

HIV AUSTRALIA



HIV and young people

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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* examines HIV and other sexually transmissible infections (STIs) among young people in Australia.

Authors discuss latest statistics, research, and health promotion initiatives focusing on people under 30, emphasising the importance of peer-lead approaches and communication strategies that directly involve young people speaking for themselves about HIV and sexual health.

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NEWS

AUSTRALIA

Australian research 'wakes up' dormant HIV cells

Professor Sharon Lewin of the Alfred Hospital has reported findings of an innovative Australian study that used a cancer treatment, vorinostat, to 'wake up' or activate dormant HIV (latently infected CD4 cells). This theoretically makes it possible for these hidden HIV reservoirs to be eradicated from the blood stream either through antiretroviral treatment or by the immune system.

Lewin describes the research as an important 'first step' toward finding an HIV cure.

'We know that the virus can "hide" in cells and remain out of reach from conventional HIV therapies and the immune system,' Professor Lewin said.

'Anti-HIV drugs are unable to eradicate the virus because it burrows deeply into the DNA of immune cells where it gets stuck and goes to sleep. Anti-HIV drugs are very effective in keeping people healthy but they can't eliminate virus that is sleeping.'

The small proof-of-concept study involved 20 people with HIV, who used the drug for 14 days. The study confirmed that vorinostat is safe and well tolerated but found that there was no change in HIV DNA, which suggests additional strategies will be needed to eliminate latently infected cells.

TGA approves first rapid HIV test for Australia

In December 2012, the Therapeutic Goods Administration (TGA) approved the first rapid HIV test – the Determine rapid HIV test, produced by Alere – for use in Australia.

'Rapid HIV testing will help make HIV testing easier, increase the level of testing, and enable earlier diagnosis, so it's very welcome news' said Rob Lake, Executive Director of the Australian Federation of AIDS Organisations (AFAO).

The approval of a rapid HIV test is a significant step towards fulfilling the actions outlined in the Melbourne Declaration (www.melbournedeclaration.com), which called for the approval of rapid HIV testing in Australia to help achieve the target of a 50% reduction in sexual transmission of HIV by 2015.

Rob Lake says that AFAO is hopeful for a speedy implementation to enable its use. 'With several more HIV tests awaiting approval by the TGA, we are optimistic that in 2013, we will see major expansion of HIV testing', said Lake.

Victorian rapid HIV testing trial

Trial of a community-based rapid HIV testing service in Victoria is expected to be up and running by July 2013. The pilot rapid HIV testing project was announced in January by Victorian Minister for Health, David Davis.

The trial is the result a partnership between the Department of Health Victoria, the Burnet Institute and the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC).

The service will prioritise ease of access and convenience, as well as fostering an atmosphere in which gay men will feel very welcome and 'at home'. This will be supported by having peer workers providing the service; it is anticipated that testing will also be overseen by an experienced HIV and sexual health nurse.

Appropriate pre- and post-test discussions will be part of the service, as well as referrals to medical and sexual health services.

'By providing affordable, accessible, convenient rapid HIV testing, we can reduce a number of barriers to testing – such as the need to return for results – and provide an incentive

to frequent testing by getting results in 20 minutes or less,' Mr Davis said.

NSW government unveils new HIV strategy

The NSW Health Minister Jillian Skinner has announced an ambitious new HIV strategy which sets out targets to virtually eradicate HIV transmission in NSW by 2020.

The strategy, announced on World AIDS Day 2012, is being hailed as a first of its kind in Australia for being responsive to recent scientific evidence and advances in HIV prevention and treatment. Targets include reducing HIV transmission among gay and other men who have sex with men by 80% by 2020, and increasing the proportion of people with HIV on antiretroviral treatment to 90%.

A key part of the strategy is getting more people with HIV on to treatment, in recognition of evidence that HIV treatments have significant health benefits for people with HIV and can reduce viral load to an undetectable level, significantly reducing the likelihood of HIV transmission. The plan also includes a commitment to roll out rapid testing for HIV, as convenient and regular testing is crucial to reducing transmission rates.

Jo Watson, Executive Director of The National Association of People Living with HIV Australia (NAPWHA) welcomed the strategy, saying: 'NSW has shown what needs to be done and what can be done ... NAPWHA calls on all other State/Territory governments and the Commonwealth government to follow the lead of NSW to put Australia's HIV response back on track,' Ms Watson said.

Ending HIV in NSW

ACON has launched a new statewide education campaign aimed at mobilising NSW's gay community to help eliminate HIV transmission within the next ten years.

The campaign, Ending HIV, aims to educate gay men about advances in testing technologies and HIV

treatments, and the very real possibility that HIV transmission could be virtually eliminated within the decade as a result of these advances.

The campaign uses clear, simple messaging encouraging gay men to 'test more', 'treat early' and 'stay safe'. It reinforces aims outlined in the NSW HIV Strategy 2012-2015 and the Melbourne Declaration (melbournedeclaration.com.au), and aligns with prevention and treatment targets set out in the United Nations 2011 Political Declaration on HIV.

'This new education campaign is the first initiative in NSW, and indeed in Australia, that seeks to inform and inspire gay men about the opportunities that new technologies and scientific advances provide us in relation to eliminating HIV transmissions,' ACON President, Mark Orr says.

The Ending HIV campaign can be viewed at www.endinghiv.org.au

World first HPV immunisation program for boys

Federal Minister for Health, Tanya Plibersek, has announced the world's first National Human Papilloma Virus (HPV) Immunisation program for boys.

From early 2013, the current school-based HPV Vaccination Program for females aged 12–13 years will be extended to include males aged 12–13 years. There will also be a catch-up program in 2013 and 2014 for males aged 14–15 years.

Gardasil, the vaccine used in the program, protects against four types of HPV that are pre-cursors to some cancers, including cervical cancer, as well as genital warts in men and women. A number of vaccine preventable subtypes of HPV have been associated with the development of certain cancers, including anal, penile, and oropharyngeal cancers.

Men who have sex with men are approximately 17 times more likely to develop anal cancer than men who only have sex with women. Further, HIV-positive men have near-universal rates

of HPV infection and are more likely to get severe cases of genital warts that are harder to treat, and have higher rates of anal cancer.

For further details about the program, visit: <http://hpv.health.gov.au/the-program>

New hepatitis C treatments for the PBS

Two new hepatitis C (HCV) drugs, telaprevir and boceprevir, will soon be made available at reduced cost through the Australian Pharmaceutical Benefits Scheme (PBS). The new drugs are used to treat genotype 1 HCV, which affects more than half of the 226,700 Australians living with chronic hepatitis C. The new drugs have been described as 'ground-breaking' for their potential to double the HCV cure rate and shorten treatment duration by six months.

The announcement was applauded by organisations that support people living with chronic hepatitis, including AIVL (the Australian Injecting Drug Users League) and Hepatitis NSW.

'It is very good news indeed that these medications will now be made available to those who need them before they could become ineligible for treatment due to the stage of their liver disease progression,' said Annie Madden, Executive Officer of AIVL.

In Australia, although people with a history of injecting drug use represent over 80% of those with living with chronic HCV, cases of sexual transmission of HCV are also on the rise. People with HIV/HCV coinfection are at particular risk, as the effect of HIV can accelerate progression of liver cirrhosis and liver cancer.

A recent community forum held by ACON and Hepatitis NSW highlighted that approximately 500 to 1,000 HCV cases have so far been identified among HIV-positive Australian gay men; in these cases it is clear that transmission did not occur through the most common routes of transmission (sharing of needles or other injecting equipment such as tourniquets).

Youth Affairs Council calls for mandatory sex education in WA

Extremely high rates of chlamydia among young people have prompted the Youth Affairs Council of WA (YACWA) to call for sex education to become mandatory in all secondary schools.

The YACWA said more than 80% of newly reported chlamydia cases were in people under the age of 30.

'Chlamydia rates have more than tripled in the last decade, with one in five people under the age of 30 now estimated to have the infection,' said YACWA Executive Officer Craig Comrie.

Mr Comrie said the danger with chlamydia was that about 80% of people who had the infection showed no symptoms, so had no idea they were passing it on to others. Chlamydia is a sexually transmissible infection (STI) and without early treatment can cause infertility in both males and females.

'Currently there is a national curriculum for sex ed, but West Australian schools are under no obligation to implement it,' Mr Comrie said.

INTERNATIONAL

'Functional' HIV cure reported in a child

A baby born with detectable viral load to a mother who had not received prenatal HIV care showed no sign of viral replication at the age of 26 months, leading the doctors involved in the case to describe it as a 'functional' cure. (Where HIV remains in the body but does not replicate.)

The baby was started on a regimen of AZT/3TC and nevirapine at the age of 30 hours, and treatment continued until the baby was 18 months old.

At 18 months of age, the child's ARVs were discontinued after the mother withdrew the child from care for unknown reasons. About half a year later,

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medical professionals discovered that the child maintained an undetectable viral load (less than 20 copies/mL) and had no HIV antibodies. After screening the child with a highly sensitive viral RNA and DNA test, the medical team found extremely low viral levels.

'This case suggests that providing antiretroviral therapy within the very first few days of life to infants infected with HIV through their mothers via pregnancy or delivery may prevent HIV from establishing a reservoir, or hiding place, in their bodies and, therefore, achieve a cure for those children,' said Deborah Persaud, MD, Associate Professor of Infectious Diseases at the Johns Hopkins Children's Center.

Early HIV treatment boosts immune response

A recent study, published in the *New England Journal of Medicine*, indicates that starting HIV treatment within four months of seroconversion is the optimal time to commence treatment, as there is an increased likelihood for recovery of healthy CD4+ counts.

The study was co-authored by Monash University's Associate Professor Edwina Wright with physicians from The University of Texas and the University of California, and followed 468 participants in the US for a 48-week period.

In response to the growing body of evidence about the benefits of early uptake of ARV medication, Living Positive Victoria has released a position statement urging people with HIV to consider early treatment.

'HIV treatments are now more effective, have fewer side effects and are easier to take than ever before and there is growing evidence that not only do these treatments support and protect an individual's immune system, they can significantly decrease the forward transmission of HIV,' said Living Positive Victoria's Sam Venning.

Living Positive Victoria's position statement is available at: www.livingpositivevictoria.org.au

VOICE results

A large African trial of vaginal microbicides and oral pre-exposure prophylaxis (PrEP) found that none of the drugs tested significantly reduced HIV acquisition.

The VOICE (Vaginal and Oral Interventions to Control the Epidemic) trial tested daily oral tenofovir, daily oral Truvada, and daily 1% vaginal tenofovir gel with 5,029 young unmarried women at five sites in southern Africa and Uganda.

The lack of effectiveness is attributed to very low adherence and is consistent with other PrEP trials such as FEM-PrEP.

The researchers recommended that products that are long acting and require minimal adherence may be more suitable, and stressed the need for more research into the social and cultural determinants of adherence in young high risk populations.

Responding to the announcement, Global Advocacy for HIV Prevention (AVAC) commented that 'Biomedical tools do not work in a vacuum but rather in the complex realities of women's and girls' lives' and said the results 'provide an urgent reminder that products must meet the needs of the people using them.'

UK health experts declare unprotected sex with low viral load 'low risk'

The British HIV Association (BHIVA) and the Department of Health's Expert Advisory Group on AIDS (EAGA) have published a consensus position statement about the effectiveness of HIV treatment to reduce the risk of HIV transmission.

The statement draws on evidence from the HPTN 052 trial that showed that risk of HIV transmission is reduced by 96% between serodiscordant heterosexual couples, when the HIV-positive partner is receiving antiretroviral treatment (ART).

The statement concludes that successful ART 'is as effective as consistent condom use in limiting viral transmission', providing no STIs are

present, viral load testing is done every three to four months and the person has a sustained viral load of below 50 copies/mL for at least six months.

Notably, the BHIVA statement extrapolates the HPTN 052 findings to anal sex. Despite the absence of data relating to anal intercourse among homosexual or heterosexual couples, the statement concludes that '... extremely low risk of transmission can also be anticipated for these practices, provided the same conditions stated above are met.'

New strategy for Cambodia's HIV response

The Cambodian People Living with HIV Network (CPN+) opened its first General Assembly in five years on 11 February as part of the re-launch of the network, which has been through significant institutional reforms over the last 12 months. CPN+ is the largest national network of people living with HIV in Cambodia, with over 27,000 HIV-positive members across 18 provinces.

The meeting was attended by more than 90 people living with HIV, government, development partners, and civil society. Members contributed to the development of CPN+'s long term strategy on achieving the goals of zero new HIV infections, zero AIDS-related deaths and zero HIV-related discrimination.

The five-year strategic plan *Building Positive Futures* will guide CPN+ through improving access to quality health services, strengthening HIV-sensitivity of social protection schemes, promoting the rights of PLHIV and their families, and strengthening links with other national networks of PLHIV and most-at-risk populations.

'The General Assembly is a critical milestone in CPN+'s institutional strengthening' says Mr. Sorn Sothearith, CPN+ National Coordinator. 'It is a timely opportunity for members to renew their collective commitment to achieving CPN+'s vision of all Cambodian PLHIV living positive and healthy lives, empowered to assert and enjoy their rights, free from stigma and discrimination.'



Vale Professor Anthony Smith

By Bill Whittaker

Many people have been saddened by the recent death of our colleague and friend, Professor Anthony Smith.

Anthony was widely known both in Australia and internationally for his work as an outstanding researcher, and also for his passion as an HIV activist spanning some 25 years.

In addition, so many others will remember Anthony as a thoroughly decent, dignified, thoughtful, talented, optimistic, likeable and supportive friend and colleague. I will certainly remember Anthony this way and with great fondness.

I first met Anthony in 1988, soon after he started involvement with the Northern Territory response to HIV. Up to this point, his professional life had been as a researcher in zoology culminating in being conferred with a PhD by the ANU in 1988. However, by

the late 1980s, Anthony had also begun to get involved in HIV-related research, including through the Menzies School of Research in Darwin.

Anthony's interest in HIV soon not only encompassed HIV research but also community advocacy. At this time, the Australian community response to HIV was building quickly, but it also remained fragile in many areas, with homophobia and AIDS-phobia all too common in many parts of the country. Governmental and media responses in the Northern Territory and Queensland were often at the extreme end of the scale and HIV organisations were particularly vulnerable.

It was in this environment that Anthony joined the board of the Northern Territory AIDS Council (NTAC) in 1988 and soon after that took up the role of President. Dino Hodge, who was on the NTAC board

at the time, remembers Anthony becoming President, 'when no-one else in the community was prepared to take it on. It was still a period of widespread public fear and panic about HIV and a time of incredibly poor relations between the Northern Territory (NT) Government and the communities most directly affected at that time by HIV. Anthony took on the leadership role and met the demands of it admirably'.

Anthony moved to establish links with the NT Government and the Commonwealth Health Department and his leadership saw the NTAC secure funding and resources for urgently needed community-based HIV prevention and care programs. Again, as Dino Hodge recollects: 'I recall being incredibly impressed with the way that Anthony was able to

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represent the community and to convey the issues to the Government, which at that time was being non-receptive. It was a challenging thing for him to have done, to stand up and take on that role. At the time, it was truly courageous.'

In his role as President of NTAC, Anthony also represented the NT community-based HIV response at the national level through the Australian Federation of AIDS Organisations (AFAO). I was on the board of AFAO at the time and Anthony added a lot of value to the work of the Federation, ably representing the NT perspective, but always within a context of what might best support an effective national response as well.

It was also around this time that the 'courtship' of Anthony and Dennis Altman began. It caused much amusement within AFAO, probably because we saw a romantic (almost) side of Dennis not seen too often – given his daunting reputation as an iconic activist. Yes, Dennis is hardly a shrinking violet, but Anthony seemed more than a match for him (and I think Dennis really liked that!). Soon after, Anthony moved from the NT to live with Dennis in Clifton Hill in Melbourne.

Anthony and I served as Vice-President and President of AFAO respectively, so I worked closely with him at AFAO in the early 1990s. These were very difficult years, with few HIV treatments and rising rates of HIV illness and death. At the same time, AFAO led ambitious programs for reform of clinical trials, drug approval and funding mechanisms. Anthony was incredibly supportive of my work as President and during this time he made many important contributions to legal reform efforts, anti-discrimination, prevention, research and of course the policy and advocacy agenda of AFAO itself.

Anthony joined La Trobe University in 1993 as part of the Centre for the Study of STDs (which later became The Australian Research Centre in Sex, Health and Society [ARCSHS]), where



Anthony in the early 1990s

he worked for nearly 20 years. Anthony secured a chair in the Centre in 2007 and worked as a Deputy Director until his illness last year. As Anthony's professional colleagues at ARCSHS have written:

Anthony was one of the pre-eminent scholars in sexuality research on both the national and international stage. He carried out research which was both rigorous and ethical, and emphasised these values in his teaching and mentoring of others. He leaves an enormous legacy having held numerous nationally competitive grants, published over 300 journal articles, co-edited a book and collaborated with around 65 other academics on his various research projects. His work has been cited more than 3,000 times by researchers all over the world.¹

I last spoke with Anthony just a few weeks before his death. He was cheerful and optimistic and I am so glad I had the chance to chat to him. His main concern was for his partner, Dennis, not for himself. I found that very typical of Anthony.

It is a cliché, but an apt one – a great many people will miss Anthony, but also celebrate the fact we've been privileged to have been part of his life.

Reference

- 1 Vale Professor Anthony Smith. Retrieved from: http://ashm.org.au/default2.asp?active_page_id=570

Bill Whittaker is a former President of the Australian Federation of AIDS Organisations (AFAO).

For further reflections on Anthony's life, visit the AFAO blog at:
<http://afaotalks.blogspot.com.au>

Sexually transmissible infections among young people in Australia: an overview

By **Melanie Middleton** and **Ann McDonald**

In this article, the Kirby Institute provides a snapshot of the latest surveillance data on sexually transmissible infections (STIs) and HIV among young people in Australia.

Although rates of HIV among young people are increasing in many parts of the world, in Australia the data indicate that sustained and increasingly high rates of STIs among young people are a more immediate concern. However, the data also reflects a small increase in HIV among young men who have sex with men (MSM), indicating that this issue does need to be focused on among this population.

For an expanded version of this article which includes further graphs of the data cited, see *HIV Australia* online at www.afa.org.au

Introduction

A variety of socio-cultural factors such as increased duration between sexual debut and the formation of long-term partnerships, low rates of condom use and poor access to services, make young people vulnerable to sexually transmissible infections (STIs).¹ As such, young people were named as a priority group in the *2010 National Sexually Transmissible Infections Strategy*.

This article provides an overview of national trends in four notifiable STIs: chlamydia, HIV, gonorrhoea and infectious syphilis. More detailed analyses and information on surveillance methodology can be found in the 2012 issue of *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report*, published by the Kirby Institute.

Chlamydia

The number of diagnoses of chlamydia and the chlamydia diagnosis rate per 100,000 male and female population in the age groups 10–14 years, 15–19 years and 20–24 years, increased every year over the past ten years, from 2002 to 2011. Diagnoses were more frequent in women than men, with two infections reported for every 100 women aged 15–24 years compared to one for every 100 men in the same age group.

The rate of chlamydia diagnosis among males in the age group 20–24 years was

at least double the rate among males in the age group 15–19 years throughout the past ten years. In the years from 2007 to 2011, the rate of chlamydia diagnosis among females in the 15–19 year age group increased relative to that in the 20–24 year age group, resulting in females in the age group 15–19 years recording the highest rate of chlamydia diagnosis in 2010 and 2011. Notification rates among people aged 15–19 years were broadly similar in most states and territories, with the highest rates found in jurisdictions with a higher proportion of Aboriginal and Torres Strait Islander people, reflecting a rate of infection in those communities that is four times higher than the national average.

Consistent with trends in the general population, the rate of notification has increased more than three fold over the past 10 years. However, when notification data was combined with testing data from Medicare, the proportion of positive tests has remained stable at around 15% for the past five years, suggesting that the incidence of infection has not increased during this time despite the increasing number of diagnoses. Data from sentinel surveillance in sexual health clinics supports this, with the proportion of heterosexual men and women aged less than 25 years diagnosed with chlamydia remaining stable over the same timeframe.²

Gonorrhoea

By contrast to chlamydia, gonorrhoea affects two distinct population sub-groups rather than the general population: men who have sex with men and Aboriginal and Torres Strait Islander people. In young people, the highest rate of gonorrhoea diagnosis was in men aged 20–24 years followed by women aged 15–19 years. In 2011, the largest number of notifications (1,260) was in non-Indigenous men, but the highest rate of diagnosis was in Aboriginal and Torres Strait Islander women aged 15–19 years. The rate of diagnosis in Aboriginal and Torres Strait Islander men and women aged 15–24 years was more than 30 times higher than the rate in non-Indigenous men and women of the same age.

In the Aboriginal and Torres Strait Islander population, diagnoses were more frequently made in women than in men and in women aged 15–19 years than in women aged 20–24 years, a trend that was reversed in men, suggesting that a heterosexual mode of transmission predominates for this population. The rate of diagnosis in non-Indigenous men aged 20–24 years was three times higher than the corresponding rate for women, indicating that a substantial number of infections in this population are in men who have sex with men.

Infectious syphilis

Infectious syphilis is not for the most part a disease affecting young people. In 2011, only 20% of cases occurred in people aged less than 25 years and almost half of these cases were in men aged 20–24 years of age. The rate of notification almost doubled between 2004 (3.2 per 100,000 people) to 2011 (5.9 per 100,000 people). Again, this was due to the influence of diagnoses in men aged 20–24 years reflecting the ongoing epidemic in men who have sex with men that began early last decade.

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Table 1: Number of new diagnoses of HIV infection, 2002–2011, by exposure category, year and sex

Exposure category	2002–2006		2007–2011		2002–2011		Total ¹
	Male	Female	Male	Female	Male	Female	
Men who have sex with men	297	—	376	—	673	—	673 (71.6)
Injecting drug use	13	7	4	3	17	10	27 (2.9)
Heterosexual contact	24	89	44	83	68	172	240 (25.5)
Sex with an injecting drug user	0	5	0	4	0	9	9
Sex with a bisexual male	—	8	—	4	—	12	12
From a high prevalence country	12	36	16	40	28	76	104
Sex with person from a high prevalence country	6	12	4	8	10	20	30
Sex with person with medically-acquired HIV	0	1	0	0	0	1	1
Sex with HIV infected person, other exposure	1	7	4	6	5	13	18
Heterosexual contact, not further specified	5	20	20	21	25	41	66
Other/undetermined²	10	7	12	9	22	16	42
Total¹	344	103	436	95	780	198	982

1. Total includes four cases whose sex was reported as transgender.

2. The 'Other/undetermined' includes four cases whose sex was reported as transgender. The 'Other/undetermined' exposure category was excluded from the calculation of the percentage of cases attributed to each exposure category.

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Though the overall rate of infectious syphilis for Aboriginal and Torres Strait Islander young people is significantly lower than other STIs, it is still many orders higher than the rate in non-Indigenous populations. Unlike men who have sex with men, there has not been a sustained outbreak of infectious syphilis in young Aboriginal and Torres Strait Islander people in recent years. The rate is highest among women aged 15–19 years, with peaks in 2006 and 2011 indicating outbreaks in this population in those years.

HIV

Over the past ten years, from 2002 to 2011, 982 cases of HIV infection were reported in Australia among people aged 10–24 years at HIV diagnosis (Table 1).

Among males, the age specific rate of HIV diagnosis in the age group 20–24 years was stable at around 8.8 per 100,000 population in 2002–2011 and was approximately seven times the rate in the age group 15–19 years. The rate of HIV diagnosis among females in the 20–24 year age group declined from 2.2 per 100,000 in 2002–2006 to 1.6 in 2007–2011. The rate of HIV diagnosis for both males and females was less than two per 100,000 for the age groups 10–14 years and 15–19 years.

The pattern of exposure to HIV among cases aged 10 to 24 years was similar to the total number of HIV diagnoses in Australia in 2002 to 2011 in that the majority of diagnoses were among men who have sex with men, approximately 3% were attributed to injecting drug use, 25% were attributed to heterosexual contact and 56% of diagnoses attributed to heterosexual

contact were among people from high prevalence countries or their partners.

Conclusion

Continuing high rates of diagnosis of chlamydial infection and diagnoses of gonorrhoea and infectious syphilis among specific population subgroups of young people in Australia indicates a need for the development of preventive interventions tailored for a young, newly sexually active population.

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Over the past ten years, from 2002 to 2011, 982 cases of HIV infection were reported in Australia among people aged 10–24 years at HIV diagnosis.

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Young gay men: capable, resilient and resourceful

By James Gray, Thomas Munro and Michael Yates

The age distribution of the HIV epidemic in New South Wales has been changing in recent years. For most of the last ten years the demographic that made up the highest number of new diagnoses was the 30–39 year age category. Recently we have seen a spike in the 20–29 age range, which reached its highest level in well over a decade in 2011 – although it is important to note that these age tranches are quite arbitrary and cover men at very different points in their lives.

This recent change in the notification data has prompted a much needed reflection on the state of our prevention efforts with younger gay men. This article will outline some of these health promotion approaches and methods of engagement used by The Young Gay Men's Project at ACON, which focuses specifically on the health and wellbeing of gay men aged 26 and under.

Although talking about 'young people' or 'young gay men' as a unified category for targeted HIV prevention and sexual

health promotion presents challenges, new methods of approaching health promotion for this demographic are clearly required. We also have a range of opportunities to engage with these men.

We believe that the resilience of young gay men should not be undervalued. Young people have greater access to information than any prior generation and are highly competent at interpreting what is most relevant to them. Providing accurate, up-to-date information about pleasure and risk is crucial to ensuring that young gay men are equipped to make informed decisions about their sexual health.

We should feel optimistic about our ability to lower the numbers of new HIV infections and permanently turn around the destructive effects of HIV. Indeed, there is far more cause to feel optimistic than pessimistic. Most guys use condoms a majority of the time, and antiretroviral medication is more effective and available than it's

ever been. The impact of undetectable viral load (UDVL) on decreasing the likelihood of transmission and new prevention 'tools', including pre-exposure prophylaxis (PrEP), are giving gay men more opportunities to reduce HIV transmission.

However, driving down HIV infections in those under 30 provides its own set of challenges and also many new opportunities. Essential to this is our understanding of who young gay men are. We can't frame young gay men as one single group of people that all have the same understanding or shared sexual practice. Nor is it helpful to position them as somehow lacking capacity or in need of rescuing from themselves. Rather we must regard them as diverse individuals who, once empowered with knowledge and information, are highly capable of making responsible decisions in

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accordance with their personal lifestyle choices and varied sexual needs.

ACON's Young Gay Men's Project utilises peer education to engage with guys on their own terms and acknowledges them as partners in our joint effort to improve the health and wellbeing of our community. As with most community-based initiatives, the attitude that is brought to work with young people is a key reason for the success or failure of an intervention.

Young gay men have been an integral part of the response to the epidemic since it began and this involvement will continue into the future. Men under 30 comprised a substantial portion of those who died from AIDS in Sydney in the early years of the epidemic. Today's generation of young gay men may not have witnessed the tragedy of what came before us, yet we have inherited this as our legacy. Peer-led responses from young gay men will continue to be an integral part of the fight against HIV until HIV has been eliminated.

HIV testing

The NSW *HIV Strategy 2012–2015* has set a number of targets to work

towards the virtual elimination of HIV transmission in NSW by 2020. These include reducing the transmission of HIV among gay men by 60% by 2015.¹ The only way that we are going to achieve these targets is by intensifying our efforts with our target populations – in our case this means increasing our targeted messaging to young gay men.

A major priority for the Young Gay Men's Project, and ACON as a whole, is to increase HIV testing rates. Young gay men report testing rates far below the level we believe is necessary. There are many reasons for this. Not all young gay men are sexually active and those that are may believe that they don't need to get tested based on their personal assessment of risk. It is therefore natural for testing rates to be slightly lower than among older gay men. It is important that we assist young gay men in recognising the need to develop a routine testing pattern relatively early in their sexual lives.

Reasons for not testing can be both psychological and circumstantial – for example, stigma and shame relating to testing, not being aware of testing services, lack of knowledge about how HIV can be passed on,

and inconvenience and cost of doctor consultations are some common reasons why testing isn't happening enough. The young men that access our services report that the length of time it takes to receive the results of a conventional blood test can be a major source of anxiety. For this reason, many would prefer rapid HIV testing to standard testing methods. Having to come back to the clinic for test results has often been described as a barrier to regular testing.

As rapid HIV testing and other structural innovations are put into place, it is vital that we don't lose touch with the community's sexual behaviours and values. We are engaging in frank and reassuring conversations with young people in their own cultural languages about sexual health and testing, and employing peer leaders to reinforce these messages. This includes the development of new multimedia resources such as sexual health testing videos, and a revitalised emphasis on testing within the curriculum of our peer education workshops.

Getting it online: sex and sexual health information

In recent years, Sydney has ranked fourth globally in the list of cities that have the highest Grindr usage rates, which highlights changes in the ways gay men are communicating and seeking sexual encounters. In addition to many gay men's love of mobile 'dating' apps, *Writing Themselves in 3²* has highlighted that the internet is the most important source of information about homophobia and discrimination, gay and lesbian relationships and gay and lesbian safe sex for young lesbian, gay, bisexual and transgender people.

Young gay men are using the internet and mobile apps to both interact and gain information and we need to be aware of the impact that these spaces have on their sexual interactions. It is important that young people learn how to navigate these spaces safely and effectively.

Today's generation of young gay men may not have witnessed the tragedy of what came before us, yet we have inherited this as our legacy. Peer-led responses from young gay men will continue to be an integral part of the fight against HIV until HIV has been eliminated.

The Young Gay Men's Project is currently developing a new workshop called 'Getting it Online' that aims to teach these skills. We aim to develop and share effective ways of negotiating safety in this context as well as effectively communicating what we want when planning a sexual encounter and how to get it. Part of the aim of Getting it Online is to provide young people who may access hook-up sites with strategies to make informed decisions allowing them to minimise risk when seeking pleasure. The workshop is also a great opportunity to challenge other issues affecting young gay men such as discrimination, drug use and physical safety when meeting unknown sexual partners.

Writing Themselves In 3 also indicates that young people are often more comfortable seeking out information online and talking about sex and sexual health through social media platforms such as Facebook. It is important to recognise that not all 'young gay men' are going to respond to the same material, or want to participate in a workshop or engage with our social marketing campaigns. Therefore it's important to communicate with them in a variety of ways that they find interesting and engaging. Online communication is a perfect medium for this sort of targeted, easily-digestible information.

Online experiences must be dynamic and interactive – with people able to ask the questions they're interested in, rather than being passive consumers of information. Nowhere is online interactivity more evident than through social media. Twitter and Facebook can be used to engage in public dialogues with people around topics that they want to talk about. These mediums can be used for much more than merely health promotion-related events and activities but can be a site for health promotion themselves. Often the challenge is making people see these issues as relevant and important.

In many cases public health practitioners have been slow to adopt and investigate emerging methods of health communication, such as using YouTube to 'vlog' health information. There is good reason for caution. With little evidence for the efficacy of these communication methods, public health practitioners are rightfully hesitant to spend limited health dollars on interventions that may not be successful. However, it is also true that change often entails risk and we can't wait for others to tell us what to do. We need to engage with young men on their own terms. If our interventions fail we need to openly acknowledge that so others can learn from our mistakes.

When exploring new ways to do health promotion in online spaces we need to challenge conventional wisdom around what works, take risks and adapt our practices to emerging technologies. We can't always control or direct the sorts of interactions that occur online but these provide exciting new opportunities for engagement.

Young gay men are a diverse group of people with many skills, interests and needs and our work with them needs to

reflect this. We need to encourage their active participation rather than being didactic and seeing them as incapable of looking after their own health. Young gay men have been, and will continue to be, resilient and adaptive in the face of this health challenge.

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How to prioritise barriers to STI testing that could be addressed by sexual health programs? An example from a research study conducted among young people

By **Philippe Adam, John de Wit and Chris Bourne**

Reducing the prevalence of sexually transmitted infections (STIs) in young people through the promotion of condom use and sexual health testing is a public health priority in Australia.¹ While sexual health programs have been implemented to address these issues, a significant proportion of young people still engage in unprotected sex and rates of STI testing remain low in this population.^{2,3} The reasons why some young people do not engage in behaviours that would protect their sexual health are not fully understood. This paper reports on a study that was conducted to prioritise barriers to STI

testing that could be addressed by programs targeting young people.

A survey among young people

The survey *Getting Down To It*⁴ was launched in 2010 to address a gap in research knowledge on the sexual health needs of young people. The survey (see Box 1 for a brief description of the study) was conducted by the National Centre in HIV Social Research (NCHSR) in partnership with the New South Wales Sexually Transmissible Infections Programs Unit (NSW STIPU). The project involved establishing an ongoing

program of research on adolescents and young adults. Considering the popularity of social media among young people, the survey was conducted online using advertisements on Facebook. This aligns with the extensive program of online research conducted by NCHSR. Conducting research online offers advantages in terms of recruitment and facilitates responses to extended questionnaires. In *Getting Down To It* participants took on average 49 minutes to complete a comprehensive survey with questions on socio-demographics, sexual practices, sexual health testing and a

range of factors that may potentially operate as barriers to or facilitators of testing for STIs.

Identifying potential barriers to STI testing

To identify the range of individual and social determinants to be assessed in the study the existing literature was reviewed and this review benefitted from findings from previous assessments of the literature conducted across countries and populations.^{5,6}

While the number of studies conducted overseas on sexual health testing has increased over the last decade, understanding of the factors influencing STI testing remains, for some reason, fragmented. Individual and social determinants of testing have been studied by a range of disciplines (public health, epidemiology, social sciences, psychology) using various methods (quantitative or qualitative) and theoretical frameworks. Studies however mostly focused on a single or a few individual or social determinants of testing; this lack of comprehensiveness inflates the importance of the few factors studied.

In addition to reviewing and summarising findings from existing research, theorising in health psychology was used to group barriers and facilitators into relevant analytical categories. Different theoretical models explain health-related behaviours using different variables.

To conduct the study we did not select one theoretical model or one set of variables over others. Our approach was more eclectic and comprehensively assessed the potential contribution of key variables from several theoretical models. The following potential determinants of STI testing were selected: knowledge of STIs, perceived vulnerability of contracting STIs (the way young people perceive their odds of contracting an STI), perceived severity of STIs (whether young people perceive STIs as a serious condition), attitudes towards STI testing (whether people perceive testing to be beneficial), perceived benefits (pros) and disadvantages (cons) of testing for STIs, fears and worries associated

An overview of the survey protocol

Getting down to it is a self-report online survey of young people. Participants in the study were recruited through the internet research platform www.gettingdowntoit.net between May and October 2010. An advertising campaign on the social networking site Facebook was used as the main recruitment channel for the survey. Advertisements were only displayed to Facebook users aged 16 to 26 years, who spoke English, and who lived in NSW. The advertisement intentionally did not refer explicitly to STIs to limit potential bias in recruitment.

The sample included in the analyses consisted of 1,100 sexually active participants who provided complete data. The mean age of participants was 20.6 years. Around 40% of participants were male, 38% reported living in metropolitan Sydney, 21% had a university degree, just over 70% identified as Anglo-Australians, and only 3.4% of participants reported being of Aboriginal or Torres Strait Islander descent. In terms of sexual orientation, 71.5% of participants considered themselves heterosexual and 28.5% were non-heterosexual participants, mostly gay or bisexual.

with STI testing, perceived stigma and shame related to testing for STIs, and subjective norms related to testing for STIs (the extent to which people believe that their decision to test would be supported by others).

Reassessing common assumptions

We embarked upon an empirical assessment of the contribution of the above described determinants of STI testing and ensured that we would be able to critically assess the most commonly shared views on barriers to testing among young people. It is often assumed that lack of testing is related to poor STI knowledge and low perceptions of both the severity of STIs and the risk of contracting an STI. In line with these explanations, social marketing campaigns aimed at promoting STI testing have mostly focused on increasing young people's

knowledge of STIs and their awareness of the threat associated with having an STI. Little empirical data, however, is available to establish whether poor STI knowledge and low perceived threat of STI acquisition actually are the main factors explaining lack of STI testing. As with any behaviour, testing for STIs is potentially influenced by many individual and social factors – with each contributing to various extents. Our approach consists of supporting sexual health programs in dealing with this notion of 'causal density' by prioritising those factors that make the strongest contribution to explaining variations in STI testing behaviours.

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Lessons learned

Of the 1,100 sexually active respondents who completed the questionnaire, two-thirds reported having unprotected intercourse in the six months prior to the survey; half of these respondents had been tested for STIs. Knowledge of STIs was moderate, perceived severity of STIs was high while perceived risk of contracting an STI was low. Interestingly, STI knowledge and perceived risk only explained to a small extent the variations in STI testing among young people. No association was found between perceived severity of STIs and STI testing. These results indicate that beyond STI knowledge and the perceived threat of STIs, other individual and social factors play a role in either promoting or preventing young people to test for STIs; key factors to consider are perceptions of the pros and cons of testing, fears and worries associated with testing, and subjective norms related to testing.

Based on this assessment, possible directions for sexual health programs include addressing the perceived cons of testing – particularly the notion that STI testing is expensive and testing facilities not easy to locate – and promoting those perceived benefits of STI testing that are important to young people, such as taking responsibility for one's health and starting a new relationship safely. Interventions should also explore ways to reduce various fears and worries

associated with testing, including fear of parents' reactions, fear of negative staff attitudes, and fear of medical procedures. Lastly, sexual health programs should further strengthen the positive norms that have emerged regarding testing for STIs to ensure that as many young people as possible feel supported in their decision to test.

Implications for sexual health programs

Exploring these new directions does not mean that sexual health programs should stop investing in raising awareness and building knowledge of STIs. Promoting knowledge of STIs remains important for young people becoming sexually active and, even among older youth there is room for improvement in knowledge about specific STIs. While programs should continue to promote STI knowledge and raise awareness, it should not be expected that improvements in these areas would automatically translate into significant increases in the uptake of STI testing. There is no single magic bullet available to increase STI testing among young people. Instead, sexual health programs should rely on a comprehensive and research-driven appraisal of barriers to STI testing and address key barriers as a matter of priority. The approach developed in this project could be applied to other health-related behaviours. Reducing the gap between social science research and health promotion practice would strengthen effective responses.

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Off the map? The feasibility of HIV prevention workshops for young gay and bisexual men in rural and regional Australia

By **Aldo Spina**

Australia's response to HIV prevention among young gay and bisexual men has been characterised by long standing peer education programs that place HIV prevention within a context of support for coming out, building self-esteem and personal resilience. Young and Gay in Melbourne and Fun and Esteem in Sydney are examples of these programs. However, a limitation of these programs is their focus on city and major regional settings.

The AIDS Trust of Australia received funds from the Perpetual Funding Round 2010 to undertake a study to examine if these programs could be extended into rural and remote settings. The study was undertaken by the Australian Federation of AIDS Organisations.

The study mapped a range of services available to young gay and bisexual men (under 26), not just HIV prevention programs. Organisations were included

if they were providing a service specifically targeted at young gay and bisexual men. Services that were inclusive of young men, but more broadly targeted at gay, lesbian, bisexual and transgender (GLBT) young people were included within the study. This was in anticipation that only a few services would be targeted solely at young gay and bisexual men.

Even though the study has a particular focus on how services can be extended into rural and regional areas, it was deemed appropriate to include metropolitan services in the study to hear their experiences of what works and what doesn't, and whether they think it is feasible to extend existing metropolitan services into rural and regional areas.

Forty-five key information interviews were conducted with service providers working with young gay and bisexual men.

AIDS Councils/GLBT health organisations

The study was premised on an understanding that AIDS Councils/GLBT health organisations in each Australian jurisdiction have operated HIV prevention and wellness programs for young gay and bisexual men in major metropolitan areas. These have mostly been time limited workshops that are repeated throughout the year.

While it may have once been the case that each Australian jurisdiction operated such programs, this is no longer an accurate assessment of what occurs. These types of HIV prevention programs are running, but in fact only in three jurisdictions. And even then, in two of these jurisdictions workshops only run two or three times per year.

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There is no doubt there are some significant strengths to these programs. They address HIV and sexual health very thoroughly, while doing this in the context of broader health and wellbeing issues. Another key strength is their peer education and support approach. They are not embedded in a therapeutic approach. Program staff also indicated that workshop participants provide extremely positive feedback on the programs.

However, these programs also now face a significant challenge attracting participants. There were a range of reasons put forward as to why study informants thought increasingly they were encountering issues attracting participants.

One of the key reasons proposed was increased competition. There are more groups available to young gay and bisexual men than when these workshops first commenced running in the late eighties and early nineties. Although a few informants did note that the different workshops and groups on offer by various services in their area can attract different demographics.

Another factor that was thought to have lessened demand was the impact of social media and mobile apps. While it is hard to quantify, there is a plethora of gay male personal websites and mobile apps that are used to facilitate men meeting other men. This is not imply that all young men use these websites and apps, but it has had a significant impact on the ability of young people to seek out other young people like themselves without needing to attend a group or workshop.

More generally, some informants speculated that an increase in societal acceptance of homosexuals has also meant young gay and bisexual men probably do not feel the same need to seek out support from their peers that they once did.

Another factor put forward is that young people may not be interested in attending workshops. One informant thought it was hard to attract young

people to a workshop when they may prefer or already be accessing regular social support groups. He thought regular social support groups better meet the needs of young people (a common comment made by informants during the study). Another informant pointed out that even if young people express a desire for workshops, this does not always equate with actually attending once a workshop is scheduled.

Study conclusions

This feasibility study was designed to find out if there is a need for existing HIV prevention programs to be extended to reach young gay and bisexual men in rural and regional areas. Ultimately the study did not recommend such a course of action for four key reasons.

Existing HIV prevention programs are not appropriate to be extended:

An assumption underpinning this study was inaccurate; most AIDS Councils/GLBT health organisations are not running specific HIV programs for young gay and bisexual men. This occurs only in three AIDS Councils/GLBT health organisations. Even in those jurisdictions it was reported the programs are facing significant challenges to their ongoing viability.

Where similar workshops have been implemented in rural and regional areas, they tend to have been extended to include all GLBT young people and have run fairly infrequently. Informants working with young people indicated that these workshops are generally not preferred by young people in rural and regional areas, as young people prefer regular and ongoing groups. This means that the model of young gay and bisexual men only, time-limited workshops is not likely to be successful in rural and regional areas.

Young gay and bisexual men in rural and regional areas are not at higher risk of HIV: There is often an assumption that young gay and bisexual men are at greater risk of HIV infection than other gay men. Australian HIV

notification data does not indicate that young gay or bisexual men (under 26) are at greater risk of HIV infection than other gay men, in fact, they indicate the reverse. The national average age at HIV diagnosis among males has been relatively stable at around 37 years of age¹, indicating men in their early thirties to early forties are probably at greater risk of HIV infection. And when different states and territories have observed increases in HIV infections among 'young' gay men, these have mostly occurred among men between 25–29 years old.

Again, contrary to the assumptions that are often made, social research does not support the notion that young gay and bisexual men's sexual behaviour place them at greater risk of HIV infection.² In fact, it shows that their behaviour differs little from older men. Research has reported older and young gay men have similar rates of unprotected anal intercourse with regular and casual partners. Where there is a difference is that young people's knowledge levels were lower and they reported low testing rates. This is a cause for concern, but the response to address this is unlikely to be solved through workshops or groups alone, as these are unlikely to reach adequately large numbers of young men to make an overall population-wide difference.

If there is a need for programs, it relates to mental health and general wellbeing: Research has highlighted that gay, lesbian, bisexual and transgender people have markedly poorer mental health than that of the general population, and that GLBT young people report high or very high levels of psychological distress.³ Research with GLBT young people has reported strong links between homophobic abuse, and feeling unsafe, excessive drug use, self-harm and suicide attempts.⁴

Perhaps not unexpectedly, given they were running such services, study informants believe there were a need for social support groups for GLBT young people. They perceived a

need for young people to have a safe space to explore their sexuality and gender identity and to facilitate social connectedness. The primary purpose of such groups is to improve participants' overall health and wellbeing (including mental health), with HIV prevention being just one of many important issues to address.

Informants working in rural and regional areas, as well as outer suburbs in metropolitan areas, believed such groups needed to be inclusive of sexualities and genders. This was seen as necessary to sustain such groups. Groups targeted at only certain genders or sexualities were less likely to be successful in attracting sufficient numbers of participants. Furthermore, some informants believe the best approach to adopt when running these groups was that they needed to be open to all GLBT young people and their allies.

While there may be a need for social support groups for GLBT young people, this is not about HIV, but about overall health and wellbeing. While AIDS Councils have always recognised the importance of addressing broader health and wellbeing issues, and how that can impact on HIV prevention, it is hard to justify arguing for additional HIV prevention funds when such a program would be broadly targeted at all GLBT young people (lesbians and transgender are not generally priority population groups within national and state HIV strategies) and primarily addressing a social connectedness need.

It is difficult to justify as a priority for HIV prevention funding: In the current environment, it is hard to justify a significant additional investment of HIV prevention funds on social support groups for GLBT young people when new HIV prevention strategies have a real chance to dramatically drive down infection rates. New strategies include a focus on 'treatment as prevention', pre-exposure prophylaxis, and rapid HIV testing. These strategies, if combined with renewed HIV prevention messages targeted at priority population

groups, have the real potential to have an impact. This requires significant energy, resourcing and realignment of services, in what is largely a non-growth funding environment. In such an environment it is hard to argue that implementing social support groups for GLBT young people is an important HIV prevention priority.

Broader question: Is there a need for social support groups for GLBT young people in rural and regional areas?

Putting aside the HIV prevention focus of this study, whether there is a need for social support groups for GLBT young people in rural and regional areas, with funding sourced from elsewhere, is not clearly established by this study as this was not its purpose. While informants running such services could see a need for social support groups, the reality is that many of the groups reported that sustaining participant numbers can be challenging. And in fact, a number of informants reported that their groups were currently inactive or attracting low numbers.

While those running the groups report a need, and while research has documented the benefits of social support group⁵, many of these groups – and the research evaluating their impact – occurred before the use of social media and mobile apps became so widespread. There is a question left unanswered as to whether young people today have the same need to connect

with other GLBT young people through social support groups, when social media and mobile apps can more easily facilitate such contact. This does not negate the need to address the greater mental health burden faced by GLBT young people, but it does raise questions as to whether social support groups are still the most appropriate approach.

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The primary purpose of such groups is to improve participants' overall health and wellbeing (including mental health), with HIV prevention being just one of many important issues to address.

Testing too easy.



Where they hang out: creating a peer-led social media campaign to promote HIV testing in young gay men

By Wills Logue

Introduction: the rationale of peer-led health promotion

The use of peers in developing and implementing health promotion activities is a practice used by many community-based organisations, including those in the HIV prevention and youth sectors. Peer-developed HIV and sexually transmissible infections (STIs) campaigns have been shown to be effective in encouraging safer sex behaviour among younger gay men.¹

Over the years, The AIDS Council of South Australia (ACSA) and other AIDS Councils have used traditional health promotion strategies to promote the safe sex message – such as posters, booklets and community-based education workshops – delivered by health professionals and sometimes focus tested by community members. This article examines why ACSA chose to develop a peer-led campaign targeting young people using social media (YouTube), and how we sought to address the barriers preventing many young gay men from engaging with HIV and STI testing. We also

look at the outcomes for those peers involved in developing the campaign, and lessons learned that might inform future campaign development.

Peer power 2.0

There is a growing body of evidence which supports the incorporation of social media into health promotion², and social media websites such as Facebook, YouTube, and Twitter are being increasingly utilised by health promoters. Many young men are ‘hanging out online’ and are increasingly seeking health information via the web – specifically, on various social media platforms. This trend has been recognised in ACSA’s *Strategic Plan 2010–2015*³, which notes the importance of integrating digital technologies into the development of new health promotion campaigns.

The Health Promotion team at ACSA remain committed to the principles outlined in the *Ottawa Charter for Health Promotion* (1986), which calls for ‘strengthening community action, developing personal skills

and reorienting health care services toward prevention of illness and health promotion’⁴. The South Australian (SA) government’s *2011 Strategic Plan* also acknowledges the need for community participation to ensure young people’s wellbeing. The SA government states that: ‘As active participants in our community, young people are strong advocates. South Australia benefits when their voices are included in decision making within our community’.⁵ It is for these reasons that ACSA’s Health Promotion team engaged in a comprehensive community participation process in developing a campaign to address decreases in HIV and STI testing rates in young same-sex attracted men.

Testing rates: reviewing the evidence

ACSA reviewed data from the *2010 Adelaide Gay Community Periodic Survey* that indicated STI and HIV testing rates had declined in Adelaide. Further, this decline had been part of a decreasing trend in HIV testing amongst homosexually active men

(66.3% of men tested for HIV in 12 months prior to the survey).⁶

Similarly, 2011 figures published by Adelaide's STD Services demonstrate decreases in HIV and STI testing among men who have sex with men, who were also disproportionately represented in HIV, chlamydia, syphilis and gonorrhoea notifications.⁷ The study authors suggest that a significant factor associated with whether an individual tests for HIV is their age, with the likelihood of never being tested being three times higher in young men under the age of 30 compared to older men.⁸

The study authors explain the disparity in the following two ways: firstly, the sexual practices of gay men diversify as they get older, with risky sexual practices prompting increased testing.⁹ Secondly, as gay men age they seek out testing for STIs, and as such the probability that those men will be exposed to health promotion services also increases.¹⁰

An online study examining barriers to testing among young people in New South Wales (NSW) found that younger men who have sex with men 'were less likely to be tested for HIV/STIs ... and reported lower HIV/STI knowledge'.¹¹ This research also found a correlation between low testing rates and the level of exposure to HIV campaigns among younger gay men.¹² Although sexually active men aged 30 to 45 years have been the main target group of sexual health programs in Australia¹³, this research suggests the need for more education targeting young men regarding the need for HIV and other STI testing.

According to the *Adelaide Gay Periodic Survey*, age is a significant factor associated with whether an individual tests for HIV. The likelihood of never being tested is three-times higher in young men under the age of 30 compared to other men.¹⁴

Exploring the findings

ACSA recruited 35 gay and bisexual men aged 17–25 from the Adelaide metropolitan area to participate in a community question and answer

workshop to explore the findings of the *Adelaide Gay Community Periodic Survey*, as well as to understand why young men are not testing for STIs and HIV. The workshop explored potential campaign design and formatting ideas on how to address individual and social factors that may act as barriers to HIV and STI testing among younger gay and bisexual men.

The men who participated in the workshop were asked if they recalled any STI/HIV campaigns; of the 35 men who participated, 30% recalled the Generations Campaign (an ACSA produced and focus tested resource targeting men aged 20–65). None of the young men identified with the characters, and consequently did not believe the message targeted them.

The men were also asked about recent sexual health screening; 70% of the group had never had an HIV test, and only 50% of the group had undergone an STI health screening in the previous 12 months. This data supports the findings of the *Adelaide Gay Periodic Survey*, which indicates that younger gay men are not testing for HIV and STIs.¹⁵ This has been attributed to the focus of social marketing campaigns targeting gay men over the age of 30.¹⁶

The workshop sought clarification from the men as to why they do not test, or do not test frequently; they identified 'fear' as the primary reason for not testing. The following five reasons were frequently mentioned as barriers to HIV/STI testing:

- fear of social stigma
- fear of being identified at the clinic
- fear of the unknown
- fear of what is behind the clinic door
- fear that having a test will hurt.

A study from the US found that 92% of young people aged 18–29 use the internet, and 71% search for health information online.¹⁷ Smart phones were found to be a key way that young Americans accessed health information.¹⁸ This study supports the findings of the ACSA's workshop.

Echoing this overseas evidence, the young men interviewed by ACSA

identified the internet as being their number one source for gaining health information, followed by phoning a sexual health service. These men stated that they also accessed health information through social media platforms such as Facebook, Tumblr and Twitter, confirming the potential success of a social media based health promotion strategy.

'TESTING, Too Easy!' Developing the campaign

The ACSA workshop participants said they thought the most effective method of communicating a health message was through social media and developing a peer-based campaign that took on a 'real' or relevant message, as opposed to the traditional campaign formula of top-down health education by professionals.

Consequently, ACSA sought both community (ten men from the workshop) and sector participation in developing a peer-led social media campaign targeting same-sex attracted men aged 17–25 years. ACSA invited Sexual Health Information Networking and Education (SHine) SA and The Second Story Youth Services, (South Australia's two lead sexual health providers targeting young same sex attracted men), to assist in developing and delivering the campaign.

The working committee made recommendations based on evidence, and asked the young men to ensure the key findings were included in the campaign messages. The primary aim of the campaign was to address some of the 'fears' around testing, as identified by the young men at the workshop. The use of social media, and engaging peers from the developmental stage through to implementation had a dual purpose. Through community participation, the campaign took on a more 'real' or relevant message which helped ensure that it was promoted within the men's social networks. The community

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members involved in developing the campaign were also able to take real ownership, which in turn ensured the message of the campaign was promoted to the targeted demographic through social networks.

Based on the outcomes of the workshop, the men involved were engaged by ACSA to develop a short video and named it 'TESTING, Too Easy'¹⁹

The group met weekly at ACSA for three hours per week, working with a professional filmmaker and health professionals to create and deliver a seven-minute video, developing the characters and then the script. All participants received an incentive payment to compensate for travel and time. The video was shot at various locations across Adelaide, in a marathon 14-hour day. ACSA paid for the services of a professional cameraperson, a make-up artist, an editor, and a director who all contributed to the final product.

ACSA would like to acknowledge Youth Empowerment Against HIV (YEAH) and SHine SA for promoting the 'TESTING, Too Easy' video on their websites. Since the video launch, Google analytics statistics reveal 730+ viewings of the 40-second trailer and the full-length 7-minute video. The total minutes viewed exceed 645 minutes; the demographic indicators show 50% of those viewing the video are aged 16–30 years. Google analytics indicates that 70% of viewings are through a mobile phone. The target viewing number is 1,000 by 30 June 2013.

ACSA is currently undertaking an impact evaluation on the effectiveness of the campaign, to determine if the campaign has directly influenced the number of younger men testing for STIs and HIV. The evaluation results will provide some insight around the success of peer-based social media campaigns as an effective way of engaging with young gay men in the community.

Conclusion

Health promotion has evolved rapidly over the past ten years. Gay men of all ages are accessing more health information online, and with the use of Facebook, Twitter, YouTube and other social media platforms on the rise, the mode of online communication is changing.

There are examples from across the globe of successful social media campaigns being implemented: young people in Africa are creating rap songs about HIV and uploading them onto YouTube; The Victorian AIDS Council has embraced the two-way communication of web 2.0 in 'Down and Dirty' (www.downanddirty.org), allowing community members to post videos and encouraging online engagement to access information, knowledge, perspectives, resources and community participation.

How gay men access health information has undergone a 'revolution', and it is important that HIV health professionals engage with gay men 'where they hang out'. This will ensure we are reaching our communities.

The 'TESTING, Too Easy' video can be viewed online at ASCA's YouTube channel: <http://www.youtube.com/AIDSouncilofSA>

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Positive status: Jason's coming out story

By **Finn O'Keefe**

Jason, who's 33 years old, came out as gay when he was 14. He's been living with HIV for almost two years and recently decided to 'come out' about his HIV status to his 1,000-plus friends on Facebook. He explains that he wanted to harness the power of social media to make a difference and to help educate other young people about HIV and the importance of getting tested regularly.

'I wanted to 'come out' to everyone for quite some time now,' Jason explains. 'I saw that most people I knew with an HIV diagnosis felt ashamed, felt 'dirty' and felt like they were worthless ... Almost everyone I spoke to with the diagnosis had not dealt with it in any significant way; even my partner committed suicide after being diagnosed.'

'Once I had dealt with it and was happy again with my life, I wanted to show everyone around me that they can be proud of who they are, they can love who they are and that they deserve to be loved, no matter what life has thrown at you.'

Jason says that although coming out so publically about his HIV status was a difficult decision – and one he deliberated about for some time – it was worth it.

'It was incredibly hard,' he says, 'I hesitated for months, until one day I just did it.' Jason says that he has received an unexpected amount of support following his announcement.

'Not only were people so supportive of me, but I was contacted by many, many people who had HIV or other illnesses.'

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Being told that what I did helped them and made a difference to their life has been amazing. It gave my diagnosis worth; it made it special to me. I became even happier.

'I found many people in a similar situation to mine. By opening up to them, they in turn opened up to me, so I found the support I needed all around me. I can only suggest to try looking for support from those around you – you will probably be surprised by how much is there.'

Jason explains that although in the beginning he knew very little about HIV, he has been able to share what he has learnt with others: 'It wasn't until I decided to understand HIV, and spent hours and hours poring over research did I understand it as I do now. As for my peers, well, I have helped everyone around me see HIV differently, from increasing understanding, to reducing the stigma associated with it simply by discussing things with them, and showing them I am still the same person.'

Although Jason sees a positive diagnosis as a life changing experience, he says it is important to focus on the positives: 'It may seem impossible to deal with, but your life will go on – although, yes, it needs to change. Taking care of your health and being sexually responsible are just some of the changes, though none of these are bad. In fact, they have been great changes for me.'

Everything in life is what you make of it,' Jason concludes. 'Life gave me some

Jason's message on Facebook

I came out as being gay when I was like 14. I thought that it was going to be hard then, but it wasn't – I received nothing but support and love from everyone around me, and have still my entire life, but it's time to come out again. This time it seems harder but I hope I find it just as easy and natural as last time. Not that long ago, my partner and I had trusted each other enough to indulge in unprotected sex, and had agreed to only do this with each other. It was only a few months, however, until I found out that he wasn't keeping his side of the deal. Upset, I suggested we both get tested again; the results came back positive for HIV. I couldn't speak to my partner about his betrayal as I was still dealing with the hurt, so when he approached me to talk, I said I couldn't speak to him. It was only a few days later that he killed himself.

I have HIV and I am on medication that has completely controlled the virus and it cannot be detected in my body. I am healthier than I have ever been, and am the happiest I have been in my life. You might be wondering why come out and tell everyone this? Well I believe everything happens for a reason and I believe that I contracted this virus to help others with it, or with any illness they might feel stigmatised or ashamed of, even if its just to show them it's ok, you're ok, everything will always be ok. It's time I publicly own my status, I have HIV. I am happy. I am healthy. I am fabulous and current medication means that I can live a life almost as long as everyone else. Probably even longer than I was going to as I am now so particular with my health. Medication is improving all the time, and I believe medication will one day cure me of it completely. So if you have HIV or any illness, you might feel ashamed of, or scared of, don't be – you're still the same person and you can be happy, healthy and fabulous. Be responsible. Be happy. Get tested regularly. Love Jason.

Jason received hundreds of messages of support from people after he posted his message. He responded to this outpouring of support with a public reply:

Wow, I could never have imagined the response I have gotten today, not in all my wildest dreams. I have had so much support from everyone and the amount of private messages I have had is overwhelming. There is so much love around, it really is OK being whoever you are, and no matter what happens to you, don't be ashamed because people really do care and love. I am blessed, and so is everybody else. Be thankful for what you have, and be proud of it, no matter what. The fact we are still alive right now, means we have the greatest gift of all. Be strong, be happy, and be free. Thank you everyone for all that you have shown me today, I feel like a king, and I hope that what I have done today shows many people that whatever situation they are in, it doesn't matter, because someone will always love you, things will always get better, and life will move on ... Love J.

lemons, like it does to most people. You can either suck on them and get a sour face, or maybe, add some sugar and make yourself some lemonade ... I decided to invite everyone around, slice my lemons up and open a bottle of tequila, and celebrate this party we all call life.'

HIV Australia thanks Jason for sharing his story with us. An article about Jason's story was also featured in *QNews*.

Finn O'Keefe is Communications Officer at AFAO and an editor of *HIV Australia*.



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Paediatric HIV in Australia: 30 years of a changing landscape

By **Angela Miller, John Ziegler and Pamela Palasanthiran**

The Paediatric HIV Service at the Sydney Children's Hospital, Randwick, is the only designated Paediatric HIV Service in Australia. It provides medical, nursing and social work support to children, families and pregnant women living with HIV. The service was established in 1989 by immunologist, Associate Professor John Ziegler who remains the head of the service today.

The team comprises a full-time clinical nurse consultant, full-time senior social work cover (currently shared between two medical social workers) and medical consultants (currently shared between three doctors). Clinical services are supported by a dietitian from the HIV community team and neuropsychological testing via the Sydney Children's Hospital, Randwick. In addition to the statewide clinical support, the service provides consultation and education throughout Australia and the greater region. The service is also responsible for the coordination and provision of three residential camps each year, including the national Camp Goodtime.

A history of children and HIV in Australia: then and now

Children in Australia who became infected HIV in 1985 or earlier generally acquired the virus through contaminated blood products; these were mainly children with medical conditions that required multiple blood products for treatment (e.g. children with bleeding conditions like haemophilia, and premature babies who needed blood cells for anaemia).

Since 1985, all blood products used in Australia have been screened for HIV and new HIV infections in Australia among children are the result of mother-to-child-transmission (MTCT) – an extremely rare event in this country since the discovery of effective MTCT prevention strategies.

The Paediatric HIV service has been directly involved in the care of about 60 children with HIV. About a fifth of these children were born prior to 1985, and thus mainly contracted the virus through contaminated blood products. The remainder acquired HIV perinatally

– the majority born in the era prior to effective prevention for MTCT.

Until the mid-90s, children with HIV were often very unwell. This was a time prior to the advent of highly effective antiretroviral therapy (HAART), which did not become available until after 1997.

In those early days, children with HIV did not generally live beyond the first decade of life. Medical care was acute, and based on treatment of symptoms in children who were severely immune-compromised, with multiple HIV-related complications necessitating frequent hospital admissions. They often had difficulties with growth and were significantly smaller than other children their age.

1997 saw introduction of antiretroviral (ARV) therapy, with zidovudine (AZT) initially being the only drug available. Children commenced AZT as monotherapy, the effectiveness of which lasted a few months, at most.

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Even after more ARVs came on the market, children with HIV continued to be disadvantaged because availability of paediatric ARV formulations (syrups or solutions) was limited, making optimal therapy difficult. Nursing support was focused on end-of-life care, and social work supports revolved around bereavement support for families and permanency planning for children whose parents had died or whose parents were too unwell to care for them.

In the background was the lack of appropriate knowledge about HIV and the resultant prejudice and stigma these children and their families faced in those early days. There were instances of HIV-positive children being ostracised from schools, a cause of great angst for the families in that situation. The Paediatric HIV service assisted some families with school disclosures which helped children with HIV assimilate into school life. Many readers may recall ‘Troy’s’ story and the tireless championing by his father, Vincent, to dispel the negative myths surrounding HIV, in part via a film about Troy’s life in the early 90s (*A Kid Called Troy*).

Today, after three decades of international research, we now have strong evidence-based paediatric HIV management guidelines. Although the ‘HAART era’ dates from 1997, clear guidelines for treatment of HIV in children lagged several years behind. Thus, for children, HAART did not truly begin until around the year 2000.

HAART is now routinely used to treat HIV, and many of its components are now available as paediatric formulations. We have clear and effective management pathways, particularly regarding what ARVs to put HIV-positive children on, and the optimal timing to treat children.

Treatment is effective, and it is rare for an HIV-positive child to be hospitalised. HIV-positive children in Australia are now generally well and indistinguishable outwardly from their healthy counterparts. Multidisciplinary support focuses on the long term management of HIV as a chronic illness, addressing issues affecting medication adherence – including psycho-social issues regarding disclosure, dealing with adolescence, and transitioning to adulthood and adult services.

Mother-child-transmission (MTCT)

Associate Professor Ziegler was the first in the world to document HIV transmission via breast milk¹, information which became one key aspect in mother-to-child prevention strategies. The team later went on to define the risk of the baby being infected with HIV if exposed to HIV from breast milk, if the mother has seroconverted during the period she is also breast feeding.²

With MTCT risks ranging from 25–40% without intervention, the evolution of evidence and therefore effective strategies to reduce this risk is one of the most significant scientific developments since the epidemic. Aside from the association with breast feeding, the other landmark was the PACTG 076 study in 1994 which showed that maternal zidovudine (AZT) taken orally from the second trimester, intravenously during labour and orally to the baby for six weeks dramatically reduced the MTCT risk by two-thirds.³ Other scientific evidence followed, with the result that prevention strategies are now well established, resulting in a less than 1% risk of MTCT to the baby.

The HIV Service has seen a change in MTCT over the past 30 years. We have directly managed over 200 pregnancies for HIV-positive women (with the babies followed up at Sydney Children’s Hospital), separate to the pregnancies we have been consulted on from other institutions (generally outside of metropolitan Sydney) in the 30 years.

With the knowledge that mother-to-child prevention strategies can only be instituted if a pregnant women is known to be HIV positive, the service is a strong advocate for antenatal testing (with informed consent and follow up support provided).⁴ Antenatal testing also has the benefit of allowing women to access medication for their own health care and wellbeing.

In the background was the lack of appropriate knowledge about HIV and the resultant prejudice and stigma these children and their families faced in those early days. There were instances of HIV-positive children being ostracised from schools, a cause of great angst for the families in that situation.

Prior to 1994 (the year of PACTG 076), mother-to-child prevention strategies generally consisted of counseling mothers to not breast feed and to avoid invasive obstetric procedures. Now, we are able to confidently counsel on a broad range strategies; we adopt a multi-disciplinary/multi-facility approach by liaising closely with the woman's HIV physician, her obstetrician and the labour/postnatal ward staff. Cohesive care plans are drawn up to ensure the best outcome for delivery and post natal management/follow-up of the babies. We no longer see children infected from MTCT, *provided* the opportunity exists for implementing prevention strategies.

For all the mothers who have known their HIV status antenatally, mother-to-child prevention strategies have been effective. Children are no longer infected, except in the extremely rare instance where there have been extenuating circumstances and not all strategies have been followed. However where maternal HIV infection has not been known in the antenatal period, infections have occurred – representing missed opportunities for preventing HIV among children.⁵

Current challenges

These days, the overwhelming majority of children managed by the HIV service are clinically well, and the social ramifications of the virus have the greatest impact, particularly on the teenagers trying to navigate their way through to adulthood while managing medication, attending clinic, and undergoing regular blood tests. It is often during the teenage years that medication adherence and overall wellbeing become a seemingly insurmountable challenge for some young people.

In a country where there are approximately 80 HIV-positive children, social isolation remains a significant burden for those children.

Spread throughout Australia, they are can be aware that there are no other children or young people in their region who are also living with HIV.

Often conscious of the discrimination and ignorance experienced by their parents in the early years, many of these children and young people will not disclose their HIV status to peers, extended family, school or other community members. Taking daily medication and attending appointments in these circumstances becomes an obvious challenge when school, sports, community and peer commitments become the focus.

Furthermore, a number of young people have lost either one or both parents and/or a sibling to the virus now live in foster care with members of their extended family. The service has also seen an increase in the number of HIV-positive children arriving in Australia either with their family or as a result of inter-country adoption.

Camps

All of the above factors influence the child or young person in a variety of

ways and it is for these reasons that the Paediatric HIV Service has established residential support camps (e.g. Camp Goodtime), in an attempt to address some of these challenges.

The camps aim to:

- reduce social isolation
- provide education and information
- facilitate the development of peer support
- provide respite
- provide a therapeutic and recreational environment.

Many families, children and young people report that the greatest benefit of the camps is having the capacity to talk openly with others in a similar situation, not having to keep a secret and being able to be 100% themselves for the several days at camp. Many of the teens have established and maintained strong connections with each other – forged over five days of intense connection, fun and the shared bond of living with HIV. Learning strategies to manage their virus, prevention, methods of disclosure and

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Many of the teens have established and maintained strong connections with each other – forged over five days of intense connection, fun and the shared bond of living with HIV. Learning strategies to manage their virus, prevention, methods of disclosure and sharing their experiences ...

sharing their experiences often provides the participants with the sustenance to manage once they return to their world away from camp.

Funding for these camps have relied completely on the generous support of sponsors, donors and various fundraising events, as the service does not receive government funding for the camps. In addition, many volunteers generously donate their time yearly to assist the running of the camps. Over \$100,000 per year is required for these camps. Without the generous fiscal donations of our sponsors and donors, these camps will not be possible.

Transition

An additional challenge now faced by HIV-positive children who are living beyond the first decade of life is their transition to young adulthood, and the 'transition' of health care to adult services. The Paediatric HIV service has played a part in transitioning several teenagers to adult services. Successful transition to adult services requires comprehensive planning from an early age. This can include the provision of support and education to the young person, aimed at establishing an appropriate level of independence in their health care knowledge and management. Acknowledging the

differences in a paediatric setting compared to an adult hospital or sexual health clinic has proven to be important, and care needs to be taken to ensure young people have every opportunity to embrace their transition and not fall through the gaps of the health care system.

Disclosure

The issue of disclosure has become a key focus of discussion both at the camps and via clinical work with the young people who are HIV-positive. Fearful of a negative reaction, most choose not to share this significant piece of personal information with their friends. As their peer connections become stronger, many teens struggle with decision making regarding whether they should disclose and how to choose whom to disclose to. This is followed by the need to develop strategies for when, how and where to disclose, and how to manage the reaction they may receive. A challenge at the best of times, disclosure has allowed some teens to receive great support from their peers, whilst others have lost friendships – and potentially their confidence to disclose again.

On a final note, pregnant women with HIV and children with HIV are rarely noted on priority population lists in the

HIV sector. We are currently fortunate that there are only a small number of children living with HIV in Australia, as a result of successful harm reduction approach to intravenous drug use from the early 80s and effective mother-to-child prevention strategies. However, we must not be complacent about these successes. Appropriate antenatal testing, supports and education must remain important policies to ensure every baby at risk of MTCT has the benefits of prevention strategies, and that children with HIV continue to receive the highest of level of care and in a stigma free environment.

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Successful transition to adult services requires comprehensive planning from an early age.

This can include the provision of support and education to the young person, aimed at establishing an appropriate level of independence in their health care knowledge and management.

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When HIV-positive children grow up: a critical review of the 'transition' literature

By Christy Newman and Asha Persson

The global context

An estimated 2.1 million children under 15 years of age are living with HIV around the world today. More than 90% are believed to have been infected through mother-to-child transmission. During the early epidemic, perinatally acquired HIV was regarded as an inevitably fatal illness in all parts of the world, with death likely to occur in early childhood. This is still the case in many low- and middle-income countries, with only 28% of HIV-positive children receiving antiretroviral treatment in 2009.¹

In contrast, most children living in high-income or 'developed' countries such as Australia do have access to treatments and have benefited from medical advances since the mid-nineties, which have had a dramatic impact on their survival and quality of life. Many

of these children are now ageing into adolescence and adulthood, and this has given rise to a growing body of research literature on 'transition' issues in this population.

We conducted a critical discourse analysis of the international literature on transition in perinatally-infected HIV-positive children, most of which is from the USA. This literature commonly described these HIV-positive young people as a 'new' or 'emerging' population in the epidemic. The most consistent message in this literature was that the transition of children with HIV to adolescence and adulthood brings with it a unique and complex set of challenges and risks, for which clinicians and the children themselves are ill-prepared.

Here is an example from one of the articles we reviewed:

Teenage and preteen long-term survivors are a relatively new part of the HIV scene, and AIDS healthcare and service providers are ill-equipped to meet the unique set of needs they present. The reason for this lack of preparedness is simple enough. Put bluntly, these kids weren't supposed to live this long.²

Two issues were singled out as particularly challenging, namely transition to adolescent sexuality and transition into adult clinical care. The full analysis can be read in *Qualitative Health Research*³, but we provide an abridged version of some of the key ideas here.

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Transition to adolescent sexuality

Adolescence was commonly framed in the literature as a critical time for perinatally infected youth because it was during this time that their budding sexuality was believed to collide with the difficult realities of having a sexually transmissible disease. Not only did these adolescents have to negotiate their first sexual experiences with an altered body shape, they also had to confront issues brought about by having a highly stigmatised disease, typically laden with fear and misinformation, as well as having to weigh the possibility of infecting someone else against their own desire for sexual intimacy.

It was this last issue that was of most concern in the literature, seemingly driven by an assumption that these adolescents were either unable or inadequately equipped to manage their own sexuality safely. This turned on the notion that adolescence is a stage of life in which risk-taking and experimentation with drugs and multiple sexual partnerships begin and escalate, and that there was no reason to believe that HIV-positive adolescents would act any different. This assumption was often qualified by an admission that little was actually known about the sexual practices of this group, given that perinatally infected adolescents remained relatively under-studied because of their recent emergence in the epidemic.

But this did not prevent their sexuality from being pronounced as a critical

concern, even when the authors' own research findings suggested otherwise. So despite some evidence that perinatally infected adolescents were less likely to be sexually active, less likely to engage in penetrative sex, were confident in their ability to negotiate safer sex, and sustained their use of condoms over time, authors repeatedly reached this same conclusion: that multilevel prevention initiatives were urgently required to reduce or prevent 'risky sexual behaviors' among this population.

One of the few articles that presented a different approach was that of Fernet and colleagues, who did not position these young people as a public health problem in need of constant supervision, but rather recognised that they might already have a good understanding of their situation and might already be employing harm reduction strategies. On this basis, the authors recommended that what these young people really needed support around was the emotional aspects of dealing with sexuality in the context of HIV, because it was this dimension that was identified as the greatest challenge facing the young participants in their study.⁴

Transition to adult care

Just like any other kind of health care, HIV care is delivered to children in quite different ways depending on the country and setting. However, the literature on the transition of perinatally infected young people to adult HIV services – which is mostly

from the US – represents this as a single and momentous event, usually occurring at or soon after turning 18.

A common concern in this literature related to the capacity of young people to 'self-manage' their HIV care, because moving to an adult health service required them to take responsibility for many aspects of their health for the first time, particularly medical appointments, service costs, and medication adherence. This concern seemed to be often based on the assumption that these young people had been overly protected since birth and were therefore unable to be trusted to look after their own health care needs appropriately. There were some occasional and implicit suggestions in the literature that some young people might have developed the skills required to successfully transition to adult care. But overall, very little attention was paid to the factors that might support young people in actively participating in this process.

The general picture painted was one of pediatric care providers forming a kind of 'extended family' for HIV-positive children that created a safe, supportive environment for them to grow up in, but leaving these young people ill-equipped to face the 'real' world of adult care and, potentially, of adult life more generally. As one young adult with HIV was quoted: 'When you transition into adult care you have to find a new family'.⁵ And yet there is little real evidence from this literature that considers how young people themselves feel about this.

We also found no research literature on how health care providers can be supported through the process of transitioning young people, a problematic gap when one considers that clinicians are also likely to require emotional support to cope with the end of an often very longstanding care relationship with their young patients. Nonetheless, this literature was still dominated to a large extent

The general picture painted was one of pediatric care providers forming a kind of 'extended family' for HIV-positive children that created a safe, supportive environment for them to grow up in ...

by the concerns of clinicians. Thus there is a significant need to also pay closer attention to the voices and experiences of perinatally infected young people themselves.

The Australian setting

While there is a small cohort of perinatally-infected HIV-positive children who are currently growing up in Australia, no published research exists on this population in this setting. This is a conspicuous gap because although a relatively small population, they are important in terms of both HIV prevention and the delivery of care, and in terms of the broader aim of promoting the health and wellbeing of people living with HIV in Australia.

The National Centre in HIV Social Research (NCHSR) has developed a qualitative study that aims to produce the first empirical exploration of this cohort in Australia by gathering in-depth information both from children and young people with HIV in NSW, and from clinicians who provide direct care to this population across Australia. This study will provide timely insights into the key issues associated with transition for this largely hidden group in the epidemic, particularly issues associated with becoming sexually active and remaining engaged with HIV treatment and care during a time of life that typically features considerable change.

There is no doubt that growing up with a stigmatised, chronic and sexually transmissible disease can pose numerous and complex challenges, or that substantial support might be required to help young people navigate this process. However, the existing transition literature tends to uncritically reproduce a limited repertoire of assumed facts about children with HIV. This literature rarely considers the possibility that these young people might have developed, for instance, resilience, foresight, coping strategies, expertise, or life skills as a result of their illness. It also rarely includes the

views and experiences of the young people themselves.

In contrast, our study hopes to describe the perspectives of HIV-positive children and young people themselves to gain a better understanding of how they address the challenges of growing up with HIV, and to provide them with a unique opportunity to tell their stories and contribute to the knowledge base to inform future models of care. Paying more deliberate attention to these young people as a vital source of knowledge and information about what it means to grow up with HIV could offer invaluable insights into how clinical and psychosocial care services can most appropriately support them as they move into adulthood.

Getting involved

We are very grateful to have been recently awarded a Gilead Fellowship Grant to assist us with the costs of conducting interviews with children and young people living with HIV in NSW. We are also continuing to interview clinicians (doctors, nurses, social workers, counsellors and so on) who provide care to this population around Australia.

We are very keen to hear from anyone interested in taking part in an interview, so please don't hesitate to contact Asha Persson at a.persson@unsw.edu.au, or Christy Newman at c.newman@unsw.edu.au at any point during 2013.

The study is conducted in collaboration with the Paediatric HIV Service at Sydney Children's

Hospital, and in close consultation with several partner organisations, including the Australasian Society for HIV Medicine (ASHM), the National Association of People with HIV Australia (NAPWHA), Positive Life NSW, and YEAH (Youth Empowerment Against HIV/AIDS).

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Dr Christy Newman is Senior Research Fellow and Postgraduate Research Coordinator at the National Centre in HIV Social Research. Dr Asha Persson is Research Fellow at the National Centre in HIV Social Research.

However, the existing transition literature tends to uncritically reproduce a limited repertoire of assumed facts about children with HIV.

HIV-positive children transitioning to adolescence and adulthood in NSW

If you're aged between 12 and 21 years and you've had HIV since you were little, we'd like to invite you to participate in a study about the experiences of growing up with HIV in NSW.

This qualitative pilot study will identify and explore key issues associated with the transition to adolescence and adulthood for children living with HIV in NSW and their implications for health, HIV prevention and clinical care in NSW. No published research exists on this population in Australia to date. Thus the study will produce the first empirical picture of this population in Australia, by gathering in-depth information both from young people with HIV in NSW and from clinicians who provide direct care to this population in NSW and in other states.

We also want to interview clinicians experienced in caring for children and young people around Australia. Your participation is confidential.

contact

Dr Christy Newman c.newman@unsw.edu.au to participate in a confidential interview,

Dr Asha Persson a.persson@unsw.edu.au for more information about the study or visit

<http://nchsr.arts.unsw.edu.au/centre-research/research-areas/hiv-and-sexual-health/#HIV-positive%20children>

youme&hiv—the serodiscordant couples study

This is a qualitative study for gay and heterosexual people who are in an intimate relationship with someone who does not have the same HIV status as they do.

This study, which aims to better understand the experiences and prevention needs of both gay and heterosexual serodiscordant couples in urban and regional areas in NSW, will be the first major study of its kind. The information gained will help to identify the needs of both HIV-positive and HIV-negative partners and will assist in the development of policy and health promotion for people in serodiscordant relationships in NSW.

We are now looking for participants and encourage you to contact us. Your participation is confidential.

contact

Asha Persson a.persson@unsw.edu.au for more information or to participate in a confidential interview.
Alternatively you may visit our website
<http://nchsr.org/youmeandhiv>



Two studies recruiting now!

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Sexuality education in Australian Secondary Schools: averting a sexual health crisis among young people

By James May

Introduction

Sexually transmitted infections (STIs) have risen sharply among young people in Australia in recent years, leading to calls for more effective and targeted approaches to sexual health education in schools.

The Australian Curriculum, Assessment and Reporting Authority (ACARA) is currently conducting consultation on a review of the Australian Curriculum: Health and Physical Education from pre-school to Year 10, which includes content on 'relationships and sexuality'.¹ Input is currently being sought through an online consultation, which is open for public comment until April 2013.² The revised curriculum is due for publication on the Australian Curriculum website in 2013.³

A review of sexuality education in Australian schools is much needed. While there is evidence to suggest that current sexual health programs in secondary schools are adequate for some young people, there are discrepancies

around the quality of material being taught, the targeting of materials and inconsistencies in individual curricula and teaching approaches. Current sexual health programs for Australian school students are also failing to address the needs of same-sex attracted and gender questioning (SSAGQ) young people.

In some jurisdictions, the involvement of community organisations using trained peer educators is enhancing program quality and providing valuable insights into the benefits of involving sexual health experts and peer educators in both program development and delivery.

Sexuality education – the Australian context

'Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and

safe sexual experiences, free of coercion, discrimination and violence.'⁴

The World Health Organization (WHO) (1998) asserts that young people need access to specific skills-based education in order to care for their sexual health. Young people must be able to⁵:

- make sound decisions about relationships and sexual intercourse and stand up for those decisions
- deal with pressures for unwanted sex or drug use
- recognise a situation which may turn risky or violent
- know how and where to ask for help and support
- know how to negotiate protected sex and other forms of safe sex when ready for sexual relationships.

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These principles are generally supported by education authorities in Australia. However, research suggests that they are not being taught consistently to all students.

Australian secondary students see school programs as some of their most useful sources of information about sexual health and relationships; they are the most popular source of knowledge for both young men (48.5%) and young women (48.8%).⁶ It is therefore essential to provide an effective level of sexuality education in schools to promote the sexual health of all young Australians.⁷

Despite its overwhelming value to young people, sexuality education in Australia has been described as ‘inconsistent and ad hoc’ and poorly resourced within education departments.⁸ Feedback from teachers indicates there is a great variation in teachers’ knowledge about how to teach sexuality education.⁹

Young people themselves should also be consulted about the development and implementation of sexual health and sexuality education programs. As one recent report states: ‘Young people are the best experts on their own experience, and their voices are key to understanding what works and what gaps must be addressed in sexual health education in Australia today.’¹⁰

STIs and young people – a sexual health crisis

Research indicates that young people’s knowledge about STIs and how they are transmitted remains inadequate, even though teachers have usually covered the basics on this subject.¹¹

According to the authors of the *Let’s Talk About Sex: National Youth Survey 2012*:

Australia’s young people are facing a sexual health crisis of epidemic scale, with 75% of all Sexually Transmitted Infections (STIs) in Australia occurring amongst young people, and a 20% increase in the rate of STIs diagnosed amongst people aged 15–29 in the past three years.¹²

Debate continues around how much information students need about STIs and blood borne viruses but all school programs should at least convey essential sexual health information to students, including¹³:

- that they can acquire an STI through particular kinds of sexual behavior
- what symptoms they might experience
- that symptoms may not always accompany an STI
- that testing and treatment is simple for many (but not all) STIs
- that untreated STIs have health consequences

- where and when to get tested regularly after commencing sexual activity.

Research shows that young Australian students are generally sexually experienced and need sexuality education programs to reflect what is going on in their lives.¹⁴ In surveys conducted in 2008 most students (78%) said they had experienced some form of sexual activity.¹⁵ Although 52% of sexually active students reported having had sex with one partner in the previous year, 45% reported having sex with more than one person.¹⁶

When questioned about the last time they had sexual intercourse, two in five students reported using a condom, but more than one quarter did not. Half the respondents said they ‘always’ used condoms when they had sex in the previous year. 43% said they only used condoms ‘sometimes’, and 7% ‘never’ used condoms when they had sex in the previous year.¹⁷

Of particular concern is that just under one third of the sample reported experiencing unwanted sex as a result of coercion or the influence of drugs and/or alcohol. The majority of students (80%) in this report stated that they had drunk alcohol while almost a quarter of sexually active students in another report said that the last time they had sex they were either drunk or high.^{18,19}

Education programs need to give young people the ability to negotiate peer pressure to use drugs and alcohol and engage in sex. These issues are clearly linked.

Same-sex attracted and gender questioning youth (SSAGQ)

Up to 11% of any school population will include same-sex attracted students and research indicates that the sexual health of these students is often neglected.²⁰ These students are generally more sexually active than their heterosexual peers; many are more likely to report engaging in sexual risk taking with partners of both

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sexes during high school and have higher rates of pregnancy and STIs than students that report exclusively heterosexual attraction.²¹

Furthermore, credible sources for information on sex and relationships such as teachers and parents – highly regarded by most young people²² – are often not accessible for same-sex attracted young people, who are compelled to rely on less reliable sources such as the internet.²³

Fourty-four percent of SSAGQ students said that they found school sexuality education not useful at all, 40% felt it was only partly useful, 11% found it moderately useful and 5% found sexuality education very useful.²⁴ Distinguishing features of sexuality education that these students said was valuable included²⁵:

- sexuality education that combines a large variety of positive messages
- critical thinking and exposure to more fluid constructions of sexuality
- wide-reaching inclusion of same-sex attraction and sexual diversity beyond token attempts
- anti-discrimination and anti-homophobia efforts
- sexuality education that changes the social dynamic at school so that people become more understanding and supportive
- teachers who go into detail, are supportive and use diverse resources.

Schools are missing the opportunity to promote equal sexual health outcomes for these students. A recent survey of teachers provided further evidence that the lack of attention paid to SSAGQ students is a significant problem across Australia – one which teachers recognise needs more training and resources.²⁶

The value of sexual health 'experts' and peer educators

Research demonstrates that young people want external agencies to play a role in the delivery of sexual health

education in schools, with an emphasis on peer education. Students involved in the recent *Let's Talk About Sex: National Youth Survey 2012* reported that they preferred sexual health peer educators (i.e. trained young people, 68%) and sexual health educators from community organisations (68%) to complement sex education programs in their schools.²⁷

Living Positive Victoria's Rural HIV and Sexual Health Project is one such program that strives to meet this need through its Positive Speakers' Bureau. HIV-positive speakers have been visiting schools for over 20 years, and in 2009 presented to more than 6,000 people across a range of settings and contexts.

The Positive Speakers' Bureau delivers presentations at secondary schools in both metropolitan and rural areas. The school presentations are to Years 9–12 and are part of the Department of Education's *Catching On Everywhere* sexuality education program for Victorian schools.²⁸

Living Positive Victoria reports an increase in requests from rural secondary schools for HIV-positive speakers in the period 2008 to 2009, as well as an increase in requests to provide speakers for hard-to-reach rural populations. There has been encouraging feedback from secondary

school nurses about the impact of HIV-positive speakers in addressing unsafe sex practises amongst students; positive speakers can play an important role as effective sexual health educators.²⁹

Data clearly shows that secondary school nurses, student welfare coordinators and other teachers believe the presentations are a highly informative, dynamic and compelling means of gaining insights into the lived experience of being HIV-positive. They also believe that the presentations are an effective means for young people to gain a greater understanding of sexual health and wellbeing. Comments include³⁰:

'It was good to reinforce the "safe sex" message. The personal stories made it all the more "real" for students and really hit home that their sexual health is their responsibility.'

'By giving detailed explanations of how their personal experience of unprotected sex occurred, it let the students know that care and planning is required to stay safe.'

*'The presentation is part of our whole school approach to wellbeing and an important, integral part of how we educate our young people. Very, very valuable.'*³⁰

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Feedback from young people in the *Let's Talk About Sex: National Youth Survey* was similar³¹:

I have found that external sexual health educators who specialise solely in teaching sexual health education are the most effective, as they immediately have more credibility to the students, who accept their information more readily than from their school teachers.'

'I prefer trained individuals, qualified to teach according to a range of different situations from a professional, non-biased, non-judgmental perspective.'

'I would like sex ed. to sit with lots of people, so that students get a range of opinions and people they can seek out advice from – people that can have an ongoing relationship with young people, and can be trusted by students while still being appropriate to the school and its beliefs.'

Summary

Australia is facing a sexual health crisis among its young people, and is falling well short of the protocols established by the WHO to give them the resources they need to understand and care for their sexual health. Sexuality education is inconsistent across Australia's states and territories, with a variety of interest groups producing their own curricula in various government and private schools.

Many teachers do not have adequate resources, training or support to provide students with the breadth of information they need to care for their sexual health. Current information

resources do not appear to adequately engage some groups of young people; same-sex attracted youth feel that these resources do not meet their needs at all.

Young people need to have a say in the development of policies and sexual health education programs. They need to be empowered with adequate information to manage their choices and behavior with regards to their sexual health. Strong partnerships with external agencies such as Living Positive Victoria are highly regarded by secondary students, who value the knowledge of peer educators. We already face a dire situation in terms of negative sexual health outcomes for young people in Australia; schools need to act urgently and implement comprehensive sexuality education programs to reduce further harm and protect those at risk.

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... schools need to act urgently and implement comprehensive sexuality education programs to reduce further harm and protect those at risk.

James May is a freelance writer, based in Melbourne, who regularly contributes work to the HIV sector in Victoria. He has written for various magazines including *MCV*, *Positive Living* and *HIV Australia*.



Sex education needs to begin earlier

By **Jenny Walsh**

When should sex education begin for children? According to some parent groups who advised the Australian Curriculum, Assessment and Reporting Authority (ACARA), not until Grades 5 and 6. Under this pressure, ACARA pushed back sex education, revising their original guidelines that introduced it at Years 3 and 4.

But just as we've decided to push back sexual education to later years, the media has been full of discussion about the sexualisation of children, the effects of marketing on children's body image and concerns about kids' exposure to pornography.

Yet what the public and media have misunderstood here is the capacity for sex education to help combat the negative messages children are learning about sex and their bodies.

We have confused children learning about sex in an appropriate educational context with the sexualisation of children.

Look to the evidence

There is complete agreement in the literature that healthy sexual development is dependent on two-way communication between adults and children, and this needs to begin early.

Research from the fields of child abuse and sexual assault tell us that we should begin to teach children the proper names of their sexual body parts, like 'vagina', 'penis' and 'anus', right from the start (in the toddler years) and certainly after school has begun.

This gives children a common language to speak about and understand concepts like acceptable and unacceptable touching.

Later on in the middle school years, children's perceptions of sex and their bodies change. If looking at my son's bookshelf is anything to go by, we can reliably call these the 'Bum Joke years'.

The Society of Obstetricians and Gynaecologists of Canada describe this

stage as a time of curiosity, including delight in rude jokes and an interest in, and the capacity to understand, how babies are conceived.

Children are already interested, so now is not the time to shut down the conversation. To do so teaches children something else: that this is a topic fit only for school playground humour.

When does puberty begin?

Children need to understand the practical details of managing puberty before it begins to happen in their own bodies, as well as their peers'. And there is increasing evidence that puberty is happening earlier and earlier.

A US study of 4,000 children, published in 2012, found that boys are reaching puberty two years earlier than previously believed.¹ On average 'white' boys started puberty at 10, and 'black'

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children at age 9.² Other studies have suggested that girls are also beginning puberty earlier.

If we want to introduce children to some of the stages of puberty before it begins, then certainly, Year 6 is too late. By the time children reach Years 5 and 6, even if covered partly in the previous years, they need to be taught the practical side of the physical, emotional and social changes they're seeing.

With the advantage of an existing language and capacity to discuss sexual matters these children are more able to critique the media messages and images that they come across.

In recent years, many primary school teachers I work with have, in response to children's concerns, changed their programs to deal with body image, students' viewing of pornography online, and exclusion of children who do not fit 'prescribed' boy or girl interests.

Growing minds

It seems self-evident but children grow in to teenagers. The Fourth National Survey of Students Sexual Health³, which surveyed almost 3,000 students in Years 10 and 12, found that one quarter of Australian adolescents have

sexual intercourse by Year 10, and 50% by Year 12. 80% have had some kind of sexual interaction such as deep kissing and sexual touching by Year 10.

More teenagers are having sex with more partners, and the amount of unwanted encounters is also on the rise. More than a third of high school students have experienced unwanted sex, particularly young women.

Other studies have shown that Australian young people find it hard to communicate sexual boundaries. Because some programs spend their time trying to stop young people from being sexual, rather than helping them towards a healthy sexuality, young people miss the opportunity to consider 'how far do I want to go?'

The other important criticism offered by young people is that sex education is often limited to biology and disease without giving them the chance to reflect on their values and priorities. Perhaps, again, we fear that this kind of conversation will give young people license to have sex. Instead we find they are less likely to experience unplanned pregnancies, sexually transmitted infections (STIs) and sexual coercion.

School-based education programs that focus on helping young people

develop values and skills around relationships and sexual decision-making make a difference.

Greater knowledge

The evidence shows clearly that sexual learning starts before Grades 5 and 6. Before puberty, knowledge is vital to happily managing our sexual lives.

Our job as educators and parents and policy makers, is not to seal children from their sexual development, nor is it to stop the conversation. We have a part to play in setting guidelines and expectations around this aspect of children's lives, as we do any other.

A version of this article was first published by *The Conversation* on 26 October 2012.

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Jenny Walsh is the Coordinator of Sexuality Education Programs at the Australian Research Centre in Sex, Health and Society at La Trobe University. She is the author of the Victorian Department of Education and Early Childhood Development's *Catching On Early – a primary school sexuality education resource*, and WA Health's *Talk Soon, Talk Often – a guide for parents talking to their kids about sex*.



Sexual health and HIV health promotion among young culturally and linguistically diverse people in western Sydney

By Andrew C Stone and Elizabeth Mlambo

In many cultures, HIV and sexual health are subjects of great sensitivity, and occasionally can be taboo topics. Dealing with these matters across many cultures poses unique challenges. Culturally and linguistically diverse (CALD) communities in Australia encompass over 200 different language groups. Each community has its own values and challenges around sexual health and HIV, so a one-size-fits-all approach is not an option.

Western Sydney is home to some of the most culturally diverse groups in Australia (see breakout box opposite top right). The Western Sydney Local Health District (WSLHD) and Nepean Blue Mountains Local Health District (NBMLHD) HIV, Hepatitis and Sexual Health Promotion Team (the Team) works with a range of western Sydney populations, both CALD and non-CALD.

We frame our work as the support and development of communities which are 'Sex Aware, Sex Positive and Sex Responsible.' Our approach allows us to work in a way which is flexible and adaptable for each of the different populations we work with, but which remains culturally sensitive and respectful.

This approach requires a detailed level of engagement with communities, as what is culturally respectful and acceptable for one community may not be for another. The success of our approach is evidenced by the fact that in all our work to date, key community leaders, agency workers, and the community members themselves have all been comfortable with our positive framework which positions sexual health as being about awareness, responsibility, and positive attitudes.

This framework guides our approach when working with Western Sydney's diverse populations of young people.

The building blocks of sexual awareness, positivity and responsibility

Being 'sexually responsible' means practising sexual behaviours that ensure the physical, emotional and relational wellbeing of all involved. In order for this to happen, people first need to be aware of their bodies (and how they function), their feelings, and their desires – this is being 'sex aware'. They also need to be informed of the risks and benefits attached to sexual expression and how best to manage these. In addition, it's important to know where and how to access help in relation to sexual health and expression.

Knowledge of anatomy, disease, condom usage and the location of supportive doctors and health services like sexual health clinics, are not enough to ensure 'sex responsible' behaviour. This information has been widely disseminated for 20 years, but for the last decade we have seen rising levels of STIs and HIV. The Team believes that a person has to affirm their own sexuality as good, and as an individual right, before they can truly care for their body, their mind and their sexual partners: that is, by being 'sex positive'. Learning to understand and accept other people's rights to sexual expression, however different to one's own choices, is also a part of being 'sex-positive.' Being 'sex aware' and 'sex positive' are the necessary foundations for being 'sex responsible'.

Engaging young people

In reaching Western Sydney's young and diverse population with this message, our Team members regularly attend heaving dance parties, muddy soccer pitches, colourful carnivals and busy youth centres.

'If you want to be effective, you've got to go to where the people are,' says Youth Sexual Health Promotion Officer, Andrew Stone.

Attending dance parties, Migrant Resource Centre homework groups, and soccer tournaments might seem peripheral to promoting good knowledge and practices around HIV and STIs among CALD young people. However, the Team have found this to be one of the most important components of the project targeting young CALD people. Ryan Buesnel, manager of Auburn Youth Centre, explains:

'The process of engaging young people takes time, and developing rapport is more important initially than just running an activity or program. You can't always expect a young person to immediately feel comfortable discussing significant issues they are facing. Very few adults feel comfortable doing that, so why do we expect it of young people? A gentle and long-term approach is needed if meaningful work is to take place, hence the importance of building trust and strong relationships.'

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The Team's work in Auburn, Blacktown and Holroyd local government areas (LGAs) has been running for over a year. Much of the work to date has been focused on developing relationships with relevant community workers.

Trust is the foundation of any good relationship, and reliability is a key in developing trust. As such, members of the Sexual Health Promotion Team regularly attend youth interagency meetings; work closely with Migrant Resource Centres in the area (running, for example, sexual health sessions at homework groups); provide training, resources and support to youth centre staff; and attend youth and community events such as cultural festivals.

These relationships have led to centres using existing programs to develop and run targeted sexual health projects. These are based on the sex aware, sex responsible and sex positive philosophy, and therefore better engage with young CALD people who access the centres.

Programs such as the NSW statewide Sexual Health Week and World AIDS Day Red Ribbon Community Grants offer grants of up to \$1000 to organisations who wish to promote sexual health and knowledge of HIV to young people. The Team has assisted youth organisations in these LGAs in writing applications, and planning and budgeting for events funded through these grant schemes. Team members also make themselves available to attend and participate in funded events and programs. Grant winners from 2012 included Auburn Diversity Services, the NSW Multicultural Disability Advocacy Association and Football United (see breakout box bottom right). Holroyd Youth Service has also successfully produced HIV awareness multimedia resources with their young people using community grants.

These programs and events are evaluated by the workers in local agencies and centres, allowing them to tailor their future programs and events to the sexual health needs of the specific populations of young people with whom they work. The Team

The cultural diversity of western Sydney

- 56.9% of Auburn LGA's population was born outside Australia; 86.3% of Auburn's Australia-born population had one or both parents born overseas; 76.4% of Auburn's population speak a language other than English at home.
- 49.6% of Holroyd LGA's population were born outside Australia; 75.1% of Holroyd's Australian-born population had one or both parents born overseas; 55.2% of Holroyd's population speak a language other than English at home.
- 42.3% of Blacktown LGA's population were born outside Australia; 64.7% of Blacktown's population had one or both parents born overseas; 41.3% of Blacktown's population speak a language other than English at home.

Football United

Football United is an organisation which aims to promote tolerance and harmony through soccer. In a partnership between Football United, WSLHD and NBMLHD, The Sexual Health Promotion Team and the Sydney South West Local Health District's Team, a series of workshops on sexual health were run as part of Football United's scheduled training sessions. These workshops covered information about accessing sexual health services and information, healthy sexual relationships and safe sex awareness.

At the end of each workshop there was a quiz based on the workshop, and for each correct answer participants were allowed one shot at the goal – in the style of a penalty shoot-out. At the end of each weekly shoot-out the highest goal-scorer was given a new soccer ball. At the end of the four weeks of sessions, the participant with the highest over-all score was awarded a highly coveted pair of soccer boots.

works closely with local workers, whose insight and experience has greatly assisted them in ensuring that learning environments are culturally appropriate.

For example, through these programs they have learnt that it is considered appropriate across many cultures for sex and relationships to be discussed in a single-gender environment. For this, separate male and female facilitators are needed. In fact, in some cultures the topic of sex is so sensitive that sexual health information sessions need to be advertised as a 'men's/ women's event' or 'health event'. This may seem disingenuous, but it has been the experience of the Team that participants are invariably glad to have the opportunity to talk about sex in a manner which they experience as being respectful of culture and traditions.

Reaching certain priority populations, for example religious groups, presents another challenge. The support and approval of community leaders is needed to access groups like these, and great care must be taken in both the choice and presentation of educational material. Taking care not to offend community members is most important but offence is sometimes unavoidable. A concern might be raised after a safe sex demonstration, such as how to put a condom on a plastic penis model – but

condom use is a critical 'sex responsible' skill, and it is important that all sexually active young people have the skills to practise safe sex.

The Team has found that providing a facilitator who is not part of the CALD group they are working with can be particularly helpful. For some CALD young people, there is a greater level of comfort and belief in the confidential nature of the discussions when they have a facilitator from a different cultural background.

The Team has been developing and implementing a project targeting CALD young people in the LGAs of Auburn, Holroyd and Blacktown people for over a year. Consultations with youth councils, community members and community workers have shown that for any work to effect lasting change, the whole community needs to be involved. As the project continues, the 'Sex Aware, Sex Positive, Sex Responsible' approach will be extended to the broader communities.

Andrew Stone is Youth Health Promotion Officer, the Lemongrove Unit, the HARP (HIV And Related Programs) Team of the WSLHD and NBMLHD. Elizabeth Mlambo is Health Promotion Officer, the Lemongrove Unit, the HARP Team of the WSLHD and NBMLHD.



Love sex? Love condoms! The NSW Festivals initiative

By Brooke Shepherd

Background

The NSW Festival Initiative (the Initiative) is a program led by the NSW Sexually Transmissible Infections Programs Unit (STIPU) in a partnership with HIV/AIDS and Related Programs (HARP) Health Promotion teams across NSW, Family Planning NSW and the NSW Sexual Health Infoline.

The Initiative is based on the Get Tested, Play Safe (GTPS) campaign, a 2009 NSW Ministry of Health statewide advertising campaign aimed at increasing awareness of issues relating to sexually transmissible infections (STI) testing, treatment and prevention among heterosexual young people aged 16–24 years old. GTPS focused on supporting behavior change regarding visiting general practitioners and improving young peoples' skills in relation to sexual health communication and prevention practices.

In 2011, in acknowledgement of the unique environment of festivals, a pilot Festivals Initiative was developed to extend the reach of the campaign and further engage directly with the target audience. The Initiative focused two aims of the GTPS campaign for its mission statement: 'Improve young heterosexual people's skill in relation to sexual health communication and prevention practices.'

A second GTPS campaign objective, 'To increase awareness of the importance of using condoms to prevent STIs', was also identified as the most appropriate in delivering suitable social marketing strategies in a festival environment.

Why festivals?

With marketers constantly looking for ways to build relationships with the youth segment, traditional channels (TV, radio and print) of reaching a target audience are shifting. Marketers have discovered that they have to reach out to young people in new and innovative ways. For a message to resonate with young people, it must be taken to them – to skate parks, concerts, clubs, shopping malls, and sporting events – in order to be heard.¹

Music festivals tap into the youth market's desire for experiential activity and are therefore well placed to promote and reinforce social marketing messages.² This is a space that typically attracts a sub-population of young people that are at a higher risk of STIs than the broader population of 16–24 year olds.³ They are also a population that may engage in other social practices that are associated with increased levels of risk such as illicit drug use and unsafe alcohol consumption.⁴

Music festivals also provide an ideal platform to develop partnerships between the health and entertainment sectors for aligning congruent messages, accessing target audiences en masse and value adding to the experience of the festival-goer.⁵

Further, this group – often referred to as 'Gen Y' – are defined by their love of experimentation, innovation, technology and collaboration.⁶ They are image conscious and place importance on belonging. Young people may feel comfortable socialising in large groups, and may have a somewhat looser definition of what it means to be a friend.⁷ Gen Y has grown up with technology.⁸

The exponential rise in popularity of online social media and social networking sites among this group highlights the necessity for marketers to access audiences through these means.⁹ In Australia alone, there are currently over 12,000,000 Facebook users, with 25% aged between 18–24 years.¹⁰ In the lead up to and across the music festival season, the level of engagement with websites, social media and social networking sites associated with music festivals rises exponentially. So, while 60,000 people may attend

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a particular music festival in Sydney, 190,000 may engage with that same event through its Facebook page.

Messaging

To engage with the festival goers appropriately, it is important that the health promotion messages become an intrinsic part of the festival experience. 'Love Sex? Love Condoms!' was adopted as the festival brand, increasing the prominence of the condom use message. GTPS graphics were used in order to echo the original campaign advertising and take advantage of the reach that the GTPS campaign achieved.

Engagement

Festival partnerships have two components, acquisition and activation.

Acquisition rights refer to partnering with the music festival promoter, providing access to festival co-branding, online messaging through social media engagement, data and online evaluation channels. Examples include co-branding and messaging on festival posters, flyers, banners, ticketing, lanyards and entry/exit signage at the festivals and running promotional activities in the lead up to the event.

Activation rights refer to targeted community engagement activities – online via the festival Facebook pages or at the festival event itself. All of the festival partnerships to date have utilised a range of acquisition and activation strategies to promote the 'Love Sex? Love Condoms!' message.

Both elements of the festival partnership (acquisition and activation) offer the project with an excellent co-branding opportunity. Festival attendance ranges from 15,000–75,000 and online engagement from 150,000–400,000. Since the NSW Festivals Initiative commenced in 2011, partnerships have been formed at four festivals, three based in Sydney and one in the Hunter, with a fifth partnership currently underway.

Project elements

Our major engagement strategy at the events is the 'Love Sex? Love

Condoms!' operating booth. At this site, health promotion staff, sexual health nurses and peer educators engage festival goers in a range of activities to debunk myths about condom use, STI testing and to encourage talking about sexual health with friends and partners. This includes a life-sized interactive game that allows festival goers to engage with sexual health and STIs in a fun and humorous manner, an information booth that distributes condoms and other relevant sexual health information and a range of sexy carnival style-cutouts where festival goers can photograph each other.

The Festival Facebook Newsfeeds connects members of the target audience who didn't interact with the campaign onsite, or who didn't attend the event. In addition, a simple website (www.daretoscore.com.au) has been developed to allow festival goers and other interested young people to assess their sexual health risk and is used in the lead up to festival events as well as engagements at the event.

Conclusion

Sexual health promotion messaging in the festival environment has been very well received. Since the commencement of the project, there has been a trend of increased visibility of campaign messaging across the festivals. The Initiative appears to be relevant, cost-effective, appropriate and increasingly visible in the festival environment to increase awareness of the importance of using condoms to prevent STIs and pathways for information and testing.

The Initiative is currently developing a survey instrument in order to undertake further evaluation. This will include capturing the characteristics of young people attending festivals, including their exposure and engagement, their understanding of the messages and the potential effect of the initiative on their sexual behaviours. This will allow a more tailored approach to the activities.

The festival space offers an innovative and unique platform for positive brand alignment and large-scale exposure to young people right across NSW, not only for those who attend the event on the day but also for those large numbers

of people who engage with festivals and messaging online. The audiences attending festivals are a group who tend to engage in risky sexual practices and we must continue to work with this population in order to achieve longer term change in social practices.

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Prevention as hyperbole; culture as concupiscence¹

By **Gary Dowsett**

This is the first in a series of articles drawn from presentations given at the 2012 Australasian HIV/AIDS Conference. Contributors discuss responses to HIV in the combination prevention era and themes connected with working to achieve targets set out in the *United Nations 2011 Political Declaration on HIV/AIDS* (UNPD).

For further discussion about implications of the UNPD in the Australian context, see <http://www.unpdaction.org.au> and the Melbourne declaration (melbournedelcaration.com.au).

One of the powerful dynamics underpinning HIV and AIDS since its beginning is what Paula Treichler (1988)² memorably termed an 'epidemic of signification', an overabundance of meaning and meaning-making practices. In a sense, there has always been a constant struggle over 'naming' and 'labelling' in this pandemic. That struggle has occurred in the naming of the illness: what is now AIDS was early on GRID

or 'gay-related immune deficiency' in medical terms; the 'gay plague' at the hands of the media and other commentators. There was argument about naming the virus itself: LAV, HTLV III or eventually HIV, which signified more than just naming and acknowledgement of the science and the discovery, but also ownership of the technology and the considerable income that derived from its application in the HIV antibody test.

We all play the game. For 30 years social researchers in this country have named research projects with smart acronyms, some dull (like SAPA or the Social Aspects of the Prevention of AIDS, the first one I worked on 26 years ago), some wicked (like PASH, the Pleasure and Sexual Health study). My best, or worst, go at it was CRAP, literally CRAP, the Cultural Representations of AIDS Project, which Michael Hurley and I dreamed up 20 years ago comparing gay community prevention imagery in Sydney and Darwin.

More can be at stake in the naming: the demands from those infected with HIV to be regarded and called 'people living with HIV' rather than 'sufferers or victims dying' from it was a powerful

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discursive shift in the framing the pandemic. In contrast, the invention of men who have sex with men (MSM) as a term was a damaging move despite its attempt to shift the politics of AIDS from identity to practice. Unfortunately, it effectively erased and still erases the cultural work of the world's gay communities in the history of the pandemic.

Recently, we've seen another Western acronym, TG (transgender), colonise the great varieties of cross/multi-gendered cultures in the word into one collapsed category as if these cultures are all the same and vulnerable to HIV in the same way. Now, just as the 2012 ASHM conference happened, we have an even newer, nonsense acronym from amFAR – 'GMT', standing for gay men, other MSM, and transgender – further collapsing these complex and very different sexual and gender cultures, thereby eliding differences in vulnerability and erasing differential contributions to the global response even further. What a major step backwards!

The UN in leading the global response is equally canny in shifting the stakes and the focus when its needs to raise money, bring new partners into the game or even seem more successful at its job. Remember: universal access, a multi-sectoral response, enabling environments, structural interventions, prevention science, to name but a few. In Washington DC at AIDS 2012, we heard an 'AIDS-free generation',

'15 million by 2015' (remember three by five), innovative financing mechanisms, implementation science – and so the list goes on. The discursive is a powerful tool, not just window dressing. These manoeuvres shift attention, refocus effort, redefine success or failure, prioritise certain policies and practices, and diffuse and sometimes even silence criticism.

Historically, in terms of gay men's HIV prevention, we see effects in the original communitarian and cultural approach of sustaining safe sex for all losing momentum in the mid-1990s with the onset of HAART, in what I then termed the beginning of the 'post-AIDS' era as the commonality of gay men's experience of the pandemic began to fracture and diversify. This approach was tested even more during the last 15 years as a focus on community-based prevention itself was challenged by more psychosocial (or behavioural), individualistic models of prevention fostered by the notions of prevention science from the year 2000 onwards. More recently, the re-badging of prevention activity as the deployment of prevention technologies has removed the cultural and community focus from centre to periphery. Now the ascendency of biomedical prevention has rendered even that periphery largely irrelevant. The shift to 'biomedical technologies and interventions' has come about as a result of research findings on treatments and their role in reducing viral load,

as a response to cautious evidence on microbicide success, contested evidence on the efficacy of male circumcision in specific populations, encouraging effectiveness of treatment use by the uninfected, and the continuing vagaries of vaccines. The hyperbolic discourse absorbing current HIV debate on 'treatment as prevention', and the 'prevention revolution' reveals yet again the longstanding tendency for HIV politics to swamp the world of practice and encourage us to lose sight of all we have learned in 30 years of pandemic. The potential for effective treatment to lower viral load is not news – that was clear by 1996. Indeed, former President of ACON, Rolf Petherbridge, argued then, before the Vancouver conference announcement on HAART that year, that lowering viral load would eventually become a significant part of prevention; it was really a matter of time. So, it is nonsense to call this a prevention revolution. Evolution – yes; revolution – no.

The hyperbole surrounding biomedical prevention consistently fails to note that a technology has no effect until it is used; hence, the important conceptual and terminological difference between 'experimental efficacy' and 'real-world effectiveness'. Herein lies the rub: many studies of prevention technologies, and much of the hyperbole surrounding their almost always partially protective efficacy, fail to account for the behavioural dynamics of such technologies' everyday use and the social and cultural contexts that structure that use, the users' understandings of that use and its effects, and its effectiveness through the micro-politics of practice, and the structural factors underpinning social contexts.

It is neither novel nor simplistic to point out that no technology exists without or outside human behaviour, and that all human behaviour is socially determined and culturally comprehended. Yet, we see in the hyperbole on biomedical prevention not simply neglect of the behavioural underpinnings of prevention, but an

In contrast, the invention of men who have sex with men (MSM) as a term was a damaging move despite its attempt to shift the politics of AIDS from identity to practice.

enduring and conscious tendency in medical science to disregard the social and cultural when it suits its purposes. That said, just when we least expect it, the social returns and transforms any technology into a practice. We only have to note the innovative sexual cultures of gay men the world over throughout the pandemic, evolving from the only really revolutionary moment we have had so far: gay men in so many countries taking up condoms so fast and so widely in the first few years of the pandemic. Now that was social revolution.

It will be at this level – the level of the social structuring of the micro-politics of daily practice – that new sex and pleasure cultures will arise to absorb, interpret and express the possibilities and constraints that biomedical technologies offer ... just as the mechanical technology of condom use, once bedded in so to speak, was culturally reframed by gay men for nearly 30 years in inventive practices of safe sex. We can now see a messy future upon us as PrEP (pre-exposure prophylaxis), PEP (post-exposure prophylaxis), microbicides, instant and/or home HIV testing, and viral load reduction, etc., will be used to think prevention possibilities. These biomedical prevention possibilities will produce their cultural forms and interpretations, the own adaptive practices, and their own successes and mistakes. All technologies ‘shape-shift’ in human hands and in daily practice.

So, more than ever we need to think about how we pursue our understandings of this pandemic and how we deploy our knowledge habits, our scientific utterances, and our prevention practices. We need to be more careful about our speech acts, our cultural reframing, if we are to manage this next step carefully. For we will see increases in HIV incidence directly related to the cultural reframing and enactment of each biomedical technology as it rolls out. We will see mistakes made in understanding them (e.g. as Jonathan Stadler reported in the

microbicide trials in South Africa.) We will see misinterpretation (e.g. the hotly contested debate on male circumcision as some advocate hyperbolically, despite the evidence, for its use in other populations and places). We will see technology misuse (e.g. one potential consequence of ‘home’ HIV testing). And we will see error at the individual level that will lead to infection.

Just what levels of error are we prepared to tolerate? This is particularly important as we soften our requirements for efficacy and accept lower levels of effectiveness in what seems at times renewed desperation as much as optimism to find an ‘end to AIDS’. Depending on the setting, there will be inefficiency, irresponsibility and corruption at corporate, institutional and governmental levels in different places at different times (as Heather Worth and colleagues reported at the recent ASHM conference on the link between governance and ART and preventing mother-to-child transmission [PMTCT], when there are fewer controls on political corruption, there is less access to PMTCT programs). These too are vital behavioural constituents of effective prevention as much as sustained condom use after male circumcision and individual adherence to treatment regimes.

What has always struck me about the hyperbole, the sloganeering, the capturing of discursive fields, is how remarkably unknowing we are about human sexuality and pleasure-taking

of all kinds. I’ve been to many AIDS conferences in my time, and witnessed the sharing of orgasms that so many of them are for many who attend. In all that conferential concupiscence, it seems strange that the prevailing understanding of human desire is reduced to behavioural variables to be controlled for in our science. Biomedical prevention will certainly be one of the next steps historically, but anyone who thinks it will be the silver bullet fails to understand history and culture. We need to be talking about and advocating for prevention interventions as practices, as linguistically and culturally framed, and profoundly social enactments within intersecting personal, interpersonal, communitarian, institutional and historical contexts. If we do not, then as George Santayana’s (1863–1952) famous maxim reminds us: ‘Those who cannot remember the past are condemned to repeat it’.

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What has always struck me about the hyperbole, the sloganeering, the capturing of discursive fields, is how remarkably unknowing we are about human sexuality and pleasure-taking of all kinds.



REGIONAL FEATURE 'Self-issues': MSM and transgender youth – HIV and the psychosocial side of sexual risk-taking

By **Attapon Ed Ngoskin**

Public health practitioners and policy makers generally do not possess a deep understanding of 'self-issues' and their links with HIV-related sexual risk-taking. To explore these issues, Youth Voices Count organised a three-day consultation in Bangkok in October 2012, bringing together young men who have sex with men (MSM) and transgender women from 14 countries throughout Asia and the Pacific.

Youth Voices Count (YVC) is a regional network of young MSM and transgender people in Asia and the Pacific that supports responses to HIV in the region through community mobilisation and capacity building, and advocates for meaningful participation of young MSM and transgender people in policy and decision making processes.

'Self-issues', describes a specific set of issues that positively or negatively impact self-acceptance, self-esteem and confidence. While HIV and human rights experts understand how laws and legal environments create barriers to the provision of and access to HIV and other health services¹, self-issues – including self-stigma – are much harder to deal with. Tackling these issues involve understanding

the knowledge, skills, perceptions and experiences of young people that ultimately influence individual choices of the sexual activities they decide to perform with their partners – be it protected or unprotected.

In Asia and the Pacific, young men who have sex with men and young transgender people are most at risk of acquiring HIV, making them the so-called primary 'target group' for HIV prevention programs; a typical indicator of success in these expert interventions is the number of condoms distributed. However, the lived realities of these young people are complex. Little is understood about their lifestyles and sexuality, particularly how cultures of ignorance and silence permeate thinking and directly impact upon young people's psychological wellbeing as they grow up: that being gay, lesbian, bisexual or transgender is somehow un-natural, bad, wrong and immoral.

Consider the typical experience of a young female transgender – similar to many stories shared at the three day YVC consultation – and imagine the impact that 'self-issues' have on self-acceptance and self-esteem:

Imagine being perceived by your family and society as a person with no career prospects (apart from working in beauty parlors or the entertainment industry); being the subject of domestic abuse or sexual coercion; being bullied by your peers in school and harassed by police officers; and being excluded from the sexual education that only talks of heteronormativity.² The World Health Organization, the international public health institution that is supposed to provide normative guidance to countries, even embraces the 'abnormality' of transgender, recognising their identity as 'one form of mental and behavioural disorders'.³

How then do these self-issues relate to risk-taking?

Regrettably, it is very common in Asia and the Pacific to be disowned by your family once you have disclosed your gender identity or your HIV status. Homelessness and financial instability are very common among MSM and transgender individuals. This extreme marginalisation leads many people to undertake sex work out of financial necessity. Lack of self and societal acceptance can also lead to destructive

self-coping behaviour such as substance abuse as a result of anxiety, isolation, stress and feelings of helplessness or depression; these are scenarios in which a young person may engage in 'risky' sexual activities.

One thing that we have learned: knowledge and practice are totally two different things. Circumstances create power imbalances and complacency with HIV risks despite a person's knowledge about protection. A power dynamic between insertive and receptive partners can make it difficult to negotiate condom use. Unprotected penetration may be seen by people as a sign of trust or desire for love, relationships and connectedness. For some young transgender people, it is also often seen to validate gender identity.

Another influencing factor – and one not usually discussed – is the individual perception of beauty and how it can influence sexual risk-taking to a significant degree. Many young MSM and transgender people choose to perform unprotected sex with someone they have just met because they meet their ideal perception of beauty; they are ready to jeopardise their wellbeing for unprotected sex regardless of the potential consequences. The desire for unprotected sex can then lead to feelings of shame and consequently low self-esteem, as it goes against the socially accepted perception of safe sex. Low self-esteem and depression can prevent people from taking basic care of or protecting themselves.

Government responses throughout Asia and the Pacific to deal with the complexities influencing sexual risk-taking among MSM and transgender communities are sorely lacking, and shockingly, are in part due to simple ignorance of the issues. According to a study by amfAR, governments profess a 'lack of data' to justify the absence of effective MSM programming.⁴

Same-sex behavior between consenting adult men is illegal in 78 countries worldwide, in seven of which is punished by death.⁵ Countries that criminalise same-sex sexual practices also spend fewer resources on HIV-related health services for MSM and do less to track and understand the epidemic in their nations. A review

across 42 low and middle-income countries, conducted by the Global Forum on MSM and HIV (MSMGF) in 2010, revealed that less than 2% of national HIV prevention spending is dedicated to MSM.⁶ Condom-compatible lubricants, considered a core commodity for MSM by PEPFAR, are not accessible to MSM in all countries receiving PEPFAR funding. The situation is even more desperate for young MSM, as no services are officially able to provide harm reduction and/or housing support to people under the age of 18 due to the parental consent policy still imposed by many countries in Asia and the Pacific.⁷

The participants at the YVC Consultation called for a comprehensive response to address both psycho-social needs and sexual wellbeing of young MSM and young transgender people. This involves creating acceptance of sexuality, lifestyle and identity, both among 'the self' and within broader society, and creating safe spaces and supportive environments within families, schools and employers.

This set of complex issues needs multifaceted programs that help to improve self-esteem to respond to the evidence that those who accept their sexuality and identity are psychologically healthy, more likely to disclose their positive HIV status with their casual sexual partners and are less likely to engage in sexual risk-taking. Programs and policies must at the same time address other social vulnerabilities and structural or legal environments that might encourage sexual risk-taking and that drive youth away from health and other support services.

During 2013, Youth Voices Count and its members will undertake action research in 10 countries in Asia. The findings from the research will be used to develop advocacy campaigns in those countries on self-stigma for young men who have sex with men and transgender people. AFAO is supporting the action research component of the project in five countries (Indonesia, Laos PDR, Mongolia, The Philippines and Sri Lanka.)

Changing societal attitudes and perceptions is not easy, but Youth Voices Count believe that each of us

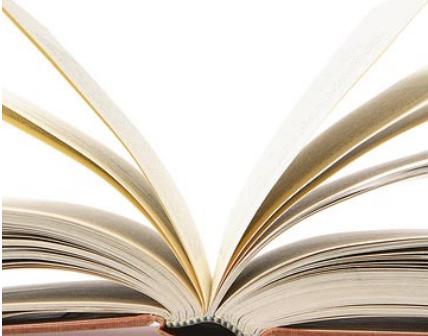
can play our part to ensure the voices of at-risk young people are heard and that they are meaningfully engaged in policy decisions that affect their lives. Unless this happens, we are unlikely to find a perfect solution to minimise the projected upsurge of HIV infections among MSM and transgender people in the region over the next decade.

A version of this article, written by Amy Coulterman, originally appeared on the NGO Delegation to the UNAIDS Program Coordinating Board site at: <http://unaidspcbngo.org/?p=19266>

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- 3 World Health Organization. (2010). *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, F64.0. In October 2012, An online petition was started at change.org demanding that the World Health Organization (WHO) eliminate the diagnosis 'transsexualism' from the mental disorders section of the International Classification of Diseases (ICD). The current edition, ICD-10, was endorsed in 1990 and is being revised. The ICD-11 is expected to be complete by 2015. For further information see: <http://www.who.int/classifications/icd/en/>
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Attapon Ed Ngoskin is a Core Working Group Member of Youth Voices Count.



BOOK REVIEW:
HOW AIDS ENDS: AN ANTHOLOGY FROM SAN FRANCISCO AIDS FOUNDATION
 Edited by Reilly O'Neal

At the most recent World AIDS Conference, US Secretary of State Hillary Clinton raised the prospect of an 'AIDS-free generation.' 'The goal of an AIDS-free generation may be ambitious,' she said, 'but it is possible with the knowledge and interventions we have right now ... imagine what the world will look like when we succeed.' Her pronouncement may be premature, but with huge increases in the number of people on treatment and the effectiveness of treatment as prevention now proven, a world after AIDS is now, just, imaginable.

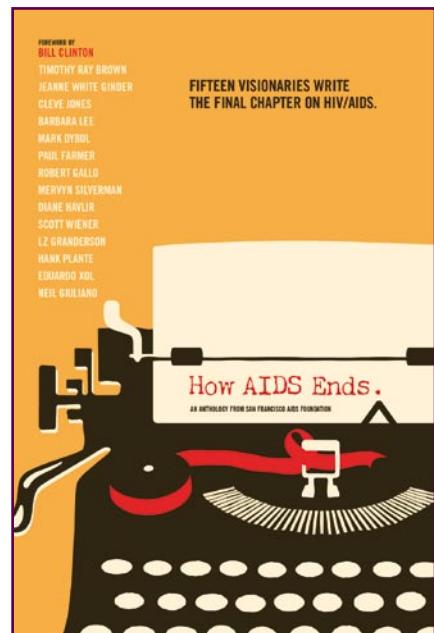
It is in this atmosphere of hope that the San Francisco AIDS Foundation has produced *How AIDS Ends*, an anthology of writings in which each author is asked: 'when the history of HIV/AIDS is written, what will the final chapter look like?' This is an appealing question, and the anthology has attracted some impressive contributors, with a foreword by Bill Clinton and pieces from luminaries of the HIV world such as Robert Gallo (credited with identifying HIV), Cleve Jones (founder of the Quilt Project) and the 'Berlin patient', Timothy Ray Brown, the first person to be cured of HIV.

Indeed, Brown's chapter is one of the most interesting, recounting the (no doubt harrowing) treatments he received for leukaemia, which failed. The innovative stem cell treatment he received was a last resort, and

Brown was given only a 5% chance of survival. But what is most inspiring about Brown's story is not just that the treatment cured both his leukaemia and HIV, but his response. Brown started his own Foundation dedicated to finding a cure for HIV. 'I want other people to benefit from this,' he writes. 'I don't want to be the only person in the world cured of HIV.'

Many of the pieces look back into the history of the epidemic, rather than forward to the future. For a reader without a strong background in HIV, these accounts are certainly interesting in themselves. For example, Scott Wiener, a city Councillor in San Francisco, writes about leadership. 'In 1997, he says, there were few gay male elected officials in San Francisco. I asked someone I knew at the time why that was, and he responded, "Most of the people who would've held those positions are dead". Wiener's account is an arresting reminder of the effects of the epidemic on the gay community.

Unfortunately, the anthology degenerates into a pep talk about the need for more education, more compassion, more work, and more funding. No doubt this is the purpose of the book, as AIDS will not end without all of these things, but it makes for rather dreary reading. As medical anthropologist Paul Farmer and his colleagues point out, 'Lofty dreams of the end of AIDS must be interrogated, asking *where*, *when*, and for *whom*'. The book is disappointingly short on this sort of interrogation. And for all the illustrious names, the contributors are



ultimately repetitive. Despite all the talk of the millions of people affected by HIV around the world, all of the contributors come from the US, and most are white. While Mark Dybul, Executive Director of the Global Fund to Fight AIDS, TB and Malaria, speaks of industrious Africans helping their communities, it would be great to hear from some of the Africans themselves, and their own dreams about the end of AIDS. Perhaps these voices are less appealing to potential funders.

While Mark Dybul, Executive Director of the Global Fund to Fight AIDS, TB and Malaria, speaks of industrious Africans helping their communities, it would be great to hear from some of the Africans themselves, and their own dreams about the end of AIDS.

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



TREATMENT BRIEFS

VERY EARLY TREATMENT RESTRICTS HIV RESERVOIR

Very early antiretroviral treatment may limit the size of the HIV reservoir in adults and children, according to studies presented at the 20th Conference on Retroviruses and Opportunistic Infections (CROI) in Atlanta.

Background: the problem of HIV persistence in the human body

The primary obstacle to the elimination of HIV from the human body is the ability of the virus to persist in a latent form within CD4 cells that are in a resting state.

Latently infected cells form a 'reservoir' of cells that are constantly being activated to produce HIV, which then goes on to establish latent infections in other cells.

In people taking antiretroviral therapy, that process of activation causes a very low level of viral replication, below the limits of detection of all but the most sensitive experimental tests, because antiretroviral therapy shuts down this re-seeding process. Yet, only a very small number of latently infected cells are needed in order to establish a detectable level of virus production within days of halting antiretroviral therapy.

For this reason, studies of treatment interruption have consistently shown that viral load rebounds to a level corresponding to the pre-treatment peak within a few weeks of stopping treatment.

Limiting the size of the reservoir by early treatment

Dr Jintanat Ananworanich presented work from Thailand on attempts to reduce the size of this reservoir by offering a process of very fast

diagnosis and treatment initiation, in a setting with a high incidence of HIV infection.¹ A median of two days after diagnosis, participants started antiretroviral therapy with a regimen that included raltegravir in order to achieve very rapid viral load reduction. Of the 75 participants, 91% were men who have sex with men. The presentation was based on 68 participants for whom quantification of HIV DNA had taken place. Just over one-third (37%) were HIV RNA positive but negative for p24 antigen and negative for HIV antibody by third-generation ELISA test. The median time between enrolment and exposure was 15 days.

Patients in this sub-set had the lowest HIV DNA levels prior to treatment; 92% had undetectable integrated HIV DNA in PBMCs and 88% had undetectable integrated HIV DNA in the sigmoid colon, indicating that a reservoir of detectable infected cells had not yet been established (although it should be noted that this study sampled a limited number of cell types).

Participants who were in other stages of acute infection (either positive for both HIV RNA and p24 antigen, or positive on ELISA but western blot negative) showed substantial reductions in HIV DNA within 12 weeks of starting antiretroviral treatment, and reached undetectable levels of integrated HIV DNA in PBMCs by week 24.

Overall, seven out of ten patients who underwent sigmoid biopsy, and who had detectable integrated HIV DNA at baseline, had undetectable HIV DNA by week 24 of treatment. Analysis of CD4 central memory cells (the key reservoir for infection) showed very limited infection compared to transitional and effector memory CD4 cells at baseline, and this trend persisted after 24 weeks of treatment.

Patients treated early in acute infection, regardless of stage, showed similar characteristics to 'elite' HIV controllers – a small or undetectable reservoir of HIV DNA, and a bias towards infection of transitional and effector cells rather than central memory cells, concluded Dr Ananworanich. These patients may be ideal candidates

for future cure studies which look at the use of therapeutic vaccines in combination with agents that can deplete the HIV reservoir. In due course, treatment interruptions might also be attempted in order to determine whether any of these patients is functionally cured, and if so, what might be the immunologic correlates of a functional cure.

Dr Katherine Luzuriaga from the University of Massachusetts Med School also presented data on the characteristics of the HIV reservoir after early treatment, this time in five adolescents with a median age of 16 who had received antiretroviral treatment since soon after birth (median two months of age).² It was impossible to isolate replication-competent HIV DNA from any of these patients, although proviral DNA was detectable at a low level, and they had no HIV-specific antibody or CD8+ T-cell responses. In comparison, four age-matched young people who had begun HIV treatment in later childhood, and who had sustained undetectable viral load ever since, had detectable HIV RNA (8 copies/mL) by ultrasensitive assay and HIV antibody and CD8+ T-cell responses to a broad range of HIV genes, indicating ongoing replication.

Dr Luzuriaga's group suggested that these young people, like the acutely infected Thai patients described by Dr Ananworanich, could be 'prime candidates for interventions to achieve functional cure or eradication.'

Study findings sound a cautionary note on eradication theory

Caution regarding the stubborn persistence of the HIV reservoir came in a series of presentations from research groups that had evaluated a variety of cell types, and also questioned the assays used to assess reservoir size. Maria Buzon and colleagues at the Ragon Institute, Harvard University, identified a pool of long-lasting cells, memory T-cell stem cells, which harbour high levels of HIV DNA despite long-term antiretroviral treatment, and which become more

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important as a proportion of all infected cells as time goes on.³ Natalia Soriano-Sorabia of University of North Carolina, Chapel Hill, identified gamma-delta T-cells as an important and hitherto unmeasured reservoir.⁴

Another problematic issue for HIV eradication is to determine what to measure. Assays which seek to measure replication-competent HIV in the laboratory from cells harvested from patients – viral outgrowth – may undercount cells containing HIV DNA that might only be induced to replicate in certain restricted circumstances.

Ya-Chi Ho of Johns Hopkins University, Baltimore, described an analysis of the gene sequences of HIV proviruses that could not be induced to replicate after one round of activation in a viral outgrowth assay.⁵ Of these 88% were defective, but 12% had an intact viral genome, suggesting that they might have the potential to infect other cells if they could be triggered to replicate. This finding led Ho and colleagues to estimate that the average latent reservoir could be 48 times larger than currently estimated.

Adapted from Keith Alcorn
(aidsmap.com)

Published: 5 March 2013

INTENSIFIED TREATMENT QUICKLY REDUCES LOW-LEVEL VIRAL SHEDDING IN SEMEN

A study published in the *Journal of Infectious Diseases* showed that intensified antiretroviral (ARV) therapy with maraviroc and raltegravir transiently reduced the occurrence of isolated shedding of HIV in semen but did not prevent high-level shedding.⁶

Although ARV therapy dramatically reduces HIV transmission, isolated shedding of HIV in semen can still occur in the absence of detectable viremia or genital infections. The investigators hypothesised that intensifying therapy with drugs known to be active in semen might prevent shedding. Paired blood and semen samples were collected monthly for six months from HIV-positive men starting therapy that was intensified

with maraviroc and raltegravir in an open-label fashion. Compared with 25 controls who started standard ARV therapy, the semen viral load in 13 men who started intensified therapy was more rapidly suppressed ($P = .043$). Shedding was detected at >1 visit in two participants (15%) receiving intensified therapy and in 12 controls (48%) receiving standard therapy ($P = .040$). Among those receiving intensified therapy, shedding was associated with lower raltegravir concentrations in blood and semen, compared with complete HIV suppression ($P = .03$). Prolonged, high-level shedding (>5000 RNA copies/mL) was observed in one man receiving intensified therapy (8%), despite rapid viremia suppression and therapeutic drug levels. In a parallel, prospective cohort study, viral shedding was ceased after more than three years on effective RRV therapy.

META-ANALYSIS SHOWS SUPERIORITY OF INTEGRASE INHIBITORS IN FIRST-LINE HIV THERAPY AND BENEFITS FOR PEOPLE CHANGING TREATMENT DUE TO RESISTANCE

Antiretroviral combinations based on an integrase inhibitor are superior to other first-line HIV treatment regimens, according to the results of a meta-analysis published in the open access journal *PLoS One*.⁷ The study also showed the benefits of integrase inhibitor-containing regimens for people changing HIV therapy after virological failure. However, switching to an integrase inhibitor was not supported for people whose existing therapy was suppressing viral load.

The investigators performed a systematic review and meta-analysis of current evidence for the use of integrase inhibitors. A total of 16 studies published or presented between 2006 and 2012 met the inclusion criteria and were included in the analysis. A review of the ten studies involving treatment-naïve patients showed that use of an integrase inhibitor achieved better virologic outcomes. A sub-analysis compared first-line integrase inhibitor-based therapy to treatment including the non-nucleoside reverse transcriptase

inhibitor, efavirenz. Results showed the superiority of the combinations that included an integrase inhibitor.

Results from three studies involving treatment-experienced patients with virological failure were examined. The results favoured the use of an integrase inhibitor. The investigators also examined outcomes among treatment-experienced patients who had an undetectable viral load when they switched to an integrase inhibitor. In the modified intent-to-treat analysis, there was a non-significant trend suggesting the inferiority of integrase inhibitor-based therapy. The as-treated analysis clearly showed inferiority of integrase inhibitors when patients were switching from boosted protease inhibitors.

Adapted from Michael Carter
(aidsmap.com)
Published: 26 February 2013

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● March

14

NCHSR Seminar Series: 'Who's going to look after HIV? General practitioners, generational change and the imagined future of HIV care'

– Dr Christy Newman

Sydney, Australia

<http://nchsr.arts.unsw.edu.au/conferences-seminars-workshops>

20–22

11th European Meeting on HIV and Hepatitis Treatment Strategies and Antiviral Drug Resistance

Rome, Italy

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

● April

3–8

Immune Activation in HIV Infection: Basic Mechanisms and Clinical Implications

Colorado, United States of America

[www.keystonesymposia.org](http://keystonesymposia.org)

7–9

YTH LIVE 2013

San Francisco, United States of America

<http://ythlive.org>

7–10

12th National Rural Health Conference – Strong Commitment. Bright Future.

Adelaide, Australia

<http://nrha.org.au/12nrhc>

10

NCHSR Seminar Series: 'Perceived risk of HIV infection among HIV-negative gay men in Sydney' – Dr Limin Mao

Sydney, Australia

<http://nchsr.arts.unsw.edu.au/conferences-seminars-workshops>

● April (continued)

15–16

PHAA National Social Inclusion and Complex Needs Conference and Complex Needs Conference

Canberra, Australia

http://www.phaa.net.au/Complex_Needs_Conference.php

18–20

Health in Difference 2013. Our Bodies. Our Minds. The 8th National LGBTI Health Conference.

Melbourne, Australia

<http://www.lgbtihealth.org.au/hid>

22–24

14th International Workshop on Clinical Pharmacology of HIV Therapy

Liverpool, United Kingdom

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

● May

10–11

2nd Asian Meeting on Hepatitis and HIV

Beijing, China

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

14–17

7th INTEREST Workshop

Dakar, Senegal

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

30–31

9th International Workshop on HIV and Hepatitis Co-infection

Rome, Italy

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

END ING HIV

Everything has changed. Advances in HIV treatment offer improved health benefits and the potential to dramatically reduce the risk of HIV transmission among gay men by 2020 if we:

$$\left[\text{TEST MORE} \right] + \left[\text{TREAT EARLY} \right] + \left[\text{STAY SAFE} \right] = \boxed{\text{ENDING HIV}}$$

Get tested at least twice a year. To decrease undiagnosed infections, to increase access to treatments, more of us need to know our HIV status earlier.

Poz guys – advances in HIV treatment offer improved health benefits and the potential to dramatically reduce the risk of passing on HIV.

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