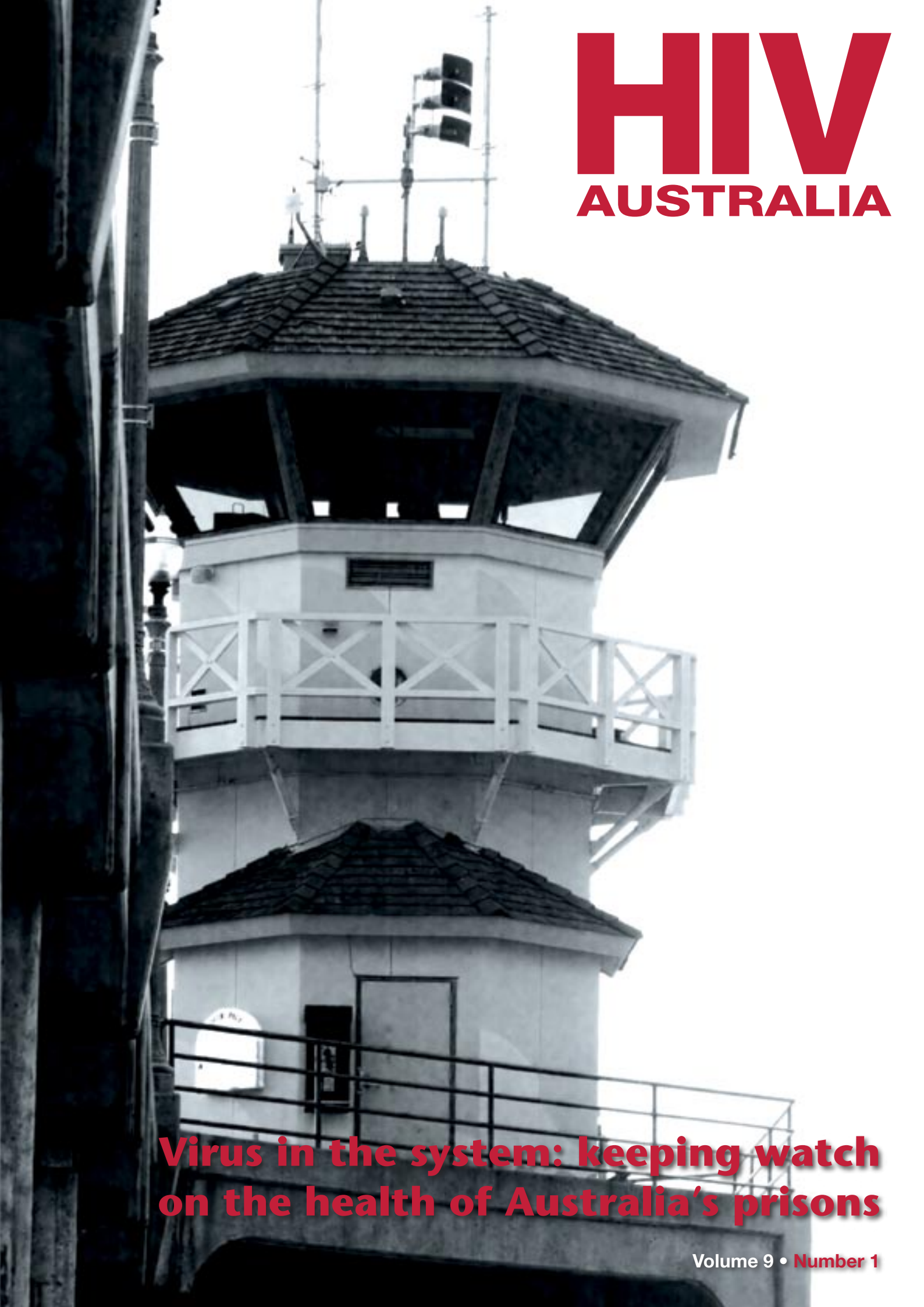

HIV AUSTRALIA

Virus in the system: keeping watch on the health of Australia's prisons

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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.

This issue of *HIV Australia* focuses on blood borne viruses (BBVs) and sexually transmissible infections (STIs) within the prison system. Contributors examine surveillance and management of STIs, BBVs and other health issues in Australian correctional facilities, identifying current successes and gaps – particularly in relation to communities that are disproportionately affected.

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HIV Australia welcomes submissions from interested authors.
To submit an article or report for consideration, email editor@afao.org.au

AUSTRALIAN NEWS

New date for Sydney Candlelight memorial

The Sydney Candlelight Memorial, commemorating people lost to HIV/AIDS, will now be held each year on 15 May, to coincide with similar events held internationally and in other Australian states. Previously the event was held on 1 December as part of World AIDS Day. This year the Sydney event will take place on Sunday 15 May at Slide, 41 Oxford Street from 3.30pm.

AMC prison reviews tabled

Two reports reviewing the first 12 months of operation of the Alexander Maconochie Centre (AMC), the ACT's prison, were tabled by Attorney General Simon Corbell earlier this month.

The reports identify ' … a number of significant outcomes' in the AMC, including 'a high quality of services available to detainees' and 'a strong basis to provide for a human rights compliant facility', but also raise concerns about a range of areas. One notable finding was that the government had been given incorrect advice about the extent of drug-testing of detainees on admission to the facility.

The Attorney General has announced the establishment of a new AMC Task Force to provide the government with advice on addressing the issues. The ACT Chief Minister Jon Stanhope has previously suggested that the review process of the AMC could include reconsideration of a needle and syringe program within the facility, although to date there have been no further announcements regarding this.

NCHECR celebrates 25 years and announces name change

The National Centre for HIV Epidemiology and Clinical Research (NCHECR), based at the University of NSW (UNSW), recently celebrated its 25th anniversary with the launch of a new name – the Kirby Institute for infection and immunity in society.

The Kirby Institute takes its name from former Justice of the High Court of Australia Michael Kirby, who has been associated with the centre since its inception. 'The name change is designed to convey the breadth of our work which, these days, is far greater than just HIV,' explained Professor David Cooper.

NCHECR was established in 1986 in response to the emerging HIV pandemic. Today, the Kirby Institute's 160 researchers work on a range of blood borne viruses including HIV, viral hepatitis and other diseases affecting specific communities such as Indigenous people, prisoners, sex workers and injecting drug users.

New AFAO Executive Director

Don Baxter, Executive Director of the Australian Federation of AIDS Organisations (AFAO), is stepping down from the role after ten years. Don was closely involved in the initial grass-roots HIV community response in Sydney's gay community from 1983 and was a founding member of the AIDS Council of NSW.

Don has subsequently been in national leadership positions, including his role as the executive director of AFAO, and as a member of key advisory and decision-making bodies in Australia's national HIV response – in both elected positions and Ministerially-appointed ones.

Over the last decade Don has led the development of AFAO's International Program, including a particular focus on men who have sex with men (MSM) and HIV – both in the Asia-Pacific and globally. In his role as founding Co-Chair of the Global Forum on MSM and HIV, Don initiated the first MSM Pre-Conference Satellite (held at the 2004 Bangkok International AIDS Conference) and currently runs MSM-specific programs aimed primarily at developing effective national MSM community advocacy organisations in Indonesia, Papua New Guinea and the Pacific. Don will continue to focus on HIV advocacy work in the Asia Pacific though his role as Co-Chair of the Global Forum on MSM and HIV.

Don's successor will be Rob Lake, who is currently CEO of Positive Life NSW. Mr Lake, who has over two decades of experience in the HIV sector, will commence as as AFAO's Executive Director in June.

AFAO President Graham Brown welcomed the appointment saying that Mr Lake was selected from a strong field of Australian and international candidates. 'AFAO is delighted that Mr Lake – a well-known advocate for people living with HIV/AIDS – has accepted the position. On behalf of the board and staff, I welcome Rob to AFAO. We look forward to his leadership within the organisation and throughout the sector,' Dr Brown said.

E-Health for Indigenous communities

Minister for Health and Ageing Nicola Roxon has announced that the Northern Territory Department of Health and Families has been selected as one of nine new e-health lead national implementation sites for the federal government's $467 million national personally controlled electronic health records (PCEHR) project.

Minister for Indigenous Health, Warren Snowdon, says the announcement places Indigenous Australians 'front and centre' of e-health, and will enhance the quality of service for Territorians and Indigenous Australians in six East Kimberley hospitals in Western Australia and in remote Aboriginal Community Controlled Health Services in South Australia.

'We know many Indigenous Australians are required to travel regularly to access a range of services, and now this record will follow them wherever they go.
This will provide patients with continuity of care and … improved health outcomes for the Indigenous community' Minister Snowdon said.

NEWS FROM THE ASIA PACIFIC

Asian regional meeting tackles punitive HIV laws

A two-day regional meeting, hosted by the Global Commission on HIV and the Law, was held in Thailand, 16–17 February 2011. Delegates discussed how punitive laws and social stigma prevent people accessing health services and undermine the effectiveness of HIV/AIDS treatment and prevention programs.

90% of Asian countries have laws discriminating against people with living with HIV and at-risk communities. According to UNAIDS, 29 countries in the region criminalise some aspects of prostitution, 19 countries criminalise same-sex relations and many enforce compulsory detention for drug users. 16 nations impose travel restrictions on people with HIV, including developed countries such as Singapore (which denies visas even for short-term stays), South Korea – and Australia and New Zealand.

Inadequate care for HIV-positive prisoners in Thailand

In a presentation at Thailand's 13th National AIDS conference, held 29–31 March 2011, it was reported that the Corrections Department is struggling to provide adequate HIV treatment to foreign and stateless prisoners who are not eligible to access free antiretrovirals under the country's universal healthcare coverage (UC).

Speaking at the conference, Panuwat Mukdasanit from Ban Kai Hospital said that out of approximately 1,000 HIV-positive inmates sent to the hospital, only around 400 received antiretrovirals – with some HIV-positive prisoners dying from opportunistic infections due to lack of treatment.

According to official Corrections Department figures reported by *The Bangkok Post*, 30% of the 220,000 prisoners in Thai correctional facilities are foreign, migrants or stateless.

Nipha Ngamtrairai from the Corrections Department says 'a lack of funding is denying that opportunity to stateless HIV-positive prisoners, who have the same right to treatment as people living with HIV/AIDS outside the prison'.

New application for generic HIV drug in India

Pharmacy corporation Cipla has applied for a 'voluntary licence' allowing production of a generic version of Merck's antiretrovial drug, *Isentress*. Although Merck is selling the drug in India for a fourth of the US price, Cipla claims the drug is unaffordable for many Indian patients. Under Indian patent law, a generic drug manufacturer can invoke the compulsory licensing provision once the patent completes three years of treatment with the drug.

A transcript of an interview about the Cipla case by pharamaasiannews.com is available at: http://www.moneycontrol.com/news/business/cipla-tells-merck-your-anti-aids-drug-too-costlyindia_533783-1.html

Concern over HIV rates in Filipinos working overseas

According to National HIV and AIDS Registry data, Overseas Filipino workers (OFWs) comprise a quarter of the 6,326 total cases of HIV in the Philippines.

Speaking to *The Philippine Daily Inquirer*, Arnel Ty, a representative of the Liquefied Petroleum Gas Marketers' Association (LPGMA), said that HIV is 'ravaging our OFWs', due largely to high-risk sexual behaviour. Since 1984, a total of 1,558 OFWs have been found HIV-positive (including some AIDS diagnoses). 96%, or 1,496, of the overseas workers with HIV/AIDS, acquired the disease through unprotected sexual contact.

Ty is advocating for review of the 1998 AIDS Prevention and Control Law to help address the issue and is also appealing for increased public funding for HIV education and prevention programs.

HIV computer modelling tool launched in Indonesia

A team of Indonesian and Australian researchers has developed a new computerised tool to help reduce HIV infection and track disease burden across the Indonesian archipelago. The HIV in Indonesia Model (HIM) was launched in Jakarta in March 2011.

'HIV has had considerable negative impact in Indonesia,' said lead researcher Associate Professor David Wilson, from the Kirby Institute for infection and immunity in society (formerly the National Centre in HIV Epidemiology and Clinical Research [NCHECR]). 'Last year almost 485,000 Indonesians were living with HIV. This number is estimated to grow to 744,000 by 2020, with around 50,000 new infections each year'.

'HIM will allow Indonesia to understand the drivers for their epidemic and project the future course,' Associate Professor Wilson said.

HIM was developed for the Indonesian Ministry of Health and the National AIDS Commission and was funded by the Australian Agency for International Development (AusAID) with assistance from the World Bank.

INTERNATIONAL NEWS

Australia to grant licences to export pharmaceuticals to developing countries

The Australian Government has announced legislation that will allow Australian courts to grant compulsory licences to manufacture and export patented pharmaceuticals to assist countries dealing with epidemics and other types of health crises.

The new system implements an international agreement on public health in the World Trade Organization, amending the *Agreement on Trade-Related Aspects of Intellectual Property Rights* (the TRIPS Protocol).

Developing countries and organisations will now be able to apply for a licence to manufacture and export patented pharmaceuticals from Australia to countries in need. The government is aiming to have the new system in place by the end of 2011.

UK blood ban for gay men to be partially lifted

The UK Department of Health Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO) has advised the UK government to lift the ban on gay men donating blood on the grounds that the ban is discriminatory.

The announcement has come under fire due to a requirement that gay men must be sexually inactive for a ten year period in order to donate.

The ten year caveat is based on advice from SaBTO that restricting men who have sex with men from giving blood for five years after their last sexual encounter would reduce the risk of HIV reaching the blood supply, and this risk would be further halved if the deferral period were increased to ten years.

An estimated 86,500 people are living with HIV in Britain – a quarter unaware that they have HIV.

A lifetime ban on blood donation applies to men who have had sex with men in many countries. The Australian Red Cross Blood Service has established a review of current deferral policies relating to sexual activity of blood donors in Australia, with the Review Committee expected to discuss its draft report in June 2011.

Calls to review Ugandan HIV Control Bill

The Uganda Human Rights Commission (UHRC) is calling for a review of the *2010 HIV Prevention and Control Bill*, which has been widely condemned for violating human rights.

The bill, which imposes a 10 year prison sentence or a 4.8 million shillings fine for wilful transmission of HIV, includes clauses that criminalise 'intentional' transmission of HIV, require mandatory HIV testing and enforce open disclosure of an individual's test results.

In statements made to the committee and reported by *The Daily Monitor*, UHRC Commissioner Agaba Maguru called for discriminatory provisions in the bill to be deleted. 'We believe that the *Penal Code Act* is sufficient to deal with the exceptional circumstances where it is necessary to prosecute those who wilfully and intentionally transmit HIV,' said Mr Maguru.

World famous HIV/AIDS activist Elizabeth Taylor dies

HIV activists around the world mourned the death of actor and celebrated HIV/AIDS activist Elizabeth Taylor, who died 23 March 2011, aged 79.

Elizabeth Taylor came out in support of HIV/AIDS activism and public awareness at the very beginning of the HIV epidemic. She was a major supporter of AIDS Project Los Angeles (APLA) and a founding member of the National AIDS Research Foundation (NARF), which later became the American Foundation for AIDS Research (amfAR).

Elizabeth Taylor was instrumental in lobbing the US government for increased funding for HIV/AIDS research, public education and support services and remained an active international advocate for people living with HIV until her death.

US lawsuit on behalf of HIV-positive prisoners

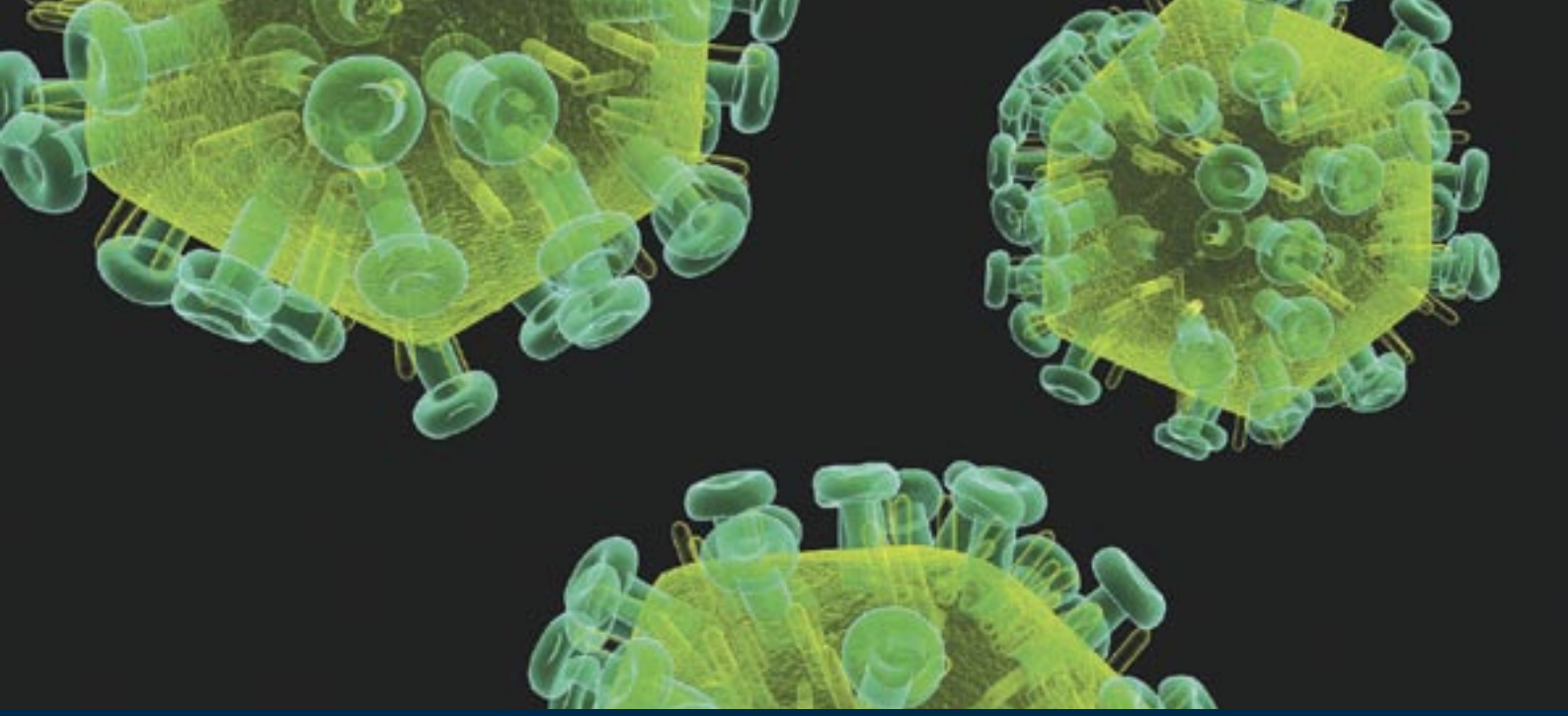
The American Civil Liberties Union (ACLU) and the American Civil Liberties Union of Alabama have filed a federal class action lawsuit on behalf of prisoners affected by US state policy that segregates HIV-positive inmates. The policy requires men with HIV to wear white armbands that publicly disclose their HIV-positive status. This forced disclosure violates medical ethics and international human rights law. The lawsuit also accuses the program of denying these prisoners access to rehabilitative and community re-entry programs and may therefore result in HIV-positive prisoners serving longer sentences.

South Carolina and Alabama are the only two US states that continue to segregate all prisoners with HIV in separate housing units. Mississippi ended its segregation policy in 2010, after the ACLU and Human Rights Watch released a report documenting the stigma, harassment and systemic discrimination faced by prisoners who are segregated on the basis of their HIV-positive status.

New UN report released

UN Secretary-General Ban Ki-moon has published a new report *Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths*. The Secretary-General's report, based on data submitted by 182 countries, will be reviewed by global leaders at a UN General Assembly High Level Meeting on AIDS, 8–10 June 2011.

In Australia a civil society meeting was held on 13 April to discuss the recommendations – convened by AusAID, the Department of Health and Ageing and the Australian Federation of AIDS Organisations.



News from the 18th Conference on Retroviruses and Opportunistic Infections (CROI 2011)

CROI is an annual conference, bringing together leading scientific researchers and clinicians to profile and debate current investigations into the biology and epidemiology of human retroviruses and associated diseases. CROI 2011 was held in Boston, US from 27 February to 2 March, 2011.

Below are summaries of some of the key presentations and announcements from this year's event, as reported by *aidsmap.com*. Conference abstracts are available on the CROI conference website: http://retroconference.org/2011

First pills-versus-gel trial finds US women prefer oral PrEP

The first head-to-head trial directly comparing the acceptability of tenofovir pills and tenofovir microbicide gel amongst HIV-negative women has found that, while African women liked both products equally, three-quarters of US women preferred a pill.

'Near perfect' adherence in early stages of Partners PrEP study

According to investigators in the Partners PrEP study, adherence levels of 99% were achieved by participants over an average four-month period during the two-year study.

Partners PrEP is a study amongst 4,700 heterosexual couples of differing (serodiscordant) HIV status at nine sites in Kenya and Uganda. The HIV-negative member of each couple will be randomised into three groups to take a daily pill containing tenofovir, or tenofovir plus FTC, or a placebo. All pills will look identical. At the end of the study HIV incidence rates in the three trial arms will be compared. Results are expected by early 2013.

Gay men reduce their risk behaviour after HIV diagnosis, studies find

A presentation comparing two studies showed that gay men diagnosed with HIV considerably reduced the amount of high-risk sex they engage in that could pass on their infection.[1,2] However the two studies disagreed on how much men reduced their risk behaviour, and for how long they sustained this reduction.

The two prospective cohort studies, from Amsterdam and San Francisco, did not look at gay men's behaviour over the same time frames, so cannot be directly compared.

Zinc finger gene therapy produces HIV-resistant CD4 T-cells

Researchers reported that gene therapy that interferes with co-receptors on the surface of T-cells can protect these cells from HIV infection, representing a potential first step toward achieving a 'functional cure'.

HIV uses two different surface co-receptors – CCR5 and CXCR4 – to enter CD4 T-cells. If the co-receptors are blocked or disrupted, the virus is unable to enter cells. Two presentations looked at using gene therapy to create cells that lack these receptor proteins and therefore are protected from infection.

This work draws upon knowledge gained from 'elite controllers', a small proportion of HIV-positive people who have a natural genetic mutation known as CCR5-delta-32. These individuals do not express CCR5 on their T-cells and are able to maintain undetectable or very low viral load without antiretroviral therapy.

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New data from PrEP study shed light on adherence, bone mineral loss and resistance

Near-perfect adherence to oral pre-exposure prophylaxis – taking HIV drugs to prevent HIV – may be achievable in the right settings.

Participants from the US sites of the international iPrEx study of tenofovir/FTC (*Truvada*) pre-exposure prophylaxis (PrEP) in men who have sex with men and transsexual women had near-perfect adherence, compared with 50% adherence from other sites, new data presented at the conference shows.

Analysis also found that adherence in men who had the highest risk of acquiring HIV, by having unprotected receptive anal sex, was, at 76%, far higher than those at lower risk, so participants were tempering their pill-taking to their perceived risk.

Another substudy has found that taking *Truvada* resulted in a small but significant loss in bone mineral density in participants. But it also found that participants' bone mineral density at the start of the study was considerably lower than would have been expected in men their age.

Updated trial results on PrEP

In the paper published on the trial findings in the *New England Journal of Medicine* last November, data were given up to May 2010. Bob Grant presented final figures for the trial, whose last participants left the trial in August 2010.

The final tally was that 130 HIV infections were seen in the 2,499 men taking part in the trial, 48 of those taking *Truvada* and 82 on placebo, a rate of 2.6% a year. There were also 10 infections in men who had acute HIV symptoms at the time they enrolled, two of whom appear to have acquired resistance to FTC, and six infections in the three months immediately following the trial, four of them in men who had taken *Truvada*.

This means that the final efficacy figure in the 'modified intent to treat' (MITT) analysis, which excluded the men who had HIV at the start of the study and ignores factors like adherence and sexual risk, was 42%.

Efficacy was greater in men over 25 (56%), in men who reported greater than 90% adherence (68%), and – for reasons that are unclear – in the relatively small number of men who were circumcised (76%).

At least one in six patients maintains a viral load over one hundred thousand

A study of patients in southern Africa diagnosed during primary HIV infection has found that one in five maintained viral loads over 100,000 copies/ml for at least 400 days after infection. One in six will maintain such a persistent high viral load for three years or more, researchers calculated.

Quantifying the percentage of patients who, off treatment, maintain high viral loads is important for calculating the likely transmission rate within a population and the prevention impact of treating them. Another study presented found that an individual with a viral load of 100,000 copies/ml is likely to transmit HIV nearly three times more often than a person with a viral load of 10,000 copies/ml.

The southern African study, from Vladimir Novitsky and colleagues from Harvard Medical School, also found that patients with viral loads over 100,000 copies/ml experienced dramatically faster declines in their CD4 counts.

High rate of HCV reinfection after treatment of acute infection in Amsterdam gay men

Amsterdam doctors reported that just over one-quarter of gay men with HIV successfully treated for acute hepatitis C infection became reinfected with hepatitis C within two years, almost all with a different genotype.

The rate was ten times higher than the rate of acquisition seen among HIV-positive men infected for the first time, and suggests that health promotion activities with this group of men need to continue after treatment of acute infection, with greater exploration of a patient's potential risk factors.

Is HIV drug resistance spreading? Early warning signals say 'yes'

Experts concluded that signals warning of the transmission of drug-resistant HIV are growing in low- and middle-income countries, and governments should step up surveillance efforts as they scale up treatment.

A World Health Organization (WHO) survey of 'early warning indicators' – levels of performance that treatment services should be hitting in order to minimise the risk of drug resistance – showed substantial problems with drug stock-outs, loss to follow-up and patients picking up drugs on time in nine African countries in 2008.

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A view from the inside: HIV support and treatment in prisons

By **Phillip Read** and **Jenny Douglas**

Introduction

Since the emergence of HIV as a major global public health issue in the early 1980s, the relationship between prison and HIV has been recognised as both complex and important. Many of the risk factors for contracting HIV, such as injection drug use and social disadvantage, also put people at higher risk of imprisonment. This is particularly the case in countries where sex work or homosexuality is considered illegal.

For much of the general population, it is likely that the thought of being sentenced to prison or contracting HIV both generate a large amount of fear and anxiety. However, for prisoners living with HIV, dealing with these two major challenges is a part of everyday life. Fortunately, in Australia there are services available within the prison system that strive to deliver HIV care of equal quality to services within the wider community.

Worldwide, the prevalence of HIV amongst the prison population varies widely. In countries where the incidence of HIV is particularly high, such as in South Africa, UNAIDS found that HIV prevalence in male prisoners exceeded 40%.[1] Even in developed settings, people living with HIV are disproportionally imprisoned. In the USA, HIV rates in prison are six times that of the general population, and similar figures exist for Ireland, France and Canada.[2]

In Australia, voluntary periodic surveys and blood borne virus screening of prison entrants are conducted every three years, providing the best estimate of HIV in Australian prisons. The most recent survey, published in 2007, reported that less than 1% of people in prison tested positive for HIV, and that the majority of these positive diagnoses were already known to the individuals before they entered the prison system.[3] Although in international terms 1% is a comparatively low figure, it is still at least double the rate of HIV found within of the general population of Australia.

Care and support in correctional facilities

Once someone living with HIV is transferred to a custodial setting, what level of care should they expect to receive? The answer to this is very clear. Article 12 of the *International Covenant on Economic, Social and Cultural Rights*[4], to which Australia signed up in 1975, states that prisoners – like all people – are entitled to enjoy the highest attainable standard of physical and mental health. Furthermore, as early as 1993, the World Health Organization

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(WHO), responding to concerns about HIV rates in prisons emphasised that ' … all prisoners have the right to receive [HIV] health care, including preventative measures, equivalent to that available in the community … '.[5]

When access to care and treatment is unrestricted, several studies from overseas have shown that virologic control of HIV for prisoners on antiretrovirals is excellent, and viral rebound is more likely upon a person's release.[6] It is important, therefore, for prison health systems to liaise with HIV services in the community in order provide continuity of care for individuals upon their release.[7]

In New South Wales, health services are provided to people in custody by Justice Health, a statutory health corporation reporting to NSW Health, and importantly, not part of Corrective Services.

Specialist HIV services are provided to inmates by visiting medical officers from community HIV-specialist centres, through the operation of monthly clinics at the two largest NSW correctional facilities at the Long Bay Complex and the Silverwater Complex. All patients in the prison system, including those on remand, who either test HIV-positive during incarceration, or who are known to be HIV-positive are assessed in person by nursing staff and then referred to specialist services. People co-infected with HIV and hepatitis C are seen by a specialist skilled in the treatment of both conditions. A 'medical hold' can be placed on these prisoners to ensure they are medically assessed by a specialist prior to transfer to another regional centre. Once assessed as stable, further consultations can be conducted by teleconference, with transfer back to the Long Bay Complex or the Silverwater Complex for face-to-face review if necessary.

Visiting specialists are supported by public/sexual health nurses employed by Justice Health at all major correctional centres in NSW, who are specifically trained in sexual health, HIV and hepatitis. All drug treatments and investigations available to people living with HIV in the community are potentially also available to those in prison. Overall HIV care and compliance with NSW health policy is coordinated by the Clinical Nurse Consultant for Sexual Health and Hepatitis. Most other states and territories operate a similar system, but for some, demand for regular clinics may be limited by the smaller number of prisoners with HIV.

HIV testing policy in NSW prisons

In NSW during the 1990s, HIV testing on reception to prison was mandatory. In 1999, this policy was replaced by voluntary targeted screening, as mandatory screening was found to be discriminatory and contravened the WHO premise that prisoners should be treated in the same way as other members of the community and not be subjected to any discriminatory practice such as involuntary testing, unnecessary segregation or isolation[8].

Currently all prisoners in NSW are offered screening for blood borne viruses and sexually transmissible infections through the Early Detection Program. This program aims to improve the capacity of people in custody to reduce the risk of becoming infected or re-infected with a blood borne virus or sexually transmissible infection and to ensure effective management and treatment of affected people. The Early Detection Program encompasses medical history-taking, risk assessment, harm minimisation education, pre-test and post-test discussion, testing, results management, referral and vaccination. Individuals can be referred to the program on reception into prison, or at any other time during incarceration. They can also self-refer or be referred by other health professionals. All Public/Sexual Health Nurses performing this screening program are required to have completed the clinical accreditation program Screening and Management of Blood Borne Viruses/Sexually Transmissible Infections in the Custodial Environment. Public/Sexual Health Nurses are employed in all centres (except for those in the most remote rural settings), so screening, care and treatment is widely available.

When access to care and treatment is unrestricted, several studies from overseas have shown that virologic control of HIV for prisoners on antiretrovirals is excellent, and viral rebound is more likely upon a person's release.

Disclosure and other challenges

Despite all this, challenges for prisoners living with HIV remain great. Disclosure is probably the greatest fear, and discrimination against HIV-positive prisoners and men who have sex with men is common. HIV-positive status is not a reason to be housed in a single cell, as this in itself may rouse suspicions over HIV status and

amount to tacit disclosure. In some circumstances patients are provided with a monthly supply of medications, yet the opportunities for discreet tablet-taking when living in a confined space with another prisoner are limited. Alternatively, drugs may be dispensed daily from a medication administration window, and although some privacy is maintained, other knowledgeable prisoners may recognise the distinctive shape and colour of some antiretrovirals. Specialist investigations are available for all prisoners, but this may require temporary transfer to another prison. For some, such a transfer may move them a long way from relatives and friends, or require being housed in a higher security facility. These complications of transfer may present a barrier when discussing medical investigation options.

Harm minimisation for HIV-positive prisoners, such as opioid substitution programs and condom and dental dam dispensers are available. Yet there continues to be debate both in Australia and internationally about the appropriateness of needle and syringe exchange in Australian prison settings. Some studies have shown evidence of their utility[9], and certainly Australia has shown leadership in this arena in a community setting, but currently, needle and syringe exchange in prison does not exist. There is evidence of a small number of HIV infections having occurred in Australian correctional facilities through the use of illicit injecting equipment[10], but in the prison environment the difficulty identifying and contact tracing injecting partners in order to offer post-exposure prophylaxis is significant[11].

There can be no doubt that the challenges of identifying, living with, and caring for people living with HIV within the prison system are significant. However, in contrast to many other countries, Australian prisons do offer a level of care comparable to that in the general community. For individuals whose HIV was a well-controlled part of their lives before entering prison, HIV can continue to be well-managed. For those entering prison without a recent history of engaging in HIV care, although initially difficult to cope with, the structure of prison may paradoxically offer an opportunity to regain control over the virus, which provides the basis for better care in the community upon release.

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There can be no doubt that the challenges of identifying, living with, and caring for people living with HIV within the prison system are significant. However, in contrast to many other countries, Australian prisons do offer a level of care comparable to that in the general community.

Prison sex. Don't believe what you see on TV.

By **Basil Donovan, Juliet Richters** and **Tony Butler**

We all know what goes on in prison, don't we? Don't drop the soap … even reputable TV channels and good movies dish out ample servings of prison sex and rape. Past research – good, but based on unrepresentative (even self-selected) samples – would have us to believe that rape is the usual outcome of incarceration, particularly if you are young or small. Lack of interest is the almost inevitable response of the print media if anyone tries to correct these myths (as also happens with 'trafficked sex slaves').

But these are not trivial issues. Men and women who are about to be imprisoned, and their families, are in fear of what is about to happen. Defence lawyers even use 'rampant' prison rape as an argument for their clients to avoid custodial sentences.

Persuaded by legal argument that the Department of Corrective Services has a duty-of-care to provide prisoners with the means to protect themselves from HIV and sexually transmissible infections (STIs), inmates in NSW prisons have been freely supplied with 30,000 condoms a month since 1996, plus dental dams. The prevalence of HIV infection in Australian prisons remains below 1%,[1] in contrast to hepatitis C virus infection which runs at about 35%. But what really happens happen in gaols? Is rape common? Do previously straight men turn gay after a few years?

Our study

We set about determining the sexual behaviour and sexual culture in the prisons of two large Australian states, New South Wales and Queensland. We chose these states because NSW prisons distribute hundreds of thousands of condoms and dental dams each year, while Queensland prisons distribute none. As prisoners are automatically excluded from

sexual behaviour surveys of the general population, we adapted the methodology of the Australian Study of Health and Relationships and used computer-assisted telephone interviews.[2] Randomly selected prisoners were brought by officers to empty rooms or clinics where they could use our phones to do their interviews.

We surveyed representative samples of 900 men and 134 women in 14 Queensland prisons, and 1,162 men and 201 women in 28 NSW prisons, with very high response rates within both states. Only prisoners from high-security prisons were excluded from the survey, as were individuals who were too ill, or dangerous, or away at court, or in hospital.

The full reports are available in two monographs that are accessible online.[3,4] These are large reports and our analyses are ongoing, but here we present a few snippets that caught our attention – some were quite unexpected.

Before prison

As expected, prison inmates were much less educated and tended to come from poorer socio-economic areas than the general population. Between one-in-four and one-in-five prisoners were from an Aboriginal and/or Torres Strait Islander background. Overall, prisoners reported having sex for the first time at a younger than average age, and reported more engagement in sex work, more sexual partners, and more STIs in their past than the general population.

An extraordinary 60% of women and 13% of the men reported sexual coercion (including rape) prior to their imprisonment. Around a third of men and women feared that they would be sexually assaulted in prison.

Sexual identity, attraction, and experience

Overwhelmingly, male inmates identified as heterosexual or straight (95%), while a few saw themselves as bisexual (3%), homosexual (1%) or unsure (0.5%). That said, 8% of the men had at least occasionally felt some attraction to another man, and 13% reported at least some past same-sex contact.[5]

By contrast, only 63% of female inmates described themselves as heterosexual, 29% as bisexual, 7% as lesbian, and 1% as 'other'.[6]

Sexual attitudes and STI knowledge

Overall, our research found that prisoners share similar attitudes toward sexual matters with the general population, with two notable exceptions. Male prisoners were three times more likely as the general population to agree with the statement 'abortion is wrong' and female prisoners were almost twice as likely to agree with this statement. Male prisoners were twice as likely (61%) to agree with the statement 'sex between two adult men is always wrong' than men in the general community. Male prisons are very homophobic environments.[7]

Interestingly, despite their much lower educational levels, prisoners' responses to knowledge questions about STIs did not differ greatly from the general population.

Sex in prison

Contrary to what you see on TV, only 7% of male prisoners reported any sex with another inmate and, if reported, for more than half the respondents this was only occasional and did not involve anal intercourse. Of those men, most said they had sex for pleasure (79%), sometimes for protection (15%), and rarely for drugs (2%) or other goods (4%). Interestingly, 10 of the 26 men who identified as gay did not report any sex in prison.[8]

By contrast, women prisoners were much more sexually active: 36% reported sex with other inmates, with oral sex involved in about 60% of encounters. Home-made dildos were common (including an unfired clay item that disintegrated inside one woman) and were often shared.[9]

Sexual coercion in prison

Sexual coercion was a rare event in prisons – and it seems to be getting even rarer.[10] Only 2.5% of male prisoners and 3.9% of female prisoners reported that they had been forced or frightened into unwanted sexual

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activity in prison. Almost half of these instances only occurred once, and for some individuals the event dated back decades.[11,12,13]

Indeed, our evidence suggests that these people may be at less risk of sexual coercion and rape inside prison than outside. The reasons for sexual coercion fading out of prisons probably reflects a much improved prison culture, more sympathetic management applying the principle of duty-of care, fewer prisoners per cell, and video surveillance.[14]

So what happens to the condoms and dams?

Before condoms were to be introduced into NSW prisons there were strong objections by prison officers who thought that they might encourage more sex and rape or be used as weapons. In brief, these predictions were wrong.[15] That said, there is so little anal sex in male prisons that sex cannot account for the consumption of 30,000 condoms a month. Some are indeed used to secrete contraband, including drugs. Some are liberated of their lubricant for use as hair gel, or they are used as household ties or masturbatory aids.[16]

As in the general community, dental dams in women's prisons are rarely (4% ever) used for oral sex.[17] Instead, they are reborn as tobacco pouches, hair bands and doilies.[18]

Conclusion

Due to sheer repetition it will take generations to correct deep-seated misconceptions of rampant prison sex and rape. At least we now have a little more science available to inform policy decisions.

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Photography credit: The black and white photograph accompanying this article is from a series taken in NSW correctional centres by Sue Paull, 1995–2008. The image is reproduced courtesy of the photographer.

Before condoms were to be introduced into NSW prisons there were strong objections by prison officers who thought that they might encourage more sex and rape or be used as weapons. In brief, these predictions were wrong.

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Prisons, injecting drug use and blood borne viruses: continuing challenges

By **Lorana Bartels**

The Australian Institute of Criminology (AIC) has long been concerned with the prevalence and transmission of HIV and other blood borne viruses (BBVs) in Australian prisons. In 1991, the AIC noted that 'the increase in identified HIV seropositive prisoners in Australia's gaols ... is of major concern, and raises serious questions concerning legal obligations within the prison community'.[1] In 1994, the AIC published recommendations on prison HIV peer education, noting the need for such education to cover hepatitis prevention as well as HIV, and that it should be targeted to minority groups.[2]

Many years later little has changed. There are still no needle and syringe programs (NSPs) in Australian custodial settings, and the specific needs of Indigenous and female prisoners remain unmet.

Prevalence data

The most recent Australian data on the prevalence of HIV and other BBVs among prison inmates are from the *2007 National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey* ('the survey'), which involved 740 prison entrants from all jurisdictions except the Northern Territory.[3]

HIV

Less than 1% of prison inmates who were tested upon admission during the survey period tested positive to HIV. However, due to inconsistent testing policies for BBVs in correctional facilities across various states[4], it is likely that this is an incomplete picture. In South Australia, for example, The Kirby Institute (formerly the National Centre in HIV Epidemiology and Clinical Research [NCHECR]) reported that only 15% of South Australian male admissions were tested for HIV in 2009.[5]

Hepatitis B

The survey found that 21% of prison entrants screened upon admission tested positive to hepatitis B.[6] This figure was highest in NSW and Western Australia (27% and 28%) and lowest in Queensland and Tasmania (9%); hepatitis was also much more common among injecting drug users (IDUs).

Hepatitis C

The survey found that 35% of prison entrants that were screened tested positive to hepatitis C. The rate was highest in NSW and Victoria (42% and 41%) and lowest in Western Australia (21%). Injecting drug users were much more likely to test positive to hepatitis C than non-IDUs (60%).

In terms of prevalence, hepatitis C appears to represent the greatest concern in relation to BBVs in Australian prisons. To this end, in 2008 the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH) released *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings.*[7] These have been endorsed by all Australian health and corrections ministers.

NSPs in correctional settings

Prison-based NSPs have been running in a number of countries for over ten years, including Switzerland, Germany and Spain[8] – but to date no NSPs have been established in Australian prisons. This is despite the fact that international research on provision of NSPs in prisons has shown reductions in needle sharing, and reduction in rates of BBV transmission.[9,10,11] In an evaluation of community-based NSPs in Australia, NCHECR estimated that for every dollar invested in such programs, more than four dollars were

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returned in healthcare cost-savings over ten years if only direct costs were included, with greater returns expected over the longer term.[12]

The Australian Government has recently released three strategies which call for NSP trials in custodial settings: the *Sixth National HIV Strategy 2010–2013*[13]; the *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013*[14]; and the *Third National Hepatitis C Strategy 2010–2013*[15]. The strategies have all recommended that:

> *In view of the well-documented return on investment and the effectiveness of Australian community-based NSPs, it is appropriate … for state and territory governments to identify opportunities for trialling this approach in Australian custodial settings. This is also supported by the international evidence demonstrating the effectiveness of prison NSPs.*

There is also political will. In January 2011, the ACT Chief Minister, Jon Stanhope, acknowledged it was 'inevitable and appropriate and indeed the appropriate moral response for us to consider a needle exchange' in the ACT prison.[16] Furthermore, the NSW Coalition made a pre-election promise to consider an NSP trial in NSW prisons. At the time of publication, no further announcements have been made regarding this issue since the Coalition was elected to govern.[17]

Although both moves have met with some resistance, principally from prison staff[18,19], it would now appear certain that this long overdue measure will at least be trialled in an Australian jurisdiction.

Responding to the needs of specific groups

Women

Up to two-thirds of all female inmates have hepatitis C, compared with one in three male inmates who test antibody positive for the virus.[20,21] In addition, female prisoners report a higher incidence of continued injecting drug use (IDU) while in prison than men, with the survey indicating that female prison entrants were more likely than men to have injected drugs (73% versus 53%) and that injecting drug users were much more likely to test positive for hepatitis C than non-IDUs (78% versus 13%).[22]

The intersection of gender, drug use and BBVs has been explicitly acknowledged by the NSW Department of Corrective Services, which notes that despite 'representing only a small proportion of the overall imprisoned population, women experience higher levels of substance abuse ... than males [and] higher rates of infection with blood borne viruses'.[23] Internationally, the *Kyiv Declaration on Women's Health in Prison*[24] sets out key principles in relation to the health needs and treatment of female prisoners, including the need for specialist health care which is readily adjusted to meet individual needs in relation to HIV (including counselling and support), hepatitis and other infectious diseases.

The AIC recently reviewed good practice for women's prisons.[25] It examined developments in corrections policies, women's prison system management, corrections programs for women, and programs to address physical and mental health issues. The paper identified a number of positive developments in relation to the prevention and management of BBVs for women in some Australian custodial settings, such as:

- provision of information on BBVs on admission after a health screening, and compulsory attendance at BBV education sessions;
- monthly hepatitis C clinics at the Boronia Pre-release Centre for Women in Western Australia, where a visiting gastroenterologist provided access to the latest treatment options; and
- a review of hepatitis services and expansion of the range of services provided by sexual health nurses in NSW.

The review also considered the use of HIV prison-based peer programs in two New York State prisons.[26] Although most of the women in the programs were not HIV-positive, they were trained to provide counselling and educational workshops and facilitate support.

Indigenous prisoners

A 2001 study indicated that Indigenous injecting drug users in Sydney were more likely to be imprisoned than non-Indigenous users, the researchers suggesting that 'prison may be an ideal opportunity to promote treatment and bloodborne virus testing and to address some of the barriers identified by Indigenous IDUs'.[27]

The *2007 National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey* data also indicated that IDU is more prevalent among Indigenous than non-Indigenous prison entrants (61% versus 53%).[28] In addition, 43% of the Indigenous prison entrants screened tested positive to hepatitis C, compared with 33% of non-Indigenous entrants; this figure rose to three-quarters (72%) for Indigenous female prison entrants. For hepatitis B, 42% of entrants tested, tested positive, compared with 17% for non-Indigenous entrants. The figures for women were 39% and 22% respectively.[29]

Notably, between 2004 and 2007 the Study found there was an increase among Indigenous IDUs in the prevalence of both hepatitis B and C antibodies (from 29% to 42%, and 38% to 43% respectively).[30] This increase led the study's authors to call for targeted culturally appropriate prevention strategies including education, hepatitis B vaccination, and hepatitis C treatment. This was particularly necessary, given that none of the Indigenous respondents reported having received treatment for hepatitis C.

The National Corrections Drug Strategy 2006–2009 recognised the need for specific culturally valid policy and program initiatives to address the needs of Indigenous people in correctional and community-based

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Australian prisons: the key to closing the gap and ensuring HIV remains low in Aboriginal and Torres Strait Islander communities

By **Mary Ellen Harrod, James Ward, Simon Graham** and **Tony Butler**

Australia's response to the HIV epidemic, encompassing multi-faceted, targeted prevention efforts including condom distribution and community-based needle and syringe programs (NSPs), has been recognised worldwide as first class – particularly in prevention of the epidemic among marginalised populations including men who have sex with men, sex workers, people who inject drugs, and Australia's first peoples, Aboriginal and Torres Strait Islanders.

Rates of infection among men who have sex with men, which were at an all-time high in the early 90s, have continued to decline and remain low; HIV diagnoses among sex workers remain rare, as are diagnoses among people who have injected drugs. Continuous prevention efforts have made this the case. For Aboriginal and Torres Strait Islander people, rates of diagnosis of HIV have remained stable and on par with non-Indigenous people, equating to around 20 notifications a year since the mid- 90s.

The low prevalence of HIV among the Aboriginal and Torres Strait Islander community should be celebrated as a success story for two reasons: firstly, because this has occurred despite the fact that unique factors exist in many of these communities that increase the risk of HIV transmission within them; and secondly, because this low HIV prevalence occurs in an environment where – for almost all other diseases – Aboriginal and Torres Strait Islander people experience higher rates of disease, and poorer health outcomes. The rate of premature death among Aboriginal and Torres Strait Islander people is between two to three times that of non-Indigenous Australians.

There are a number of well-documented factors that increase vulnerability to HIV transmission in Aboriginal and Torres Strait Islander communities. Long standing, high rates of bacterial sexually transmissible infections (STIs), such as gonorrhoea and chlamydia, exist in many Indigenous communities and are a factor known to increase susceptibility to HIV. Efforts to reduce the rates of these common STIs within those communities have been largely unsuccessful, except in a few places in Australia where comprehensive programs have been implemented and sustained (notably, in Tiwi Islands and Nganampa Health Council)[1,2]. Other factors that contribute to the increased risk of HIV transmission among Aboriginal and Torres Strait Islanders include less access to appropriate primary health care services, a younger and more mobile population, and recent evidence of a rise in diagnoses among people who inject drugs within communities. Evidence for the rise in injecting drug use is apparent: 20% of new HIV infections diagnosed among Aboriginal Torres Strait Islander people over the last five years were reportedly acquired through injecting drug use, compared to 3% of new infections in the non-Indigenous population.[3]

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Incarceration, HIV and Indigenous communities: the risks

The role of incarceration in driving HIV epidemics at a community level, and the impact of this on Aboriginal Torres Strait Islander people in Australia is less well-documented – however understanding this role is vital to ensure that we close all the gaps in Aboriginal Torres Strait Islander health in Australia.

It is well-recognised that the criminal justice system is a high-risk setting for the transmission of HIV and other blood borne viruses (BBVs) among people who inject[4], and this is particularly true for Indigenous people. Rates of hepatitis C in Australian prisons have been well-established by studies as high – with an overall prevalence rate of 35% among prisoners, and a much higher rate among inmates who identify as injecting drug users (58% among males and 78% among females) in 2007.[5,6] Information on the rate of HIV infection in Australian prisons is patchy, partly due to inconsistent HIV screening policies across Australia's various states/territories.[7] Most studies estimate a very low prevalence of HIV (<1%). Worldwide, however, the rate of HIV in prisons is much higher (for example, 8% in Canada, 28% in Vietnam and 44% in South Africa[8]).

These international figures are a major cause of concern for Aboriginal and Torres Strait Islander communities in Australia. If HIV rates within Australian prisons were to increase along similar lines, the rate of HIV in the Aboriginal and Torres Strait Islander population would surely increase due to:

- the gross overrepresentation of Aboriginal and Torres Strait Islander people in the adult custodial and juvenile justice systems;
- unique factors associated with incarceration for Aboriginal and Torres Strait Islander prisoners; and
- factors within prison settings that heighten the risk of HIV and viral hepatitis transmission.

Ever since the report of the Royal Commission into Aboriginal Deaths in Custody in 1991[9], the rate at which Aboriginal and Torres Strait Islander people are incarcerated has increased dramatically. By way of example, a report from 2003 indicated that indigenous female prisoners were the fastest growing prison population during 1993 to 2003, with a recorded increase of 343% over this ten year period.[10] Current figures indicate that Aboriginal and Torres Strait Islander people are still incarcerated more than any other identifiable population in Australia. In 2009–2010, 26% of the adult prison population were identified as Aboriginal and Torres Strait Islander, despite Aboriginal and Torres Strait Islander people representing just over 2% of the Australian population.[11] The proportion of Aboriginal and Torres Strait Islander inmates varies between states/territories, with 82% of prisoners in the Northern Territory identifying as Aboriginal and and/or Torres Strait Islander. In Western Australia it is estimated that over 4% of the total Aboriginal and Torres Strait Islander people resident in that state were incarcerated in 2009–2010, a rate 25 times that of non-Indigenous people.[12] Young Aboriginal and Torres Strait Islander people (aged up to 17 years) are also over-represented in the juvenile justice system, and are 29 times more likely to be in detention than non-Indigenous youth.[13] Although there are fewer Indigenous women in custody they are currently the fastest growing segment of the prisoner population, with the rate of incarceration increasing by 34% between 2002 and 2006[14], and Aboriginal and Torres Strait Islander women 23 times more likely to be imprisoned than non-Indigenous women[15].

The role of incarceration in driving HIV epidemics at a community level, and the impact of this on Aboriginal Torres Strait Islander people in Australia is less well-documented – however understanding this role is vital to ensure that we close all the gaps in Aboriginal Torres Strait Islander health in Australia.

The other unique factor likely to have an impact on HIV and blood borne virus transmission among Aboriginal and Torres Strait Islander people in prison are the characteristics of Aboriginal and Torres Strait Islander inmates themselves. They are younger (median age 30.6 for males and 31.5 for females, compared to 34.6 for non-Indigenous males and 36.1 for non-Indigenous females), incarcerated for shorter periods of time on average (two years compared to 3.6 years for non-Indigenous prisoners) and importantly, more likely to be re-incarcerated (76% compared to 45% for non-Indigenous prisoners).[16] These factors both directly and indirectly increase the chances of HIV and viral hepatitis transmission – both within the system and outside it.

Prisons and injecting drug use

Within Australian prisons, factors that increase the risk of transmission of BBVs such as HIV and viral hepatitis include the high number of prisoners injecting[17], poor knowledge among prisoners about health risks

(particularly among young offenders), and the quality of health care provision while in this setting. Although Australia has a prohibited drug policy prison environment, data from the 2004 and 2007 *National Prison Entrants Blood Borne Viral Survey* indicates that about a third of all inmates reported injecting drugs while in prison – an environment where clean injecting equipment is not available[18]. The knowledge of young offenders about how hepatitis C is transmitted is poor, with 50% of young offenders having no knowledge and only 10% knowing that sharing needles is a risk for transmission.[19] Research from the UK also shows that large numbers of people initiate injecting in the high-risk prison environment.[20] Finally, the prison population is transient, it being estimated that up to 50,000 individuals move through state and territory prisons each year, providing ample opportunity for prison-to-community transmissions. In NSW, a quarter of prisoners stay less than seven days, and the prisoner population is highly mobile with an estimated 220,000 internal movements of prisoners each year (due to routine activities such as day release, family visits, court transfers, and movements between facilities).

Culturally appropriate care – inside and out

Keeping the rate of HIV infection low requires vigilance on the part of communities and public health authorities, and prevention efforts need to address multiple factors. In prison settings, prevention measures such as access to testing and counselling, provision of condoms, drug treatment, safe tattooing, availability of bleach and access to clean injecting equipment should be freely available to all prisoners.[21] In spite of relatively little reported homosexual sex taking place in Australian prisons[22] condoms are routinely available in some Australian jurisdictions but injecting equipment is not. This discrepancy in harm prevention policy has no valid policy rationale, given the clear evidence of heightened risk due to the sharing of injecting equipment and the need to prevent transmission of BBVs in this setting.

In spite of calls for culturally appropriate health care for all prisoners and care that is equivalent to that received by the general public[23], very few Australian prisons deliver culturally appropriate health services – that is, services delivered by Aboriginal and Torres Strait Islander people to Aboriginal and Torres Strait Islander people. Such services should be available to Indigenous inmates within prisons, with continuity of care upon release to ensure community transition to appropriate health care and ideally, ongoing care via a local Aboriginal Community Controlled Health Service.[24] This model works in practice – a STI/BBV screening and education program led by Aboriginal Health Workers not associated with the correctional system resulted in identifying a number of previously asymptomatic and untreated cases. Widespread support for such programs could be an effective way to find and treat more infections and increase Aboriginal and Torres Strait Islander inmates' knowledge of risk behaviours for STI/BBV infection.[25]

The Aboriginal Community Controlled sector in NSW has been active in forging partnerships with Justice Health NSW and local facilities. Examples of partnership initiatives include regular clinical care education and training, including Aboriginal and Torres Strait Islander prison liaison workers in blood borne viral and injecting drug use management, and putting in place agreements for local Aboriginal Community Controlled Health Services to provide care to Aboriginal and Torres Strait Islander inmates at their local prison. Currently, all prisoners in Australia are denied access to the Medicare and the PBS schemes; provision of health services for prisoners is the sole responsibility of the states and territories. One potential impact of this is that external service providers such as Aboriginal Community Controlled Health Services (to name but one group) have to negotiate with prison health services regarding payment for services provide to Aboriginal prisoners. There is often disagreement over this and consequently many Aboriginal Community Controlled Health Services do not provide a service to their local prison. It has been suggested that Aboriginal Community Controlled Health Services could undertake the Aboriginal Health Check, provide second opinions for Aboriginal prisoners, or other culturally appropriate health care if Medicare and PBS were accessible to prisoners.[26]

The provision of adequate health care and prevention services within prison requires a concerted effort

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In spite of calls for culturally appropriate health care for all prisoners and care that is equivalent to that received by the general public, very few Australian prisons deliver culturally appropriate health services – that is, services delivered by Aboriginal and Torres Strait Islander people to Aboriginal and Torres Strait Islander people.

‘I have good life here’: a Vietnamese man’s journey to access services

By **Elizabeth Crock, Talitha Walklate** and **Serge Sztrajt**

Despite anti-discrimination laws, people living with HIV can struggle to access mainstream health care and welfare services due to covert discrimination. For HIV-positive people who have been involved with the criminal justice system, access to care and support can be even further compromised. In this article, we describe the arduous journey to access housing and support services for an HIV-positive Vietnamese man, Tran*.

Tran when we met

Tran, who is 51, was diagnosed with HIV in 2001 after he developed cerebral toxoplasmosis. He is partially paralysed and he uses a wheelchair. He also has a history of syphilis, tuberculosis, hepatitis C infection, depression and post-traumatic stress disorder.

Tran was admitted to hospital in 2009 for recommencement of antiretrovirals, which he had abruptly ceased some time before. He was referred to the HIV team at a community nursing service upon discharge.

Tran arrived in Australia as a refugee in the late 1980s. In Vietnam, he was a soldier, then a prisoner of war for 12 years. He started injecting heroin at 23, and was still using when we met. He lived in public housing flat in an inner city suburb, where he slept in the lounge room. The flat was dirty, dark, sparsely furnished. Other Vietnamese men regularly slept there, also in the lounge-room.

When our Team first assisted Tran, he had no privacy and little control over who stayed in his flat. He had limited English.

The initial request for HIV team support had been simply ‘to help Tran with adherence’. It soon became evident that he was actually very committed to treatment; after three months, his blood results improved, and he was keen to commence *Suboxone* for heroin detoxification.

Tran has two children and an elderly mother. Despite his desire to see his family, his level of drug use was restricting his ability to maintain contact. He wanted to live with his mother but her flat was not wheel-chair accessible.

As we got to know Tran, he spoke of his earlier life. After the war, he worked making charcoal until arriving in Australia as a refugee. He continued to experience symptoms of post-traumatic stress disorder.

One day, Tran presented us with a letter informing him of a hearing date at the Magistrates Court at the Neighbourhood Justice Centre (NJC). The NJC provides a range of services to people in the municipality, and Tran was currently accessing Victorian Legal Aid there. This letter revealed other aspects to Tran's life, and led to a fruitful and collaborative partnership between the HIV team and the NJC. As we provided care and support to Tran, we began to understand the multifaceted, systemic and cumulative obstacles he faced when seeking access to services.

Tran needed alternative accommodation. He identified two men living with him as his 'carers'; he said they assisted him with showering, cooking, laundry, taking him shopping and collecting his medication. It soon became clear that this assistance was sporadic at best. Our home visits were frequently interrupted by people entering, conducting transactions, and others waiting outside. Tran seemed unable to control his environment and we became concerned for his welfare, as well as for staff safety. We began asking others to leave upon our arrival, with minimal success. This compelled us to develop risk management strategies, so that Tran could receive equitable access to our services without compromising staff safety.

Tran's living arrangements restricted his access to mainstream and HIV sector supports, limiting his ability to improve his health and reducing the likelihood of successful heroin withdrawal. No professionals had visited to assess his needs prior to our involvement, so despite significant disability, Tran had no home modifications to assist with his care.

The barriers

Tran lived near the local Community Health Centre (CHC), so we arranged to meet there and discovered that Tran had an established relationship with Anh, a Vietnamese Drug Safety Worker at the centre. We finally had the cultural expertise needed to deepen our engagement. Anh was invaluable as he could clarify cultural misunderstandings. We also realised that some of our confusion and communication problems were related to cognitive deficits.

Tran was very much at risk from the men using his flat. He revealed being threatened, abused and was fearful for his safety. The need for him to find alternative carers and accommodation became pressing. We arranged for local council services to provide assistance to obtain his *Suboxone* treatment. Without the commitment of this council service to equity of access, and their perseverance despite difficult circumstances, Tran would not have succeeded in his heroin detoxification.

Tran's history of risky and illegal behaviour, cultural and linguistic background, post–traumatic stress and depression, community stigma of blood borne viruses, physical and emotional isolation from family, poverty and homelessness, posed multiple challenges in gaining access to services. We observed stigmatisation and subtle but systemic discrimination in attempting to access care. Rejections were mostly couched in rationalisation related to eligibility criteria or recommendations relating to a more appropriate service; discrimination based on stigmatisation is very difficult to prove.

We knew that neuropsychological testing was needed for Tran, and he also required an aged care assessment in order to access supported accommodation, so we persevered.

Persistent advocacy

Engaging assessment services required extraordinary advocacy. We contacted multiple services including specialist programs for older people; Tran was declined assistance as he was 'younger than the prescribed age range'. The Aged Care Assessment Team was reluctant to assess him: he was 'too young' for nursing home placement and 'didn't fit the criteria'. It was unlikely that any standard Home and Community Care package[1] (would meet his needs – his cognitive impairment and other co-morbidities necessitated intensive medical, nursing and social care of a level only currently available through residential aged care services.

The volatility of Tran's home environment and the pending court case spurred us on: in desperation, and with his permission, we applied for facilities in the Alcohol and Other Drug service system. No other mainstream service would take responsibility for Tran's overall management. We sought neuropsychology testing through two public hospitals and he was placed on a waiting list. His legal situation was urgent so we also sought testing through a specialist brain injury service.

Tran also suggested that he return to a Vietnamese hostel where he had once stayed for respite, however, securing

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Tran's history of risky and illegal behaviour, cultural and linguistic background, post–traumatic stress and depression, community stigma of blood borne viruses, physical and emotional isolation from family, poverty and homelessness, posed multiple challenges in gaining access to services.

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Tran a position on the waiting list proved nigh impossible. Staff at the hostel indicated reluctance to accept him due to his drug use and criminal history. This served as a reminder that sometimes having culture in common is insufficient.

At one stage, Tran was offered accommodation in a hostel for men with alcohol and mental health problems. We then received emails from the facility raising concerns: 'what if staff find a needle in his bed?' and 'should we provide a sharps bin?' We provided practical advice on harm minimisation but the bed offer was withdrawn.

The team's role was effectively by now one of advocacy and care coordination. Neuropsychology testing confirmed that Tran did have significant cognitive deficits, including difficulties with planning and organisation, cognitive rigidity, difficulty with abstract concepts, slowed processing and difficulty sustaining attention.

Watershed

Consistent with their aims and philosophy[2], the NJC remained optimistic and supportive of Tran's potential for rehabilitation and fortunately, Tran's Victorian Legal Aid (VLA) lawyer understood that this was a case requiring a multi–faceted approach to reduce the chances of a gaol term.

The VLA realised that Tran was in a cycle of dependency and violence that had little prospect of resolution as long as Tran was dependant on the 'carers' who resided in his property. It was clear that Tran required assistance for his daily living needs – he had no aids or equipment, having only a manual wheel-chair, and no rails or assessment had been performed to assist with self–management. Due to the lack of rehabilitation for his arm or hand, Tran was unable to inject himself without assistance and he had a long-term history with heroin.

The VLA lawyer reported that Tran had stated that at one point he had ceased heroin use and that as a result one of his co–tenants had pushed him out into the middle of a busy inner city street and left him to the traffic. He had also reported that someone in his flat had left the gas on and he believed that this had been deliberate. Meetings were held to strategise with Vietnamese welfare agencies, drug and alcohol workers, psychologist services, the police and with housing workers to resolve the ongoing problems. Each service could only provide limited assistance that did not involve assertive outreach. The court did not want to sentence Tran to gaol, however, unless he could abstain from heroin and find alternative accommodation, there was little alternative. Tran's court outcomes hinged not only on his remaining on *Suboxone*, but also on finding supported accommodation. These factors required further advocacy and persistence.

Persistence wins out

Tran was by now desperate. Just as hope began to fade, the HIV team received a call from the Director of Nursing of an 'ageing-in-place' facility offering Tran a bed. This facility sought solutions rather than obstacles; they described themselves as assisting people 'rejected by the system'. We moved Tran and his few belongings into their supported accommodation in a quiet suburb. Our team provided HIV and BBV education and support to the facility and the staff embraced Tran.

As we wheeled him through the door in his wheelchair, staff members including nurses, kitchen staff and the cleaner greeted him warmly, helping him to unpack and set up his room. Tran said in a clear voice with an enormous grin 'I have good life here'. He remains there today, happier and healthier, with family members and Anh visiting regularly.

Conclusion

We have described the journey to find appropriate housing and support services for a man living with HIV from Vietnamese background facing subtle but systemic stigmatisation and discrimination. Tran's HIV-positive status, physical and cognitive disabilities, Vietnamese refugee background, history of drug use and criminal history combined to severely restrict his access to health, welfare and accommodation services. These barriers were only overcome with a commitment to equity in health care, justice, strong advocacy, persistence and interdisciplinary teamwork. Through collaboration with key services with similar philosophies, we were ultimately successful in gaining access to permanent residential care for Tran.

Postscript: Tran's viral load is now undetectable and he has gained 20 kilograms. He has reconnected with family and they visit him at the hostel. He has made friends and attends group outings with other residents. He is receiving regular physiotherapy and says that he is drug–free for the first time in nearly 40 years.

*** Consent was obtained from Tran to utilise his story but identifying details have been changed.**

References

1 'Home And Community Care' eligible provision of in-home services for the aged and disabled.

2 The aim of the NJC is to resolve, where possible, the underlying causes or problems associated with the criminal activity. Their overall purpose is to reduce recidivism or incarceration; the term used is 'therapeutic justice'.

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Health care in custody: state fails its duty of care

By **Alexandra Stratigos** and **Iain Stewart Brady**

Any of us may face criminal charges at some time in our lives, possibly spending time in the state's 'care'. The period in custody may be brief – just an overnight stay in a 'lock up' – or a longer period in remand or serving a custodial sentence.

Whatever the nature of the charges and the period of custody, the state owes people in custody a duty of care. Part of that duty is to provide access to health care. But unfortunately, in our experience at the HIV/AIDS Legal Centre (HALC) the state is failing in its duty. As a result, people living with HIV who face criminal charges cannot assume that they will have access to antiretrovirals and other medication if incarcerated, or that their right to confidentiality regarding their HIV status will be observed.

This failure of the state to meet its duty of care can start from the time of arrest. HIV-positive people cannot assume that the police will understand that they need to strictly maintain their medication regime; that medical professionals who are consulted will understand the medication needs; or that the courts will accept that any custodial sentence may have a lasting and detrimental effect upon their life.

Police bail refused – short term custody

Where a person is taken into custody and charged with an offence, it is rare for a custody officer to be persuaded to grant bail if they had no intention of doing so based upon the facts of the alleged crime. Thus, if this occurs outside of court hours the accused person is looking at spending a night in police care. Having bail refused upon arrest is therefore the first point at which an HIV-positive person's health may be placed at risk.

The risk to health is due to lack of access to treatment. The Australasian Society for HIV Medicine's *HIV Management in Australasia: A Guide for Clinical Care*, points out this risk even for those on first line treatment:

> *Adherence (to antiretroviral medication daily dosages) is increasingly recognised as the critical factor in treatment success in most individuals. Suboptimal adherence is associated with loss of virological control, development of resistance to antiretroviral drugs (often with cross-resistance) and ultimately progression of HIV disease. Clinical studies have shown that optimal virological control requires 95% adherence … In practical terms, 95% adherence in a twice-daily regimen translates to missing no more than three doses per month.*[1]

It is vitally important for people who are reliant on medication to convey this to the police and/or custody officer.

There is no obligation upon an accused person to disclose their HIV status to police. An HIV-positive person on treatment should clearly, and non-aggressively, inform police that they have a serious and chronic illness that requires treatment. From HALC's experience with clients in this situation it can go one of three ways.

Police custody

Firstly, and most preferably, after the officers indicate that the person is to be refused bail (but prior to admission into the care of a custody officer), the accused person states their need for medication and that it can be obtained at their home. Police officers can then take the accused home to retrieve the medication and then return them to the custody officer. It is our understanding that this cannot occur following being refused bail by the custody officer, as the accused is considered to be a risk and thus must remain in custody until a court has determined bail.

Secondly, following the accused person informing police of their need for medication, they may be taken to the emergency department of a hospital to receive medication. We have observed problems with this due to

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the stigma associated with presenting to a hospital handcuffed and in police custody. In these circumstances, patients are immediately treated as dangerous criminals.

Emergency departments are also busy and the doctor or nurse speaking with an accused is unlikely to be a HIV specialist. Police are required to accompany the accused at all times, making disclosure of the person's HIV status to the police unavoidable, because hospital staff seeing the accused person may not know what HIV medication(s) the individual is taking and may seek clarification.

Such disclosures to medical personnel certainly attract patient privilege and likewise the *Privacy Act* restricts the use of such information by the police. However, these protections are unlikely to be of assurance to an accused HIV-positive person in custody.

Thirdly, informed of the need for medication, police may contact a doctor/ambulance/emergency department of a hospital. The officers then indicate to the medical professional what medication has been requested by the accused. The medical professional on the other end of the phone then may appropriately indicate that 'yes the person does require their medication' and then the process of attending an emergency department of a hospital commences. Or, more commonly from our observations, the medical professional says that it's fine for the person to miss treatment for a day, on the assumption that they will be getting bail the following day.

However, not being able to access the medication at the time of arrest isn't necessarily going to mean missing just one dose. Police can detain a person for up to four hours without charging them. However, if an individual is arrested after 1pm and held until 5pm or later, their case will not be heard by a magistrate until the next day. Assuming that bail is granted the following morning, the individual could still be discharged as late as 2pm, (allowing for average processing times). Therefore, in this scenario, an HIV-positive person on first-line treatment would have been detained without access to medication for over 24 hours, and could easily miss more than one dose of their medication.

Corrective services custody

Should a person be refused bail for a longer period of time or be given a custodial sentence, they are then faced with a more serious range of problems. The health needs of an accused or a convicted person in the custody of Corrective Services are assessed and met by Justice Health. Justice Health has a number of limitations on provision of services to people living with HIV. There is a relatively small HIV-positive population in NSW prisons – reportedly only 35 HIV-positive inmates in 2005.[2] Not surprisingly, there are limited visits by HIV specialist doctors to correctional facilities.

By way of example of the problems that can ensue, if bail is refused on a Saturday morning, the accused may be relocated to a corrective services facility later that day. From this point the accused's medical treatment is the responsibility of Justice Health. The Justice Health system is able to deal with common medical issues and medical emergencies, but is not geared to respond to more complicated medical necessity at short notice. Therefore, an accused taken into custody on a Saturday is unlikely to receive medication that day or the next, for the same reasons that they are unlikely to receive treatment in police custody.

Even once a person is appropriately receiving medication through Justice Health, inmates are often relocated between facilities – particularly those on remand. Our informants report that when inmates are relocated from one custodial facility to the next, their belongings (including medications) are not transferred at the same time – often arriving several days later. This once again causes breaks to a person's treatment regime – undermining the person's general treatment adherence and potentially elevating their viral load while in custody.

Another limitation upon Justice Health is that they can only supply Pharmaceutical Benefits Scheme (PBS) certified drugs. Therefore people on trial programs, including those who are drug resistant, will not be able to access treatment whilst in custody.

The following is a case study containing excerpts from a medical report provided by a reputed HIV specialist doctor for the purposes of court proceedings.

> *Mr 'X' had spent three and half months in custody for nine counts of various offences including drug related offences, outstanding warrants, and fraud. The longer Mr 'X' remained in custody the further his health was predicted to decline.*
>
> *Whilst Justice Health may make efforts to give inmates treatment for their various medical problems, the reputed HIV specialist states that;* "Mr 'X' has advance cancer and his right testicle is approximately three times that of normal size. Remarkably Mr 'X' states that he has tried in vein (sic) for approximately two and a half months advising Justice Health of his condition (I noted this reported many times on file) and has only now received an ultrasound. This having to be done before he could see a specialist Urologist."
>
> *Due to Mr 'X's plethora of medical problems he required specialist medical assistance. As noted by the doctor,* "Mr 'X's HIV virus has over time, as evidenced by his blood results for mutation and resistance, developed a severely resistant virus. This has narrowed his already small options for medication. Unfortunately whilst incarcerated I have been advised by Justice Health that he is only able to receive PBS approved medications, this worryingly cuts out a number of new therapies accessible through the hospitals whilst in the community."
>
> *The doctor then goes on to state that;* " … the lack of adequate medication

has inevitably been a mitigating factor in his acquirement of testicular cancer, as his chronic illness increases exponentially the risk of getting cancer".

It is relevant to note that at no point during court proceedings was Mr X's HIV status mentioned, however, his various health problems were taken into consideration when it came to sentencing. Confidentiality for this person was achieved by way of a letter to both the magistrate and the prosecution requesting that their HIV status not be directly referred to in open court due to the stigma and discrimination associated with HIV.

Disclosure in court

Within the court system there is an assumption and principle of open justice. Courts are slow to allow suppression of material before them, such as a person's HIV status, in accordance with that principle.[3] While there are indirect ways to bring HIV status, relevantly, to the courts attention, where the issue is before the court there will always be a risk of wide public disclosure of HIV status through its processes.

Due to the significant health risks that people living with HIV face in custody it may be beneficial to alert the court to a person's HIV status for consideration in bail applications and sentencing. However, it is understood that due to the stigma attached to HIV, people living with HIV may be reluctant to disclose their status to their legal representative and/or an open court. This is a hurdle that an accused/convicted person must cross so as to prevent possible lasting damage to their already vulnerable health. The courts are only able to consider what is put before them. If the court is unaware of a person's HIV status the health consequences can be severe and life-long.

To date, arguments that a determinate sentence should not amount to a life sentence have not been upheld in Australian courts, however it is clear that in determining sentencing and/or grant of bail an accused/convicted person's health may be considered as a 'mitigating factor' in sentencing and as a need for an accused to be released for another lawful purpose. As His Honour Chief Justice King states in *R v Smith* (1987) 44 SASR 587[4]:

> *Generally speaking ill health will be a factor tending to mitigate punishment only when it appears that imprisonment will be a greater burden on the offender by reason of his state of health or when there is a serious risk of imprisonment having a gravely adverse effect on the offender's health.*

Smith's case involved an HIV-positive person and has continued to be upheld to date.

Following sentencing, should an HIV-positive inmate come to the harsh realisation that there is a likelihood that their incarceration may result in their death from HIV-related illness or co-morbidities (we are not being melodramatic – consider the case of Mr X, above …), this may be too late to be dealt with by the courts. It is therefore important that that legal representatives are able to properly represent their clients not only by persuasively arguing for the best outcome from a legal perspective, but also in mitigating against disclosure of a person's HIV status in open court.

The consequences of the state failing its duty

Apart from the health consequences of interrupting a person's HIV treatment regime, and potential transmission risks associated with elevated viral load, a person whose health is compromised in custody is likely to be a greater burden on society once released. Adequate and responsive HIV care and management will properly reduce this risk. The purpose of incarceration is deprivation of liberty, and the state must take due care not to exact extra-juridical punishment, by neglect or mismanagement, upon prisoners in its care.

HALC believes that NSW is failing its duty of care to its HIV-positive inmates (and, presumably, to inmates with other medical conditions), at every step of the custody process. There are practical measures that would improve access to health care at each step. However there is also much room for improvement of the processes to ensure the best outcomes and care for people living with HIV who come into custody. This article has canvassed some practical measures to ensure access to treatment and confidentiality. More reliable and systemic outcomes would be achieved by promulgation and adoption of policy by police and emergency room units to deal with the particular issues in care raised by custody of HIV-positive people. HIV awareness training for police in high prevalence precincts would further enhance such policy to deliver better quality care outcomes.

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2 Offenders Program Unit NSW, *HIV and Health Promotion Program Summary November 2005*, 3.

3 See Woodroffe, M. (2011). Closed courts for open justice. *HIV Australia, Volume 8, No 4*, AFAO, Sydney, 17.

4 *R v Smith* (1987) 44 SASR 587 per King CJ at 589.

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Can regulation prevent hepatitis C transmission in prisons?

By **Jack Wallace**

Prisons are a one of the most regulated environments in the Australian community and yet prevalence of hepatitis C in custodial settings is disproportionally high – up to six times the rate found in the general population.[1] This has occurred because a high number of people are incarcerated for drug-related offences and many people enter prison after already acquiring hepatitis C. This is compounded by the fact that there are no needle and syringe programs (NSPs) in operation within any Australian correctional facility.

Michael Levy describes prison inmates as typically male, young, Aboriginal, ill, socially disadvantaged and isolated.[2] The Australian Bureau of Statistics reported that as at 30 June 2009, out of almost 30,000 people in Australian prisons, 93% were men and 25% of all inmates were Indigenous – with Indigenous people being 14 times more likely to be imprisoned than non-Indigenous people.[3] Hepatitis C transmission occurs at a far greater rate in correctional settings than in the broader community. The Kirby Institute (formerly the National Centre in HIV Epidemiology and Clinical Research [NCHECR]) estimated that up to 14,000 inmates held in prison during a survey period in 2005 were hepatitis C antibody positive, with 7,000 to 11,000 inmates living with chronic hepatitis C infection.[4] *The National Prison Entrants Bloodborne Virus and Risk Behaviour Survey 2004 and 2007* reported that the overall hepatitis C prevalence rates among prison entrants was 35% – this ranged between 21% in Western Australia to 42% in New South Wales – with higher hepatitis C prevalence among Indigenous inmates (43%) than non-Indigenous inmates (33%).[5] In one New South Wales study, incidence of hepatitis C transmission was described as 34.2 per 100 person years, or one in three inmates who inject drugs becoming infected with hepatitis C per year whilst imprisoned.[6]

Plethora of guidelines – help or hindrance?

The Regulating Hepatitis C: Rights and Duties research project at the Australian Research Centre in Sex, Health and Society (La Trobe University) investigated the regulations within adult correctional settings relating to the prevention of hepatitis C transmission. The project was funded by the Australian Health Ministers Advisory Council and proposed a model of regulation which embeds hepatitis C prevention within correctional settings. The project audited the regulations operating within correction settings, and interviewed key stakeholders working

in corrections, correctional health and health sectors. Quotes from these interviews are used in this article.

Each Australian state or territory regulates correctional services within their jurisdiction. While the names and structures of this regulation change, its essential nature and determinant of success is of supporting and reinforcing security. This approach dominates and limits the delivery of health services, including hepatitis C prevention interventions, at a philosophical and a practical level.

Correctional settings themselves are highly regulated, with more than 220 documents providing the regulatory framework in which hepatitis C prevention interventions are implemented. These regulations include discrete legislation authorising and describing the operational scope of correctional settings; public health strategies seeking to reduce the impact of hepatitis C or illicit drug use; agreements between correctional authorities and health or correctional service providers; reviews of correctional services; and employment contracts.

Within each jurisdiction, correctional authorities produce internal guidelines including policy, manuals, operating procedures, standards, instructions, standing orders and rules. These provide the regulatory framework in which health and hepatitis C prevention interventions are implemented in custodial settings. One jurisdiction has approved more than 200 individual internal policies, while another has more than 300 individual internal policies, separated into four different forms – each with different approval protocols. This regulatory environment has been described as 'unwieldy and confusing,'[7] and correctional authorities expend significant resources to maintain this level of regulation.

In spite of this vast array of regulation, one informant reported the role of legislation 'is virtually irrelevant' in reducing hepatitis C transmission within correctional settings. Another informant was clear that the impediment to preventing hepatitis C transmission within correctional settings had a far more essential aspect: 'The culture is the obstacle.'

Much of the legislation permitting health service delivery within correctional settings was described by informants as being out of date or tokenistic. In one jurisdiction, the primary legislation provides for a 'single medical officer' across a state-wide correctional system, while in another jurisdiction an informant noted that in legislation covering correctional settings, 'if you [search for] the word "health" it only comes up once.'

In New South Wales and the Australian Capital Territory, correctional legislation goes further by determining that the medical officer within the correctional system is responsible for reducing the transmission of infectious diseases, such as hepatitis C. However, while the medical officer provides advice to correctional authorities on reducing disease transmission, this advice can be ignored on the grounds of safety or 'good order.'

A comparable level of health care for prisoners?

Inmates in correctional settings are highlighted as a priority population in hepatitis C strategies at national, state and territory levels. The *National Hepatitis C Strategy 2010–2013* notes that 'the combination of the transmission of hepatitis C in custodial settings and prisoner recidivism presents a challenge to controlling hepatitis C infection both within these settings and in the broader community.'[8]

The major national-level regulatory statement describing the operation of correctional services in Australia is the *Standard Guidelines for Corrections in Australia*. This document states that a 'comparable' level of health care should be available in correctional settings, as is available to the general community.[9] This perspective is challenged by Australia's only independent reviewer of correctional services, the Office of the Inspector of Custodial Services in Western Australia, who recommends that given the poorer health status of people going through the correctional system, a need-based health service should be provided.[10]

Harm minimisation and harm reduction have provided the strategic approach to reducing the transmission of blood borne viruses within the community for over 25 years. Needle and syringe programs are the primary form of hepatitis C prevention within the community. The distribution of needles and syringes is now by prisoners 'it's highly unsterile, it's clandestine, it's secret, and it's very, very dangerous.'

Despite the lack of any regulated NSPs in Australian correctional settings, other hepatitis C prevention interventions are available. These include access to pharmacotherapy, distribution of bleach, access to testing, provision of information and access to condoms and lube. There are, however, contradictions occurring between various correctional services in terms of which interventions are supported, with voluntary hepatitis C testing being the only intervention available to all inmates Australia-wide.[11]

Even with access to testing, the aim of providing a comparable standard of health care to inmates is challenged in Tasmania, where legislation provides for pre- and post-test counselling for members of the general community, but is explicitly omitted in correctional legislation.[12] In another challenge to equitable health care, legislation in the Northern Territory permits the use of force when testing to determine 'the medical condition of the prisoner'[13]. This permission is not used by health service providers, nor is there any evidence of support for this testing from health authorities in the Northern Territory, but it reflects the outdated nature of some regulation affecting correctional settings and the challenges to the human rights of inmates.

The community standard of maintaining the confidentiality of test results is not adhered to by most correctional authorities. The rationale for this could be that identifying inmates with hepatitis C provides safety for the correctional workforce. Given the prevalence of hepatitis C in correctional settings, any safety thought

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to be gained by open disclosure of an inmate's hepatitis C status is illusory.

Access to bleach is important in the correctional setting, given the lack of access to sterile injecting equipment. Bleach is available in several jurisdictions, and in Victoria, is provided in sachets with instructions on how to clean injecting equipment. The distribution of bleach with cleaning instructions did not occur as a result of change of legislation or regulation, but on the initiative of a health worker. As an aside, bleach has been introduced in some jurisdictions with the truthful, but ambiguous description of it being a 'cleaning agent'. This sleight of hand provides for its distribution and a rationale for correctional staff to support this distribution.

In a reflection of the lack of consistency in protecting the health of inmates, while Victoria provides bleach sachets with instructions on how to clean injecting equipment, condoms are only available in the context of conjugal visits.

Other regulatory issues

While legislation and written forms of policy provide one form of regulation, other issues determine how hepatitis C prevention interventions are implemented within correctional settings. This includes which agency provides health services to inmates. Inmate health services within correctional settings are provided by health authorities, with the exception of Western Australia and Victoria. A recent report from Western Australia[14] highlights several conflicts in health services being provided by correctional authorities, including:

- A negative impact on clinicians of inadequate corporate support from correctional authorities;
- Poorer pay for clinicians working within corrections, with chronic understaffing and professional isolation, including difficulty keeping up to date with clinical accreditation;
- Lack of expertise in managing communicable diseases; and
- The philosophical approach of corrections leading to health service provision being affected by security concerns and cost, with interventions such as bleach distribution not supported by correctional staff.

The management of health services by correction services means that the health service provision occurs within a framework where maintaining security is more important than health care needs of inmates.

Other regulatory forces include political support for 'tough on crime' or criminal policies, the media, correctional officers' unions, health care worker ethics, health-related strategies, and agreements made between stakeholders including employment contracts.

Conclusions

A question posed by the Regulating Hepatitis C: Rights and Duties project was whether regulations can prevent the transmission of hepatitis C within correctional settings. The project found that there are essential systemic problems in providing health services within correctional facilities which affect the provision of hepatitis C prevention interventions within correctional settings. The nature of Australia's political system and the lack of coordination and leadership of the federal government in the operation of correctional services mean that elements of an effective regulatory regime have been instituted inconsistently across the country.

The project is proposing to health ministers a model of regulation in which hepatitis C prevention interventions are embedded within correctional practice. The key to this model is that the punishment of imprisonment should relate solely to the loss of liberty and not the diminished health of inmates. Prisoners should return to the community after their sentence with at least the same, or even an improved, health status as they did when they entered prison. This does occur in many instances, particularly when prisons can provide a stable environment and where correctional health services can provide regular access to medical care.

The proposed model of regulation uses a human rights model which accepts that people in prison have the same human rights, including the right to life, as all other members of the community. Human rights are legislated in the Australian Capital Territory and Victoria, and while there are some concerns about the effectiveness of this legislation, at least such statutory provisions clearly detail the relationship and responsibilities of the state and its citizens.

Other aspects of the model support the development of a culture of transparency. This challenges the role of maintaining security as the primary purpose of correctional authorities and provides for the systems and services to be independently and publicly reviewed – to challenge what is now an inward looking, defensive and risk-adverse correctional culture. The model allows for issues that are broader than security, the key focus and determinant of success of correctional authorities, to be acknowledged and addressed.

Legislation and practice in Western Australia leads in terms of this independent reviewer of correctional services through the Office of the Inspector of Custodial Services.

The model reinforces the intent of the *Standard Guidelines for Corrections in Australia* in relation to the provision of health services, but requires that these guidelines be modernised, fully implemented and evaluated. This implementation requires that health interventions reflect the World Health Organization definition of health as being more than the absence of disease and that health care services to inmates include the range of hepatitis C prevention initiatives in prisons, as is available to the community.

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From the inside out: injecting drug use in the Australian prison system

By **James May**

James May examines injecting drug use (IDU) in custodial settings by interviewing two people uniquely placed to give insight into the lived experience of people who use drugs in Australian prisons.

Mark is a former NSW prison inmate and is now a counsellor at Glebe House, a rehabilitation service for men in Sydney who are released from prison with drug and/or alcohol issues. He also counsels youth aged 15–18 at a NSW TAFE college.

Mark was an injecting drug user for ten years and spent several years in the prison system in the late eighties/early nineties. He also contracted hepatitis C (HCV) at some point during his time as a drug user.
He says there are plenty of drugs available in gaol and risky behaviour is commonplace, due to the secrecy and lack of time available to use. 'More than one person will often use at the same time,' he says. 'There were times when I saw the same pick [needle] being used several times in the one session, and again after that for months at a time. The syringe would break down and we had to sharpen it on matchboxes or the cement floor – anything really. You might have half an hour for a bunch of guys to have a hit with one pick, so there's no time to clean anything properly.'

Mark says there was very little known about hepatitis C in the late eighties when he contracted the virus. Back then it was called hepatitis 'non A/non B'. Inmates were tested randomly and given very little information or health advice if they tested positive. Mark assumed it would clear itself naturally and didn't take it all that seriously – generally no one did at that time. He says liver function tests were carried out in the early to mid nineties but there was very little follow-up information provided.

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From his own observations during his time in prison, Mark says that over 50% of the prison population were drug users, although he couldn't say how many injected. He also says that more than 60% of his fellow-inmates were serving sentences for drug-related crimes. 'Many people enter the system with raging habits, while others get a taste for it on the inside as a result of boredom, depression, frustration. Any drug you want is available, but downers are probably the most popular as they're harder to detect in your behaviour.'

While he knows of a few prisons with basic drug rehabilitation facilities, Mark says it's hard to keep these programs funded adequately due to the zero-tolerance attitude. However, better liver treatments have been made available in the last ten years and the prison setting can actually be a good place to undergo therapy, as there are fewer distractions than on the outside. Mark underwent treatment for hepatitis C and cleared the virus in six months. Although the treatment was pretty tough, he highly recommends it. 'You don't really know you're suffering liver damage symptoms until treatment is finished and you're healthy.'

Mark is very concerned about the lack of information given to his clients who are diagnosed with hepatitis C. 'They're often left in constant anxiety about treatment options or they don't take it seriously at all.' He says that pre-test and post-test counselling should be more rigorous and that there should be more education about the hepatitis C virus, both in prisons and in the broader community.

In terms of needle and syringe programs (NSPs) in gaol, he says that these programs have been very effective in the community, so they would help make a difference on the inside too. 'At least [NSPs in prison] could stem the overdoses and reduce the stigma. A drug user won't stop until they're ready so you may as well make it safer to use.'

Harm Reduction Victoria (HRV), formerly VIVAIDS Inc., has been educating drug users and advocating for their rights throughout the state for around twenty years. Nadia Gavin is Project Officer for HRV's Young Drug Users Project. She works primarily with young people aged 15 to 25, who are transitioning to injecting drugs, to educate them about the risk of overdose, vein care and blood borne viruses (BBVs). She also undertakes fortnightly peer education workshops at Melbourne Assessment Prison (MAP).

According to Ms Gavin, it's hard to capture accurate statistics about injecting drug use in the prison system or the transmission of BBVs. For instance, the testing methods used for hepatitis C only identify exposure to the virus and not current infection. However, there is plenty of anecdotal evidence to suggest that large numbers of inmates are sharing injecting equipment, so transmission of BBVs would be inevitable. It is also widely accepted that many people are already infected with hepatitis C before they enter prison, which makes it hard to quantify transmission inside the system. 'Drugs are expensive to purchase in prison and the most efficient way to administer them can be via injecting,' says Ms Gavin. 'Needle-syringe programs are not in place and multiple people are put in a situation where there is a need to re-use a cut-down syringe which enables the spread of blood borne viruses.'

The number of people incarcerated worldwide for drug-related crime is on the rise and has surpassed the numbers of those committed for violent offences. 'These people have been incarcerated for non-violent offences such as possession, personal use and trafficking. However, locking people up is not reducing crime, rehabilitating offenders or stemming the flow of blood borne viruses.'

In response to injecting drug use in prisons, Australia's first 'human rights prison' – the Alexander Maconochie Centre (AMC) – was opened in Canberra in the ACT in 2009. It was proposed to be the site of the first NSP in an Australian gaol, but the idea has yet to be implemented due to political and ideological disputes.[1] Ms Gavin believes that prison warden unions are concerned that injecting equipment will be used as weapons, although she says this has not proven to be the case in various European settings where NSPs have been introduced.[2] She says the AMC project may shed further light on IDU culture in prisons and the transmission of BBVs inside the system. 'For the first time, inmates will be tested on entering the system and once again when they leave. This could be the first time we've ever had reliable statistics on blood borne viruses transmitted in a prison setting.'

Between 2004 and 2008, HRV had a contract with the Department of Justice to run overdose education workshops in major Victorian prisons including Fulham Correctional Centre, Port Phillip Prison, the Melbourne Remand Centre (MRC) and Dame Phyllis Frost (Deer Park). HRV has also been conducting workshops for inmates at the Melbourne Assessment Prison over the last three or four years. 'There is a real need for education inside the prison,' says Ms Gavin. 'There are particularly high rates of overdose among people quite soon after release. Education needs to take place while they're inside because we lose track of them after that.' Once a fortnight, two staff visit the prison and conduct the education workshops. There is a high turnover at MAP and the workshops are well attended. There are ten different session plans which include information about overdose prevention, recognition and response, pharmacotherapy, the prevention and transmission of BBVs, hepatitis C treatment services in Victoria, and harm reduction strategies. The presenters use DVDs, group activities and group discussion to engage the participants.

Nadia Gavin would like to see genuine consideration given to NSPs in the prison system. 'When the HIV epidemic hit in the eighties, Australia was seen as a forerunner in the fight to curb infection rates, but we

seem to have gone backwards in terms of IDU and HCV infection, especially in prisons.'

The sharp end of the stick – the case for NSPs in prisons

In response to injecting drug use in prisons, many countries have established a variety of carefully controlled programs that allow inmates to access sterile needles.[3] The first such program was established in Switzerland in 1992. NSPs now operate in more than fifty prisons in twelve countries in Europe and central Asia, including in Spain, Portugal and Germany. Evidence from a report by Anex, a peak NSP body in Victoria, indicates the following benefits for staff and prisoners[4]:

- No observable increase in injecting or other forms of drug use;
- Reduced blood borne virus transmission;
- Reduced needle sharing and re-use;
- Reduced injecting-related health concerns such as abscesses;
- Reduction in needle-stick injuries for prisoners and staff;
- No instances recorded of needles being used as weapons; and
- Acceptance by staff and prisoners.

In 2010, the Australian Government issued a suite of six new national BBV and sexually transmitted infection (STI) prevention strategies, including new HIV and hepatitis C strategies, as well the *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*. Each of these strategies recommends that state and territory governments identify prisons for controlled NSP trials.[5] While NSPs were criticised as being 'soft on drugs' when first introduced in the community during the mid-to-late 1980s, they are now viewed as highly cost-effective health interventions that greatly reduce the number of BBV infections annually. In 2009, the Kirby Institute (formerly known as the National Centre in HIV Epidemiology and Clinical Research [NCHECR]) released health economics figures that found the provision of sterile injecting equipment and health promotion information had prevented 32,000 HIV and 96,600 hepatitis C infections across all states and territories in the previous decade.[6] Furthermore, all Australian states and territories support the harm minimisation approach to illicit drugs. This involves three principles: reducing the supply of drugs; reducing the demand for drugs; and reducing the harms associated with drug use. Of these principles, it appears as though only supply reduction and, to a lesser extent, demand reduction are currently being employed in Australian prisons.

Conclusion

There is substantial evidence to suggest that illicit drugs are widely available in the prison system in Australia and that injecting drug use is also widespread. Due to the nature of the prison setting, these practices are being carried out in hazardous ways that are contributing to the spread of BBVs and the risk of overdose. Anecdotal evidence suggests that large numbers of the Australian prison population are HCV-positive. With more reliable testing procedures being introduced in certain facilities, these numbers could well just be the tip of the iceberg. The prison system is inundated with people who have been incarcerated for drug-related crimes and therefore, it is in the community's interest to protect inmate health though effective peer education campaigns within corrective services. This could reduce the extent of risky injecting behaviours within prisons and the associated health and safety consequences.

Finally, we need to take heed of the warnings expressed by workers like Nadia Gavin and Mark, who speak from experience within the prison sector, particularly with injecting drug users. They would like to see the harm reduction measures that have proven so effective in the community applied equally well to the prison setting. Ideally, this would include the strengthening of peer education programs and the provision of NSPs within the prison system. This would have a huge impact on not only the health and safety of inmates, but would also benefit the broader community.

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Women in NSW prisons and hepatitis C: towards a more gendered approach?

By **Kat Armstrong** and **Linda Steele**

Hepatitis C is a significant issue for women in prison. The Women in Prison Advocacy Network (WIPAN) argues that addressing the issues of women in prison with hepatitis C requires an approach which acknowledges the gendered nature of this phenomenon and is responsive to the social and practical needs of women with hepatitis C, both within prison and after release.

In New South Wales, as is the case internationally, men still represent the majority of prisoners[1], with women constituting only 7.5% of inmates in full-time custody in NSW[2]. The *2009 Inmate Health Survey of NSW Prisoners* reported that 45% of women prisoners tested positive to hepatitis C – a significantly higher prevalence rate than that found in male inmates (28%).[3]

These findings reflect a consistent pattern of gender disparity in hepatitis C rates found in female prisoners in NSW, recorded since the first health survey of NSW inmates was conducted in 1996[4]; similar hepatitis C gender disparities among prison populations has also been noted in other Australian states[5]. Although data also suggests a substantial decline in hepatitis C rates in prisons for both men and women since 2001, hepatitis C prevalence figures inside correctional facilities remain alarmingly high – particularly for women inmates – when compared with the general population.[6]

The over-representation of hepatitis C in female prisoners occurs in a context of a continuing growth in the proportion of women prisoners in NSW prisons. In 1982, female inmates in NSW represented only 3.8% of all inmates in full-time custody in NSW. This figure increased to 6.2% in 1990, rising to 7.5% in 2009.[7] This phenomenon is also reflected in nationwide data – the number of sentenced males in prison increased by 275 (1%) from 30 June 2009, while sentenced females increased by 134 (8%) in the same period.[8]

Notably, Aboriginal women are significantly over-represented in the NSW female prison population, representing 29.4% of all women in full-time custody[9], yet representing only approximately 2.1% of the NSW female population[10]. Eileen Baldry noted in 2009 that Aboriginal women are 'the most rapidly growing group in prison, having increased disproportionately against both Aboriginal males and non-Aboriginal females over the past two decades'.[11]

Why an increase of women in prison?

The conclusion of the inquiry of the New South Wales Select Committee on the Increase in Prisoner Population[12] was that most likely an 'interaction of a matrix of factors' was affecting both the flow of women into prison in NSW, their numbers and the median time they spent there. There are many

steps from a person's actions to their imprisonment, and the nature of prison populations can be influenced by changes in a number of areas: criminal behaviour, legislation, policing, prosecution, conviction, sentencing and availability of appropriate correctional facilities. Given these influences, it is therefore difficult to identify any one cause for the increase in the proportion of women prisoners.[13]

Why is a gendered approach needed?

The Women in Prison Advocacy Network (WIPAN) is concerned that due regard is not being paid to the causes and effects of the significant gender disparities in hepatitis C prevalence in the NSW prison population – the statistics and issues noted above are confirmed by WIPAN's own experiences, with many of WIPAN's clients having tested positive to hepatitis C.

While all prisoners experience significant levels of disadvantage, women prisoners constitute a minority group with specific needs, both in prison and in the post-release period.[14] Unfortunately, prison and post-release services remain largely male-centred in their approach and fail to address the specific needs of women.

The need for a women-centred approach is particularly necessary in the context of hepatitis C. 'Recent and ongoing research into psychological and social factors linked to hepatitis C infection continues to find results that differ along gender lines'.[15] Although the national guidelines on hepatitis C in Australian custodial settings contain some important considerations for addressing hepatitis C in prison, the guidelines themselves are gender neutral and do not refer to gender-specific approaches or considerations.[16]

A complexity of issues: why are women prisoners disproportionately affected?

There are numerous common features to the pathways that many women take through the criminal justice system – pathways often characterised by childhood abuse or domestic violence, substance use, poverty, homelessness and disability (notably mental illness).[17]

Clients of WIPAN have demonstrated the complex interrelationship between victimisation (particularly domestic and family violence), substance use, homelessness and criminalisation. One women ex-prisoner identified the following issues for women with hepatitis C in the prison system:

- High-risk activities related to homelessness, sex work, addiction and lack of education;
- Hepatitis C as part of a cycle or network of issues: addiction leads to homelessness, leads to prostitution for drugs, and unpaid prostitution for company or protection on the streets; and
- A lack of awareness and safe practices about hepatitis C. For example, hepatitis C can be passed on by sharing a spoon (not just needles), but a lot of people either are not aware of this or do not practice this safely regardless.

The recognition of these broader issues and the response to them is important because without appropriate support in prison (to address trauma, relationships, substance use and health issues), as well as post-release (to address housing and financial, family and ongoing health and substance use issues), women risk re-entering situations of victimisation and disadvantage.

Current research on the issue of women prisoners and hepatitis C is largely grounded in health disciplines and has not drawn upon research in criminology, feminism or the social sciences concerning the social, political and cultural context of women's imprisonment, women's sexuality and women's health. This can result in a real failure to appreciate the broader factors that characterise the issue of hepatitis C in prison.

Another women ex-prisoner, who had tested positive to hepatitis C and spoke to WIPAN about her experiences in custody did not feel that the current approaches to hepatitis C were adequate and made the following observations:

- Women in prison continue to be at risk of hepatitis C because of the drugs and needles that come into the prison system. Although there are very few needles coming into the prisons, the ones that do get through are being used over and over again by lots of women. Depending on what prison you are in and/or what section, there is not always access to bleach for rinsing needles; and
- Alcohol and other drug (AOD) programs for women in prison are only available for sentenced women with a release date and/or who are being set up with parole. In any case, not all sentenced women get access to these programs. This means that women on remand cannot engage in an AOD program. Also AOD programs are group programs and many women will not go to them because they are paranoid about opening up or cannot share honestly due to the responses of other prisoners. (The woman in this example said she would not go to the clinic due to staff name calling and what she described as an abuse of power, which left her feeling inadequate). An AOD counsellor should be available to all women prisoners, in all prisons on a regular, one-to-one basis.

The need for realistic acknowledgement of the 'poverty of prisons' has been suggested by McCabe who argues that 'there is a need to educate women

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Unfortunately, prison and post-release services remain largely male-centred in their approach and fail to address the specific needs of women.

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to inject and tattoo safely with their limited resources'.[18] Other researchers share this view. Dolan, for example, suggests prisons should facilitate safer injecting or non-injecting routes of administration.[19] It remains a crucial component of our understanding of the issues for women to have open dialogue with women prisoners so that we are well-positioned to learn from their lived experience and to help to inform future solutions.

Action – what is required?

WIPAN believes that no prisoner should exit prison unhealthier than when they entered. We also believe that women in prison should have the right to access health services equivalent to those available throughout the general community. It is detention from society that is the penalty applied to the prisoner, not the conditions under which they are detained.

Given the sharing of drug injecting equipment, the risk of a women prisoner contracting a blood borne viral infection (such as hepatitis C or HIV/AIDS) continues to exist, increasing the possibility of a prisoner leaving the prison of detention with a poorer state of health than when they entered. If prisons are to achieve the goal of providing a higher standard of prisoner rehabilitation and staff safety, the introduction of a needle and syringe program (NSP) must be pursued to minimise the risks to both Corrections Officers and prisoner health and rehabilitation outcomes.

Various countries have effectively operated needle and syringe programs in their correctional facilities: including Switzerland, Germany, Spain, Luxembourg, Iran and Portugal. Overall, prisons with NSPs have not resulted in increased drug use, have not caused security or safety concerns, and have reduced the risk of needle stick injuries to prison staff. Evaluations have shown that NSPs actually make prisons safer. NSPs also result in more people accessing drug treatment, (Royal Australasian College of Physicians).

WIPAN strongly suggests that hepatitis C and women in prison should be seen and treated as a gender issue, in research, policy development and service delivery. These complex social issues involved in women prisoners' experiences of criminalisation and of hepatitis C require targeted services specifically for women prisoners.

As stated, there should be particular attention to the issues and needs of Indigenous women, women from culturally and linguistically diverse backgrounds, and women with a disability. Most importantly, researchers, policy makers and service providers need to be receptive to the voices of women prisoners themselves.[20] WIPAN believes that if women prisoners are to be effective in making responsible and positive choices, they should be given a voice and allowed to play a vital part in finding the best outcomes for their overall situations.

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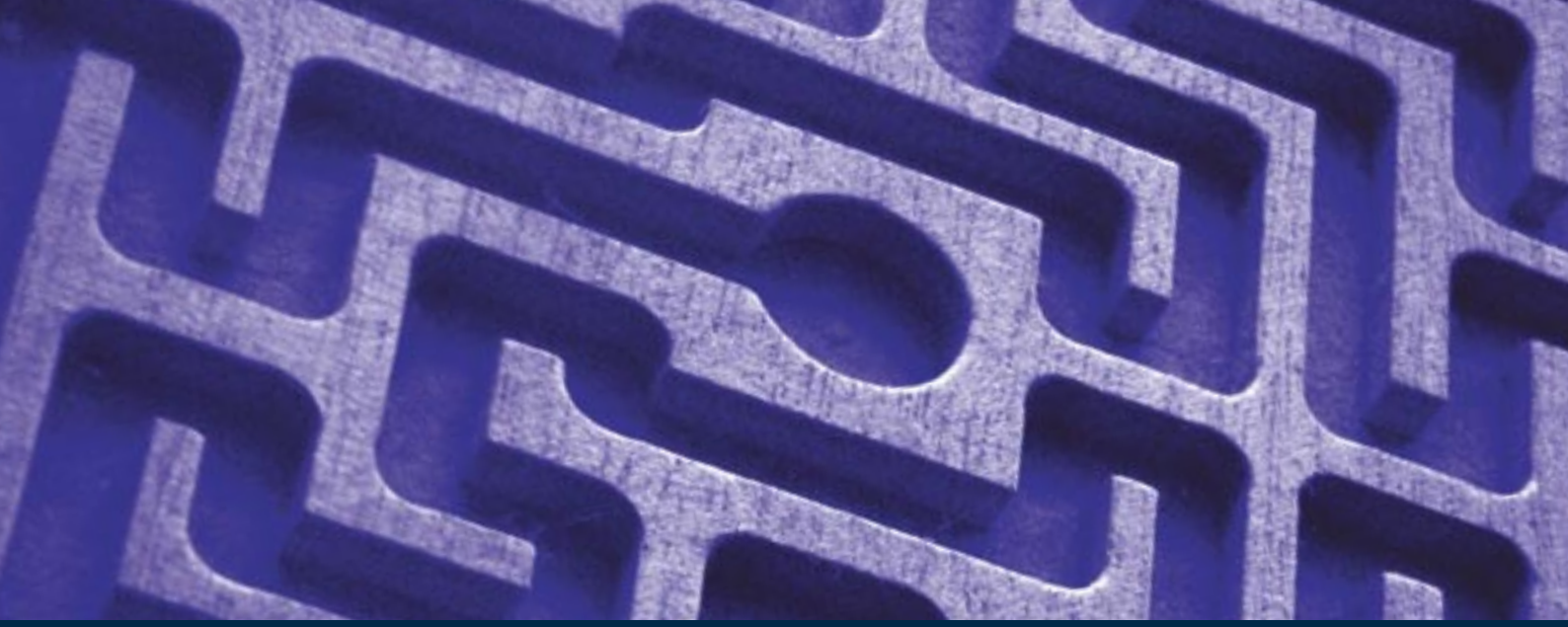

Navigating complex pathways: people with mental health disorders and cognitive disability in the criminal justice system in NSW

By **Professor Eileen Baldry**

People with mental health disorders and/or cognitive disability (MHDCD[1]) are over-represented in criminal justice system. Individuals with mental health issues or cognitive disorders are more likely to engage in high-risk behaviours, making them more vulnerable to contracting sexually transmissible infections (STIs) and blood borne viruses (BBVs) than those in the general population[2,3]; however, little is known of how or why so many persons with MHDCD (excluding forensic prisoners) end up in prison instead of in disability, care and health support services.

Interventions to prevent some persons with MHDCD from long-term involvement with the criminal justice system are hampered by lack of overall and longitudinal understanding of the human services and criminal justice system. Research is needed to provide better understanding of the life experiences and pathways that lead people with MHDCD into the system.

Building a dataset of knowledge

The MHDCD in the criminal justice system study (the study), based at the University of NSW, is building knowledge about these 'pathways' and experiences by linking data from the criminal justice system with Health and Human Services data.

Organisational partners for the study include Corrective Services NSW, NSW Police, Juvenile Justice NSW, Justice Health, Housing NSW and the NSW Council for Intellectual Disability. Data were also provided by Bureau of Crime Statistics and Research (Australia), Legal Aid, Ageing Disability and Home Care, Community Services, and the NSW Department of Health.

The study involves a cohort of 2,731 people sourced from the 2001 NSW Inmate Health Survey and from the NSW Department of Corrective Services Disability Unit Database. The project aims to collate detailed data on the life-long criminal justice involvement for this cohort of prisoners, by using linked but de-identified extant administrative records.

Through this innovative approach, the study aims to create criminal justice life course histories that describe individual and group experiences within the system. Linking data from the criminal justice system with Health and Human Services data is revealing a clear picture of the multiple factors contributing to the complex pathways travelled by people with MHDCD as they enter and navigate through services – both in the community and within correctional facilities.

Initial findings

In broad terms, pathways through community support agencies and criminal justice institutions for people with complex needs (such as dual/comorbid diagnoses and multiple combinations) can be affected by a range of factors. When compared to their single and non-diagnosis counterparts, our initial research findings indicate that people with MHDCD face significant hurdles, as outlined below.

People with MHDCD:

- experience low rates of court diversion and higher rates of Juvenile Justice contact;
- face higher rates of convictions with higher rates of low level offences;

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Regional Feature: Using animation to confront stigma, discrimination and low perceptions of personal risk to HIV/AIDS in Chiang Mai, Thailand

By **Christopher S Walsh**

Mplus is a small community-based organisation, based in Chiang Mai, Thailand, committed to reducing high-risk sexual behavior and stemming the spread of HIV. In 2008, Mplus produced a series of screen-based animations for use in real-time and online peer-based HIV outreach and prevention activities targeting men who have sex with men (MSM), male sex workers and transgender people.

The animations were produced with funding from the Australian Federation of AIDS Organisations' small grants program (2008) and have become part of Mplus' innovative suite of HIV outreach and prevention resources. Mplus outreach workers take condoms and safe-sex information – including the animations – to places where men meet other men for sex. This includes public spaces (parks, clubs, public toilets, beats); sex venues (brothels, go-go bars, saunas) and online spaces (chatrooms, social networking sites).

HIV prevention during a time of political crisis

Despite a history of successful government-led public HIV education campaigns during the early 1990s, funding for HIV prevention programs in Thailand has reduced dramatically over the past decade.[1] Prevention programs are not adequately reaching men who have sex with men, male sex workers and transgender communities.[2] These groups remain highly stigmatised and socially sanctioned members of Thai society. Thailand has also been experiencing an ongoing, often violent, political struggle between the People's Alliance for Democracy ('yellow shirts') and the People's Power Party ('red shirts'). This is particularly acute in and around Chiang Mai.[3]

Mplus is concerned that this social upheaval – in tandem with the already existing stigma and discrimination that affects communities of men who have sex with men, male sex workers and transgender people – could precipitate increased HIV infection in these populations already at a disproportionately high risk of acquiring HIV.

An estimated one-fifth (21%) of new HIV infections in Thailand occur in men who have sex with men.[4] Research indicates that these men are at a higher risk of contracting HIV in concentrated tourism areas such as Bangkok, Chiang Mai and Phuket.[5] A 2008 demographic survey found that HIV incidence among men who have sex with men in Bangkok increased from 17% in 2003 to 28% in 2005, and 31% in 2007. The rate of new HIV diagnoses in Chiang Mai rose from 15.3% in 2005 to 16.9% in 2007, while rates in Phuket increased from 5.5% to 20% in the same time period.[6] The study also found that half of the men surveyed do not use condoms and indicated that male commercial sex workers (Thai and migrant) are at high risk of contracting HIV because of unsafe sexual behavior.

A 2010 study of young men who have sex with men (15 – 24 years) in Bangkok, Chiang Mai and Phuket found high levels of inconsistent condom use among its cohort. Of the 837 participants, 33.1% were men who engaged in non-transactional sex with other men, 37.7% were male sex workers and 29.1% were transgender-identified. The study found that 46.7% of men who have sex with men, 34.9% of male sex

workers and 52.3% of transgender people reported recent inconsistent condom use.[7]

Rethinking HIV/AIDS outreach and prevention

In light of the above statistics and context-specific realities in Chiang Mai, Mplus felt that an innovative approach to HIV prevention was needed, and believed animations would enhance their existing suite of HIV/AIDS resources and approaches. To produce the animations, Mplus conducted behavioural research on the sexual practices of three target communities: young men who have sex with men, male sex workers and transgender people within the local community. Through a capacity building exercise, Mplus outreach workers and volunteers from the three target community groups designed an interview survey to uncover contextualised sexual practices unique to each of the three target communities. After analysing data generated from the interviews, Mplus co-authored a series of narratives, drafted storyboards and produced animations using context-specific examples that reflected the risky sexual behaviours reported in the interviews.

Mplus has found that the animations have been successful in helping the three target groups better understand the risks associated with sexual activities and the consequences of unsafe sex for themselves and their partners. The animations also confront the stigma associated with getting tested for HIV and misconceptions about what it means to test positive for HIV. Mplus outreach workers distribute the animations (via Bluetooth) and play them on mobile phones and MP3 players during their HIV/AIDS outreach and prevention programs. The animations are also available online from Mplus's website (www.mplusthailand.com) and on YouTube. Mplus outreach workers also encourage individuals to share the animations amongst their social networks (both online and offline) via Bluetooth and through social networking websites.

Five animations to teach about safe sex, human and legal rights

Mplus now routinely uses five animations in their HIV outreach and prevention activities. The first animation (see Figure 1) helps viewers – specifically young men who have sex with men – understand the risk associated with unprotected sex, alcohol and how to properly use of a condom.

The second animation (Figure 2) focuses on empowering transgender people to negotiate condom use with their partners, and acts as a catalyst for informed discussion in outreach that goes beyond simply advocating condom use. The animation focuses on raising awareness, self-esteem and promoting transgender solidarity.

The third animation (Figure 3) targets Thai and migrant male sex workers. This animation was produced in Burmese, Karen and Shan language versions, providing outreach workers a unique resource that transcends language barriers. This animation provides safe sex information and promotes conversations with other sex workers who share the same ethnic background. Mplus also provides migrant sex workers referrals to community-based organisations that can provide them with additional health and legal information.

The fourth animation (Figure 4) was produced for 'hidden MSM', who are difficult to target with HIV prevention messages.[8] Male-to-male sex between these often heterosexual-identified men tends to happen quickly, and this lack of time, combined with location can lead to unsafe sex.[9] This animation aims to educate men about the importance of always practising safe sex to prevent the spread of HIV within sub-populations and the wider community.

Drawing on the success of the animations, Mplus formed a new collaboration with The Open University (UK) and Bridges Across Borders South East Asia Community

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Figure 1: Mplus animation for young MSM. (http://www.youtube.com/watch?v=v9oelhJ4GYg)

Figure 2: Mplus animation targeting the transgender community. (http://www.youtube.com/watch?v=2aYGbzt6VeA)

Figure 3: Mplus animation for male sex workers. (http://www.youtube.com/watch?v=L77lug-MbJc&feature=related)

Figure 4: Mplus Animation for 'Hidden MSM'. (http://www.youtube.com/watch?v=sU36WxoMZF4)

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Figure 5: Mplus/BABSEA CLE animation educating transgender people who have experienced sexual violence about accessing legal rights and Post-exposure Prophylaxis in Chiang Mai, Thailand.

Legal Education Initiative (BABSEA CLE)[10] to produce a fifth animation for transgender people who have experienced sexual assault. The animation presents narratives collected from the local transgender community about their experiences of rape and the injustices they faced when reporting the crime to police. The animation teaches people who experienced sexual violence how to access free legal counsel at the Chiang Mai University Legal Clinic and access assistance in reporting crimes to the police. It also teaches sexual assault victims about the availability of Post-exposure Prophylaxis (PEP).[11]

Animations confronting stigma, discrimination and low perceptions of personal risk to HIV/AIDS

Mplus' animations have been successful in helping educate men who have sex with men, male sex workers and transgender people about the risks of acquiring HIV. The animations also model practical ways of negotiating safe sex with potential partners and/or clients. Although the animations can be used as stand-alone HIV prevention resources, they are particularly powerful when used in outreach and prevention, because they act as catalysts for conversation about how bodily fluids transmit the virus and the kinds of scenarios where risky behavior may lead to HIV infection. To correctly emphasise these factors, Mplus produced the animations in close collaboration with educators from the McCormick Faculty of Nursing, Payap University (Thailand).[12]

The animations were made available on YouTube in July 2009, and collectively they have been viewed more than 100,000 times. In September 2010, Mplus launched an online outreach and prevention program entitled 'The Chiang Mai Sexperts' where the animations are also used to promote conversations around safe sex, dealing with discrimination, and other key topics including human rights, health education, sexually transmitted infections, hormone use and gender reassignment surgery.

Continuous stakeholder involvement was an integral part of the production process of these HIV prevention resources. The involvement of volunteers from the three target communities throughout the entire project ensured the animations were relevant and addressed the specific prevention needs of the intended audiences. The program also provides a non-colonising capacity building experience where community/peer educators are trained with the skills and knowledge required to educate clients on how HIV is transmitted, how HIV infection can be prevented and how to protect the basic rights and dignity of men that have sex with men, male sex workers, transgender people and their sexual partners.

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The Australian Prisons Project: http://www.app.unsw.edu.au

Researchers from the Australian Prisons Project (APP) report on this innovative Australian research project, which is making a range of prison-related resources accessible online.

The Australian Prisons Project is a multi-investigator, cross-jurisdictional, Australian Research Council funded project, based at the University of New South Wales.

The project seeks to bring together the Australian experience of prison development and reform occurring from the 1970s to present day with broader penological theory.

A broad range of publications, research documents and state and territory specific information on Australian correctional facilities are all available on the project's website, including information about key changes in penal law policy and practise in Australia, and its states and territories, over the last forty years.

Key themes explored by the project, as reflected in the research available online, include the massive and continued growth of the Australian prison population across all jurisdictions since the 1980s – evidence of the re-emergence of imprisonment as a frontline criminal justice strategy in this country.

The project also examines the current shift towards mass imprisonment in Australia, which appears to represent a policy solution to the political problem posed by law and order politics, rather than a measured response to any marked increase in crime. APP research indicates that it is not unusual for contemporary Australian prisons to have design capacity to hold 1,000-plus inmates.

Importantly, it is clear that more marginalised and less powerful social groups have borne the brunt of growing prison numbers and the greater part of the social and economic costs inevitably associated with this growth. Reflective of this phenomenon in recent times are, for example:

- the large-scale 'warehousing' in prisons of persons with mental health issues;
- the significant increases in women's imprisonment (with little corresponding shift away from an existing male-centric focus within programs and policy to accommodate women's particular needs and circumstances, both pre- and post-release); and
- the highly 'racialised' punishment, with the two jurisdictions with the highest imprisonment rates (NT and WA) housing the largest proportion of Indigenous people living within their boundaries.

The project has investigated how these events do not result simply from changing 'policy settings', but are also genealogical descendents of major cultural forces shaping Australian society.

In this context, the project has researched the potential for justice re-investment to be part of a workable solution to high rates of incarceration (including re-imprisonment) of Indigenous people in Australia.

Justice re-investment, which diverts a portion of corrections budgets back into communities with high rates of offending in order to finance community-based initiatives aimed at reducing criminal behaviour and rates of recidivism, has led to reduced incarceration in high-imprisoning states in the USA and may be suited to the particular circumstances of Indigenous communities due to its focus on local ownership of relevant initiatives and redressing broad social disadvantage, for instance.

Further findings of the project include those relating to the dramatic increase in the use of remand in all Australian jurisdictions since the 1970s, which has inevitably pushed up overall prison numbers. APP research in this area reveals much about the dynamics of penal culture as it is played out between government and the judiciary in Australia, raising broader penal concerns about the association of danger and risk with particular types of offenders and crimes.

In addition, the project has been examining the introduction of post-sentence preventive confinement in the bulk of Australian jurisdictions post-2003; that is, continued detention or intensive community supervision of sex offenders who would otherwise be released at completion of a finite sentence of imprisonment. APP analysis in this area considers the meaning of such schemes within the changing cultural landscape of imprisonment, wherein the prison is increasingly imagined as a viable solution to 'unsavoury' characters as well as to criminal offending itself.

Post-September 11 2001, APP research is also looking at the way in which the spectre of terrorism, the technologies of risk and the politics of fear have provided justification for a range of security-based measures in the penal environment, including the use of 'supermax' style facilities to accommodate terrorists and other 'high-risk' inmates.

The APP has produced numerous analyses of prison and sentencing developments, as well as analyses of particular groups in prison. These, along with other key research findings, are contained in various papers produced by the project, available on the APP website. The project will conclude in 2011.

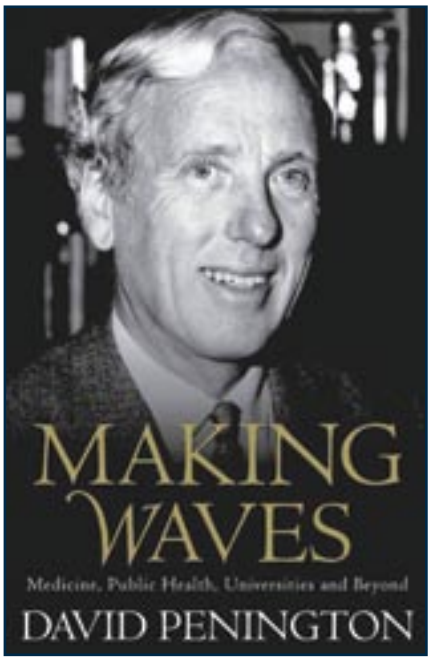
For further information about the project, or to contact the project researchers, visit the project website http://www.app.unsw.edu.au

Reviewed by **Jennifer Power**

Anyone who had anything much to do with HIV/AIDS in the 1980s might have heard of David Penington. As Chair of the Commonwealth Government's AIDS Task Force (1984–1987) Penington, a haematologist and medical academic, often came to blows with the gay community. In written histories of HIV/AIDS in Australia, Penington is usually remembered as the most vocal representative of a conservative medical elite that resisted gay community efforts to be involved in any political or medical decision making regarding HIV/AIDS.

Penington's autobiography (*Making Waves: medicine, public health, universities and beyond*) is a bit of a rejoinder to these histories. Penington doesn't see himself as an enemy of the gay community (although the tension between him and many gay men who were working in government, medicine or the community at the time is scorchingly evident in this account). In fact, Penington is resolute that his commitment to reducing the spread of HIV was about protecting the gay community.

Throughout this text, Penington is at pains to explain that the driving force behind his career was a commitment to social justice inspired by his intellectual upbringing and Christian values. He considers himself a bit of a radical in the medical establishment – and possibly he was. Medicine was a



conservative beast in the 1960s and 70s and Penington no doubt created a few waves through his efforts to introduce publicly funded medical services into disadvantaged areas. He also utilised opportunities presented by the short-lived Whitlam government to sew a few seeds of acceptance, within resistant medical ranks, for a national health insurance scheme.

But I do get a sense that Penington never fully appreciated where the gay community was coming from in those early years of HIV/AIDS. He was being asked to work with people who genuinely feared they could be subject to intense persecution as a result of this virus. Yet there is a certain lack of empathy in his account of this – Penington is obviously cynical about the need for 'gay rights' to be part of the HIV/AIDS agenda (although he clearly enjoyed the novelty of meeting with brothel owners and taking study-tours of sex-on-premises venues).

In fact, overall, as much as Penington wants to tell his readership about his passion for justice and medicine, his account of his life is strangely lacking in emotion. As a reader, I got lost in the complex and disjointed descriptions of people, places and events and found it bizarre that the details of his private life (his marriages, his affair, his children) are described as matter-of-factly as his political or academic associations. Indeed, the account of his first marriage and the birth of his first child are slipped in under the subheading 'Clinical Education in Oxford'. Whether this is a reflection of the man or a lack of editorial attention I am not sure.

That being said, if you can work your way through the minute details of Penington's writing, this is a wonderful history of the Australian medical system and the teaching of medicine in Australian universities from the perspective of an important 'player'. For people interested in this history, this book is worth a read.

***Making Waves: Medicine, Public Health, Universities and Beyond*, by David Penington, Melbourne University Publishing, 2010.**

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facilities and services. In addition, the *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013*[31] states that limited access to confidential and culturally appropriate health services exacerbates the challenges to Indigenous prisoners' health and wellbeing, and that routine screening and vaccination for BBVs and STIs should be introduced in prison and juvenile detention facilities.

The message is clear

This overview clearly reveals that Australia needs to pay heed to international studies that show the efficacy of prison-based NSP programs, and to Australian studies that highlight the need to target female and Indigenous inmates in prison-based BBV prevention programs. The rate of HIV in prisons may remain low in the general prison population, but data showing increasing rates of injecting drug use among Indigenous and female prisoners should not be ignored.

The views contained in this paper are those of the author and do not represent the Australian Government.

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where the prison system allows the community sector to take a lead role in implementing workable policies. A longer term solution is to eliminate the grossly disproportionate rate of imprisonment of Aboriginal and Torres Strait Islander people in Australia and is one important part of the picture of genuinely addressing disadvantage and the 20 year gap in life expectancy that Aboriginal and Torres Strait Islander people currently face in Australia.

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Regulation can provide a correctional environment in which hepatitis C transmission can be prevented. The challenge is to ensure that best practice can be implemented across the country.

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- are likely to have experienced earlier and more frequent contact with police;
- face higher rates imprisonments (particularly remand) from an earlier age, with shorter and more frequent prison episodes and higher continuing lifelong episodes within the criminal justice system;
- have poorer physical as well as mental health, and higher rates of alcohol and other drug use problems than those without these diagnoses;
- have experienced very poor school education and low disability service recognition and support. Although people with MHDCD have high levels of housing service support, they have high rates of tenancy failure; and
- Those with dual diagnosis of mental health and cognitive disability have higher levels of ongoing life-long criminal justice involvement than those with single or no diagnosis Those with cognitive impairment in combination with any other disability had the highest rates of involvement with the criminal justice system.

Other findings include:

- Overall, the average National Offence Index rating of the study cohort for all offences was in the lowest (least serious) 10%; and
- Only one quarter of those in the Intellectual Disability (ID) range (IQ below 70) and virtually none of those in the Borderline Functioning range (IQ between 70 and 80) were clients of Ageing Disability and Home Care (ADHC). Of those individuals who were clients of ADHC, 79% became clients only after going to prison. Those becoming clients of ADHC after going to prison fared significantly better than previously, and better than their peers with disability who were not ADHC clients.

Sub-groups within the cohort

Aboriginal people

Aboriginal people in the cohort face significant disadvantage when compared with non-Aboriginal people, with higher re-imprisonment cycling rates, higher rates of conviction for nuisance and cumulative offences, and higher rates of complex needs diagnoses

We believe that providing more timely, targeted and culturally appropriate support for Indigenous persons – 24% of the cohort – would reduce the chance of eventual imprisonment for this sub-group.[4] Such support is needed at a variety of particular points such as in early school, early family support, and through childhood disability support services.

Women

Women with complex needs have a significantly higher number and rate of custodial episodes than their male counterparts, but men spend a significantly greater number of days in custody than females.

Theoretical directions of the study

One early theoretical direction being taken by the study is to explore the nature of the space in which people within the cohort live. They appear to be cycling around in a liminal, marginalised, community/criminal justice space in which housing/homelessness is a key factor.[5,6] This is not just attributable to social exclusion; it is centred on the development of a life space straddling the community and criminal justice institutions, into which these persons are funneled. This space is created through a confluence of personal, systemic and institutional circumstances that are currently poorly understood.

We hope that this research project, in developing a dataset of knowledge, will result in a greater range of evidence, including aggregated pathway analysis of various sub-groups of people with comorbid and complex mental health disorders and cognitive disabilities, to support directing more individuals into support and care structures outside of the criminal justice system.

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TREATMENT BRIEFS

High prevalence and incidence of anal pre-cancerous lesions in men with HIV; HAART has little impact

Prevalence and incidence of high-grade pre-cancerous anal lesions in HIV-positive men who are taking antiretroviral therapy are high, Canadian investigators report in the online edition of *Clinical Infectious Diseases*.

A low nadir CD4 cell count and infection with HPV types 16 and 18 were associated with an increased risk of developing high-grade pre-cancerous anal lesions (AIN-2, 3).

The investigators hope that their findings will help identify patients who have a higher risk of HPV-associated anal disease.

Rates of HIV-related opportunistic infections have fallen significantly since the introduction of antiretroviral therapy. However, the incidence of anal cancer is increasing.

Most of the information about the risk factors for this disease in HIV-positive gay men was obtained during the era before effective antiretroviral therapy became available. These include high-grade pre-cancerous lesions, infection with HPV 16 and 18, multiple HPV infections and CD4 cell count.

Investigators from the Canadian Human Immunodeficiency and Papilloma Virus Research Group (HIPVIRG) wanted to establish a comprehensive understanding of the risk factors for progression to AIN 2 and 3. They also wished to see if treatment with anti-HIV drugs had any impact on disease progression.

Current CD4 cell count was not associated with disease progression, and there was only very modest evidence that therapy with anti-HIV drugs had a protective effect. Incidence of AIN 2 and 3 was slightly reduced among patients who had been taking HIV treatment for four or more years.

'We … found that men who had received their current HAART regimen for a longer time had a lower risk … especially after adjusting for nadir CD4 cell counts. This suggests that, although one cannot fully recover from HIV-induced immune deficiency, HAART could have some beneficial effect in reducing the risk of AIN-2,3,' comment the authors. They conclude, 'our study confirms the high prevalence and incidence of AIN-2,3 among HIV-infected MSM.'

Patients with a low nadir CD4 cell count could, the investigators believe, especially benefit from screening for pre-cancerous lesions. In addition, 'typing could also be useful as an adjunct to cytological examination in primary screening.'

The author of the accompanying editorial believes the study 'may bring us closer to the identification of biological markers of AIN progression and provide a practical screen tool for anal HPV disease.'

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— **Michael Carter**, *Aidsmap*
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Long-term HIV infection and poor inflammation control, not treatment, predicts risk of atherosclerosis

Long-term HIV infection is the only significant factor associated with thickening of the carotid intima media, a marker for atherosclerosis, a French case-control study has reported. A strong anti-inflammatory response also appears to reduce the risk of carotid intima media thickening, independent of the duration of HIV infection. (The thickening of the wall of the carotid artery due to the accumulation of cholesterol, calcium and plaques is considered a reliable indicator of the progression of cardiovascular disease).

A number of studies have shown that people with HIV infection have a higher risk of cardiovascular disease than their HIV-negative counterparts. Various risk factors have been identified, including treatment with several protease inhibitors, with the NRTIs abacavir and with ddI, as well as the widely known risk factors for heart disease of age, smoking and high lipid levels. However some studies suggest that HIV infection itself, and the inflammatory state that uncontrolled HIV infection creates, are important risk factors for cardiovascular disease.

The difficulty in assessing which of the major risk factors is most important lies in untangling the many confounding factors. For example, the majority of people with HIV in many cohort studies either smoke or have an extensive smoking history. Also, not all studies control for duration of infection, for immunodeficiency, for viral load or for duration of treatment.

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The new findings, presented recently at the 18th Conference on Retroviruses and Opportunistic Infections (CROI) in Boston, come from a study carefully designed to exclude biases, by some of the leading international experts in the metabolic complications of HIV infection, led by Dr Moise Desvarieux.

The study compared men with long-term HIV infection who had been infected for a median of more than 7.9 years with men who had been infected for less than 7.9 years and with untreated men and with HIV-negative age-matched men.

The study only recruited men who had never smoked in order to rule out any bias introduced by smoking, which is common in men with HIV infection and an independent risk factor for atherosclerosis (hardening of the arteries). The analysis controlled for CD4 count, viral load and duration of treatment.

Carotid intima media thickness (cIMT) was significantly associated with duration of infection, after adjusting for nadir (lowest ever) CD4 count, regardless of antiretroviral treatment. Greater cIMT was also associated with low levels of anti-inflammatory cytokines. Declining levels of adiponectin, a substance which regulates a number of metabolic pathways and which has been associated with a reduced risk of cardiovascular disease, was strongly correlated with cIMT thickness. However, higher levels of pro-inflammatory cytokines, suspected by some as a cause of cardiovascular disease in people with HIV, were much less strongly associated with greater cIMT.

Another study, which looked at 235,000 patients receiving care through the Kaiser Permanente network of clinics in California (20,775 HIV-positive), found that individuals with HIV infection had a 40% higher risk of myocardial infarction and 20% higher risk of any cardiovascular disease than their HIV-negative counterparts after controlling for age (both values $p < 0.001$).

In HIV-positive patients on treatment, immunodeficiency had a significant impact on cardiovascular risk: individuals with a current CD4 count below 500 cells/mm3 had a significantly higher risk of cardiovascular disease (risk ratio 1.4 for CD4 200 to 499, risk ratio 1.7 for CD4 < 200, $p < 0.001$). Those with nadir CD4 counts below 200 and now on treatment also had an elevated risk (RR 1.4, $p < 0.001$). A similar pattern for myocardial infarction was observed in treated patients, although the elevation in risk was marginally greater.

Unsurprisingly the study also found that among HIV-positive patients, age had the strongest impact on a person's risk of cardiovascular disease, with individuals aged 65 and over at 12-fold greater risk of a diagnosis of coronary heart disease than individuals aged 18 to 39, even after controlling for years since HIV diagnosis. Individuals aged 50 to 64 had a sixfold greater risk, and 40 to 49 years a 2.5-fold greater risk when compared to 18 to 39 year olds. Time since HIV diagnosis had no significant impact on risk, and even smoking had a modest impact on risk in comparison to age (RR 1.9, $p < 0.001$).

Although the authors caution that the results may be less generalisable to women and ethnic minorities, and note that they could not control for family history of heart disease, they note that their findings support earlier initiation of antiretroviral treatment.

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— **Keith Alcorn,** *Aidsmap*
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May

29–31
Rural and Remote Telehealth Conference
Cairns, Australia
http://www.hisa.org.au/telehealth

June

1–3
7th International Workshop on HIV and Hepatitis Co-Infection
Milan, Italy
http://www.virology-education.com

11–13
1st International HIV Social Science & Humanities Conference
Durban, South Africa
http://www.iaohss.org

July

14–15
6th International Workshop on HIV Transmission – Principles of Intervention
Rome, Italy
http://www.virology-education.com

13th International Workshop on Adverse Drug Reactions and Co-Morbidities in HIV
Rome, Italy
http://www.intmedpress.com/lipodystrophy

15–16
5th International Workshop on HIV Transmission
Rome, Italy
http://www.virology-education.com

15–16
3rd International Workshop on HIV Pediatrics
Rome, Italy
http://www.virology-education.com

17–20
6th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention (IAS 2011)
Rome, Italy
http://www.ias2011.org

August

26–30
10th International Congress on AIDS in Asia and the Pacific (ICAAP10)
Busan, Korea (South)
http://www.icaap10.org

September

8–10
26th IUSTI Europe Congress on STIs and HIV/AIDS and 10th BADV Congress (IUSTI BADV 2011)
Riga, Latvia
http://www.iusti-europe2011.org

26–28
Australasian HIV/AIDS Conference 2011 (23rd Annual ASHM Conference)
Canberra, Australia
http://www.hivaidsconference.com.au

The 2011 Australasian Sexual Health Conference
Canberra, Australia
http://www.sexualhealthconference.com.au/

THE PrEPARE PROJECT

Prepared for PrEP?

The PrEPARE Project is a study of gay men's attitudes towards an emerging HIV prevention technology called pre-exposure prophylaxis (PrEP).

The study will provide important information about attitudes to new HIV prevention technologies, including which men are interested in using PrEP in the future.

PrEP involves prescribing antiretroviral drugs to HIV-negative people to reduce the chance of infection if they are exposed to HIV. PrEP is not available in Australia.

The survey will take about 10 minutes to complete. HIV-positive and HIV-negative men currently living in Australia are invited to take part.

go to **www.prepareproject.net**

The PrEPARE Project is being conducted by the National Centre in HIV Social Research and AFAO. The study has been approved by the Human Research Ethics Committee of the University of New South Wales.

THE PrEPARE PROJECT