browser. A PDF version of information can also be downloaded and printed out.

Finding services in Australia lists services in regional and metropolitan areas by state, including AIDS and hepatitis councils, information about treatment and support, sexual health, and information for heterosexuals,

injecting drug users and sex workers, as well as a listing of major hospitals.

The health care workers section includes reports and other publications produced by MHAHS and other organisations, as well as statistics and general information about working with CALD communities. With links to around 50 reports and peer-reviewed articles in total, this section provides a wealth of information to assist service providers and others in their work. A range of audio-visual and text-based resources produced by MHAHS can also be ordered here.

The media section for journalists includes bilingual HIV and hepatitis C glossaries, global and local statistics, and CALD focused media campaigns produced for national health days (e.g. World Hepatitis Day, World AIDS Day). A campaign calendar outlines these events by month, to assist journalists to plan articles promoting these national events to CALD communities. **A media kit section** provides links to national health campaigns, surveillance data, Australian ethnic media contacts and media guides for journalists about HIV, hepatitis C and injecting drug use. Engaging ethnic media outlets is an important step health organisations should take to engage with CALD communities. Sonam recommends that organisations should promote their resources and campaigns to ethnic media in addition to other media outlets.

The ethos of accessibility is apparent throughout the site, with multiple entry points throughout. The site's focus on HTML is important for accessibility, as this keeps page sizes small which benefits users with limited bandwidth.

The MHAHS website is extremely well executed and a best practice model for social inclusion of CALD communities that other health organisations should both make use of and follow by example.

Reference

1 <http://www.multiculturalhivhepc.net.au>



BOOK REVIEW:
HIV IS GOD'S BLESSING:
REHABILITATING MORALITY
IN NEOLIBERAL RUSSIA
 by Jarrett Zigon. (2011).
 University of California PRESS.

Russia has one of the fastest growing HIV epidemics in the world, and one which seems to attract little media attention in the west. This is what attracted me to Jarrett Zigon's *HIV is god's blessing* ... (2011), a study of a rehabilitation program for HIV-positive injecting drug users in Russia.

This is appropriate for any study of HIV in Russia, where it is estimated that over 80% of people living with HIV are injecting drug users (p. 21). The rapid growth of drug use in Russia since the end of communism, combined with the state's rejection of harm reduction programs, has led to an HIV epidemic that is driven by injecting drug use. Zigon paints a depressing picture of the response to HIV in the former Soviet Union, which is characterised by official indifference, a crumbling health system, and severe stigmatisation of people with HIV.

Zigon's focus is on The Mill, a rehabilitation centre for injecting drug users – most of whom are HIV-positive – outside St Petersburg.

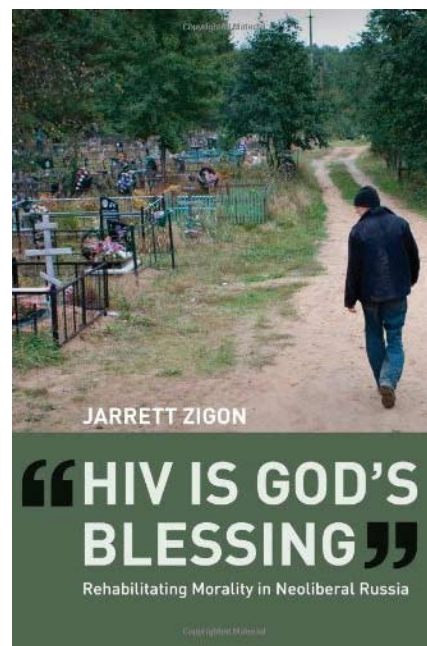
Zigon spent months interviewing staff, volunteers and residents (called, rather irritatingly, 'rehabilitants') at the Mill. The Mill is run by the Russian Orthodox Church which, having survived 70 years of state atheism, has deep roots in Russian society. Deeply conservative, it rejects harm reduction programs as 'the legalization and legitimisation of sin' (p. 56).

However, the Church does run some of the few support services for people living with HIV, of which the Mill is one. In fact, it is the only free drug rehabilitation service in the St Petersburg area – which is probably why there are so many drug users keen to get in to the program. For residents, life at the Mill sounds bleak: a strict (no coffee allowed!) regime of work, prayer, and therapy programs.

It is in this context that HIV is considered 'god's blessing', because it provides an opportunity – supposedly – for drug users to reflect on their lives and begin the process of self-improvement. The Mill's success rate is poor. After their three month stay, a few residents go to live in a monastery where life is even more ascetic. Most, however, quickly return to St Petersburg and to a life where, as one man puts it, 'everyone I know is either dead or in prison' (p. 230).

But the Mill's high failure rate is, as Zigon points out, almost incidental – at least from the perspective of the Church. The Church is concerned with the moral and spiritual wellbeing of its residents, and their decision to continue using is less important than receiving the opportunity to choose a moral life.

Zigon also seems to be only incidentally concerned with the fate of these people who he studied so conscientiously. Rather, his interest is in the curious mix of religion and self-help discourses that make up the ideology of the Mill. Zigon is an anthropologist, and his real interest is in social theory and the nature of modernity. His study of the Mill is a study of morality and what it means be a moral subject in the post-communist, neo-liberal melange that is modern Russia. This analysis is interesting and intellectually credible. But for those readers whose primary interest is in the sociology of HIV in Russia, it seems a frustrating diversion. One cannot help but wonder about the people whose lives lie behind the brief biographies, or, more importantly, what might be done to help them.



REVIEWED BY DR ABIGAIL GROVES A FREELANCE WRITER AND A FORMER POLICY ANALYST AT AFAO.



HIV Australia reviews books and other publications for readers with an interest in HIV and related issues. We welcome submissions from authors and publishing houses with suggestions of publications to review. If you would like to submit an idea for us to consider, please email editor@hivaustralia.org.au. Published works can also be mailed to Editor, *HIV Australia*, C/O AFAO, PO Box 51, Newtown NSW 2042.



RESOURCE PROFILE: A SELECTION OF RELEVANT AUSTRALIAN HEALTH RESOURCES IN COMMUNITY LANGUAGES AND/OR PLAIN ENGLISH

Multicultural HIV and Hepatitis C Service (MHAHS)

The MHAHS website provides a variety of resources about HIV, hepatitis C and sexual health available in over 25 languages, including: Akan, Amharic, Arabic, Bosnian, Burmese, Chinese, Croatian, Greek, Indonesian, Italian, Khmer, Korean, Macedonian, Portuguese, Serbian, Spanish, Shona, Somali, Tagalog, Thai, Turkish and Vietnamese.

@ <http://www.multiculturalhivhepc.net.au>

Health Translations Directory

An online directory providing links to online multilingual health resources from government departments, peak health bodies, hospitals, community health centres and welfare agencies.

@ <http://www.healthtranslations.vic.gov.au>

Diversity Health Institute Clearinghouse (resources and research papers)

Lists a range of material on multicultural health including fact sheets, reports, videos, CDs, journals, leaflets, posters and signs.

@ <http://203.32.142.106/clearinghouse/Resources.htm>

Culturally and linguistically diverse (CALD) information produced by Family Planning (WA and NSW)

Family Planning WA has produced a variety of material relating to sexual health, including information about how to put on a condom, women's health information and information about sex and the law in a range of languages, including Arabic, Chinese,

Vietnamese, Swahili, Thai, Burmese, English.

@ <http://www.fpwa.org.au/healthinformation/cald>

Family Planning NSW has produced a range of factsheets in several community languages providing essential information on topics including contraception and sexually transmissible infections.

@ http://www.fpnsw.org.au/index_nes.html

Women and HIV factsheets

The Women and HIV Factsheets provide basic information about HIV, and are particularly appropriate for women who have been recently diagnosed with HIV, and those from culturally and linguistically diverse backgrounds.

@ http://www.fpnsw.org.au/625547_8.html

Top Tips: Living Well with HIV – A Plain English Guide

A booklet containing important information about living with HIV, along with contact information for relevant organisations. Each tip is written in a relatively brief format for readers to refer to and to assist them in finding out more information about particular topics.

@ [http://www.hivtoptips.org.au/Top Tips A Plain English Guide.pdf](http://www.hivtoptips.org.au/Top%20Tips%20A%20Plain%20English%20Guide.pdf)

How to avoid contracting or spreading HIV/AIDS, hepatitis and sexually transmissible infections.

These brochures are available in plain English and 10 Asian and African languages.

@ http://www.ceh.org.au/mhss/info_for_service_providers/bbv_sti_resources.aspx

Hepatitis C in Brief – patient fact sheet

This resource is designed for people who have received a positive hepatitis C antibody test result and for people wanting to know more about hepatitis C.

@ <http://stage.ashm.org.au/hepc-factsheet/>

A range of fact sheets about HIV and hepatitis C from the NSW Multicultural Health Communication Service.

@ http://www.mhcs.health.nsw.gov.au/topics/HIV_AIDS.html#5500

Information for community members about Refugee health clinics (RHS) clinics in NSW

Pamphlet available in Arabic, Dari, Dinka, English, Farsi, and Swahili.

@ http://www.sswahs.nsw.gov.au/sswahs/refugee/about_clinics.html

@ <http://stage.ashm.org.au/hepc-factsheet/>

INFORMATION FOR SEX WORKERS

The Scarlet Alliance Migration

Project represents issues for migrant sex workers. Guided by a multilingual sex worker steering committee, the project has produced a range of translated information for sex workers in simplified Chinese, Korean and Thai.

@ <http://www.scarletalliance.org.au/thai/>

@ <http://www.scarletalliance.org.au/chinese/>

@ <http://www.scarletalliance.org.au/korean/>

The information page on laws covers brothel, private, escort, massage and street-based sex work, as well as information on the laws regarding HIV, STIs and sex work in each state and territory and visa-related information.

Resourcing health Education in the Sex Industry (RhED) is a service for the sex industry in Victoria providing free and confidential telephone, drop-in and outreach services. RhED has produced a range of bilingual factsheets for sex workers in English, Chinese and Thai. The factsheets include information on legal and illegal sex work practices in the State of Victoria, information about DIAC, and tips on dealing with immigration officials, information about sexual health and a list of legal brothels in Victoria.


@ <http://sexworker.org.au/Chinese.aspx>

@ <http://sexworker.org.au/Thai.aspx>

AUDIO-VISUAL RESOURCES


Transmission DVD kit

Four short films that increase understanding of hepatitis C and its transmission routes. Created for, and with, CALD communities using animation and hip hop to deliver their message. The kit includes detailed facilitator's notes to help you use the films for health promotion purposes.

 **Order:** <http://www.ceh.org.au>
View: http://www.ceh.org.au/mhss/info_for_service_providers/transmission_iv.aspx


Bridging Differences, Enhancing Understanding

A DVD resource kit on culturally appropriate health promotion, based on a project in which Iraqi and African families discussed hepatitis C and sexual health. Further information on the DVD resource kit and order details are available below.

 <http://www.ceh.org.au/about/projects/pages/bridgingdifferences.aspx>


Everybody's Business DVD

An audio-visual resource for trainers and educators working with people from CALD backgrounds in the areas of HIV and hepatitis C. DVDs on HIV and hepatitis C are accompanied by a facilitator's CD containing training activities and handouts in English, Arabic, Chinese (Mandarin), Indonesian, Khmer, Somali, Spanish, Thai and Vietnamese. Information and ordering information is available from the ordering resources section of the MHAHS website.

 <http://www.multiculturalhivhepc.net.au>


Living a Positive Life (CD 2005)

This multilingual HIV/AIDS audio CD captures the living experience of HIV/AIDS. Available in Arabic, Chinese (Cantonese and Mandarin), Croatian, English, Indonesian, Khmer, Spanish, Thai and Vietnamese. Information and ordering information is available from the ordering resources section of the MHAHS website.

 <http://www.multiculturalhivhepc.net.au>


About AIDS CD-ROM

The About AIDS CD-ROM provides people with basic HIV/AIDS information in an interactive format. Although designed for students learning English with the support of an English language teacher, this CD-ROM will be useful for all people requiring plain English resources.

 <http://www.fpnsw.org>


Health Check DVD: Health information for recently arrived African communities in Australia

Provides recently arrived African communities with clear information about health checks and procedures in Australia in English, Dinka, Kirundi, Swahili, Krio, Juba Arabic or Liberian Pidgin English. Extracts from the DVD can be downloaded for free in all seven languages.

 www.youtube.com/user/refugehealth

Breathing Space DVD: Stories of overcoming TB for refugee communities in Australia


Breathing Space tells the stories of three people with TB: their journey from diagnosis to treatments. The resource is available from chest clinics and other public health systems in Australia, in Dinka, Karen, Arabic, Juba Arabic, and English. The DVD dispels many of the myths and misconceptions about TB, and answers important questions on the topic. Information about ordering this DVD, as well as other health-related audio-visual multilingual resources, is available below.

 <http://www.sswahs.nsw.gov.au/sswahs/refugee/mhr.html>

INTERPRETING AND TRANSLATION SERVICES


Telephone Interpreter Service (TIS)

The Australian Government, through TIS National, provides free interpreting services to non-English speaking Australian citizens and permanent residents.


 http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/free-services.htm

To use an interpreter over the telephone 131 450


To book an onsite interpreter to attend an appointment see the Onsite Interpreter Booking Form

 http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/booking.htm

To pre-book a telephone interpreter see the Telephone Interpreter Pre-Booking Form

 http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/telephone-booking.htm

For Medical Practitioners to register for free interpreting services see Medical Practitioners Free Interpreting Registration Form


 http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/medical-practitioners.htm

NSW Government Community Relations Commission (CRC) languages services


The Language Services Division of the NSW CRC provides comprehensive interpreting and translation services in 100 languages and dialects (including Auslan). Services are available to all New South Wales Government departments and agencies, as well as private and commercial organisations, community groups and individuals. Face-to-face interpreting services are available 24 hours a day 7 days a week.

Bookings for interpreter and translator services may be made by telephoning 1300 651 500 or by emailing languageservices@crc.nsw.gov.au

Further information is available

 http://www.crc.nsw.gov.au/services/language_services

For a list detailing further resources and services for CALD communities see the online edition of *HIV Australia*

 www.afao.org.au



TREATMENT BRIEFS: AGEING AND HIV

AGEING AND HIV: SOME OLDER HIV DRUGS LINKED TO PREMATURE AGEING

Older antiretroviral drugs still widely used in low and middle-income countries accelerate a process of mutation within the DNA of mitochondrial cells that has been linked to ageing, scientists from Newcastle University report in the journal *Nature Genetics*.

The authors of the study say that their findings raise the spectre of the large-scale emergence of early ageing in people treated with the older nucleoside analogues over the next decade. However, more studies will be needed to confirm these findings. They also note that even in people no longer taking the drugs, the past mutations in mitochondrial DNA caused by AZT (zidovudine), d4T (stavudine) and ddI (didanosine) cannot be repaired by normal cellular mechanisms. They estimate that any ageing effects of the drugs are likely to be greater when taken by older people.

There is some evidence of accelerated ageing in individuals with HIV, including a higher prevalence of frailty, deterioration in lower-limb strength, modest declines in physical function when compared to HIV-negative adults of the same age, and declines in limb muscle.

It is unclear to what extent these conditions are caused by antiretroviral treatment, or if they are the long-term consequence of past opportunistic infections. The fact that these problems tend to occur in individuals over the age of 50, who were likely to have been diagnosed with AIDS and to

have suffered a series of opportunistic infections that may have resulted in permanent physical disability and reduced physical function, suggests that the notion of accelerated ageing may disguise the fact that many people with long-term HIV infection continue to experience poor health despite successful antiretroviral treatment.

Furthermore, other diseases of ageing that occur in people with HIV are either related to lifestyle, or strongly associated with immunosuppression. Examples include cancers and heart disease. However, other forms of ageing, such as weight loss, ageing of the skin, fatigue and muscle loss, have been less comprehensively studied.

Some scientists argue that some of the manifestations of ageing are the result of the long-term accumulation of mutations in the mitochondrial DNA of human cells. Mitochondria are energy-producing bodies within cells. They are more prone to mutation when copying themselves because they lack the 'proof-reading' mechanism present in other human cells. However, this explanation for ageing is not accepted by all scientists as the primary or predominant cause of age-related degeneration in bodily functions. Critics of the theory point to the vast array of factors that can cause cumulative cellular and tissue damage.

It is also unclear whether the mitochondrial changes are a cause of ageing, or just a reflection of larger processes at work in the ageing body.

Mitochondria in HIV infection

Nucleoside analogues can cause mutations in mitochondrial DNA and depletion of mitochondrial DNA.

Considerable research into the effects of nucleoside analogues on mitochondrial DNA has been carried out as a result of the recognition that many of the most serious toxicities of this class of antiretroviral drug are a consequence of mtDNA polymerase gamma inhibition. Side-effects linked to this mechanism include lactic acidosis, lipodystrophy (fat loss), myopathy (damage to skeletal and cardiac muscle) and liver failure.

The older nucleoside analogue regimens drugs d4T (stavudine) and ddI (didanosine) have a much greater effect on mitochondrial DNA than newer drugs such as abacavir and tenofovir. 3TC (lamivudine) and FTC (emtricitabine) appear to have very little effect on mitochondrial DNA. AZT (zidovudine) has an intermediate effect.

The extent of the deficiency was strongly predicted by total lifetime nucleoside analogue exposure, not current treatment, "implicating a persistent and cumulative mitochondrial defect", say the authors. The median duration of exposure was unspecified by the study authors.

Validation of the findings in larger cohorts which can provide more information about antiretroviral exposure, immunosuppression and comorbidities will be needed, as will studies which look at correlations between mtDNA mutations, ageing and antiretroviral exposure in other cell types.

Mitochondrial toxicity is strongly correlated with the severity of immunosuppression, and mitochondrial damage is dependent on the extent to which a nucleoside analogue is phosphorylated, or taken up into the active form, by a particular cell type. Thus, if the Newcastle University group's hypothesis is correct, age-related mutation would be both drug and cell-type dependent, leading to a broad spectrum of early emergence of conditions normally seen in the elderly, rather than a single pattern of accelerated ageing.

References

Payne, B., et al. (2011). Mitochondrial aging is accelerated by anti-retroviral therapy through the clonal expansion of mtDNA mutations. *Nature Genetics*, advance online publication, 26 June 2011.

Alexeyev, M. et al. (2004). Mitochondrial DNA and aging (review). *Clinical Science*, 107, 355–364.

— Keith Allcorn, *Aidsmap*
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8–11

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Cairns, Australia

http://www.ana.org.au/anwernekenhe_5.html

26–30

10th International Congress on AIDS in Asia and the Pacific (ICAAP10)

Busan, Korea (South)

<http://www.icaap10.org>

● **September**

8–10

26th IUSTI Europe Congress on STIs & HIV/AIDS and 10th BADV Congress (IUSTI BADV 2011)

Riga, Latvia

<http://www.iusti-europe2011.org>

12–15

AIDS Vaccine 2011

Bangkok, Thailand

<http://www.vaccineenterprise.com/conference/2011/agenda>

12–15

The 10th International AIDS Impact Conference

Sante Fe, New Mexico, USA

<http://www.aidsimpact.com/Conferences.asp>

26–28

Australasian HIV/AIDS Conference 2011 (23rd Annual ASHM Conference)

Canberra, Australia

<http://www.hivaidsconference.com.au>

28–30

The 2011 Australasian Sexual Health Conference

Canberra, Australia

<http://www.sexualhealthconference.com.au>

● **October**

4–7

4th International Conference on Retroviral Integration

Siena, Italy

<http://www.kuleuven.be/molmed/4icri/index.html>

12–15

13th European AIDS Conference

Belgrade, Serbia

<http://www.eacs-conference2011.co>

20–22

2011 Haemophilia Conference

Sydney, Australia

<http://www.haemophilia.org.au>

27–28

2nd International Workshop on HIV and Aging

Baltimore, USA

<http://www.virology-education.com>

● **November**

2–5

12th IUSTI World Congress

New Delhi, India

<http://delhi.iusti2011.org>

5–6

International Pediatric AIDS Conference

Mysore, Karnataka, India

<http://www.ind-ipac.com>

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