

Overview Summary of Focus Test Outcomes for HIV (Positive) Prevention Campaign

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Report Date: 6th November, 2006

Sunshine Coast (Nambour) Focus Group:

15 PLWHA were consulted at Nambour on Friday 27th October, in connection with a proposed QPP HIV prevention campaign drafts (Appendix 1). The purpose of the drafts was to illicit discussion and response, as an example only, and does not necessarily reflect final content which will be developed further by reference group consultation and PLWHA focus group analysis. A discussion group was enacted providing a brief to the PLWHA participants about increases in new HIV infections. The group was also asked to broadly consider the following, among their responses:

1. PLWHA views about the recent and ongoing HIV notification rises. What do PLWHA think about the data - what's going on?
2. Do PLWHA think QPP should be doing something in response to the data? If so, what do you think QPP's response should be?
3. Is there anything you think QPP should be careful about doing, or NOT do?
4. Do you have any other opinions or advice for QPP in relation to the data?

The verbal views of the participants were extracted based on the campaign draft text (Appendix 1), framed upon the questions above and drawing from the questions within Appendix 1.

Note: Participants were also asked to take copies of Appendix 1 home, and post written replies back to QPP.

Summary of Discussion Outcomes (Nambour):

1) The group was equally divided in a number of their responses:

- a. One portion of participants held the view that confrontational wording (such as "fucking") could be seen as "offensive language" (not by them personally, but by the wider community, although it was highlighted to them that the wider community are not in the highest risk category needing to be targeted - i.e. young 30+ yo gay men). The other portion held the view that words like "fucking" were at least "attention grabbing" (although they further commented on the limits of gay-community-wide changes in risk attitude/s based upon any text campaign, no matter how well worded).
- b. The same group who reported dislike of the word "fucking", also reported liking the words "irresponsible/responsible" (as it conveyed self-responsibility and awareness). Conversely, the remaining group proportion who reported liking the word "fucking", disliked the word/s "irresponsible/responsible" (interpreted as "blame" or "accusatory" - stigmatising).
- c. One portion of participants highly emphasized the need to impress HIV impact to health and wellbeing. They considered

that scare campaigning using the alternative word "AIDS" and its implications was necessary for people to understand the severity of HIV and why they might avoid infection at all costs. This bought up matters of further stigmatising PLWHA as "them" and furthering the divide among PLWHA not only from the general community but also among the gay community. The vocalists on this point suggested it was nonetheless required to impress upon 'risk takers' the deficit/s from having HIV. The facilitator queried how best to word this, but was not afforded any answer/s.

Note: This theme (i.e. talking up the impact and "loses" of having HIV, to impress upon the severity of infection) became very strong in the Brisbane focus test group, although the Brisbane group were more idealized to express the personal and social losses (see Brisbane report).

- d. There was also divide among the group about **who** was being targeted and **where**. Some strong opinions were delivered about campaign content needing to be directed to all community-wide, not just the gay community (nor gay imagery etc). The facilitator queried this reasoning, when the risk is in the gay community. Some felt that **broader** campaigns which highlighted that HIV was everyone's concern would serve to dismiss community-wide segregation (blame) and discrimination directed at both gay men and PLWHA. Further queried whether and how a PLWHA voice would affect the wider community, those vocal suggested community pressure would then be increased to reinforce safe sex behaviour in **everyone** (rather than a campaign talking to those who may be resistant or de-sensitises to safe sex messages - whether by complacency or unplanned risk taking or other social factors).

2) The majority of participants did not tend to prefer either version of the drafts, although they pointed out the strengths and weaknesses of each (as anticipated):

- a. **Version 1** (with 3 sub-group category messages) was seen as **repetitive**. Paradoxically however, the group made **strong mention** of those who **don't know their HIV status**, or assumptions of status needing to be targeted as well.
- b. Both versions needed to talk up the risks/deficits/severity of contracting HIV (e.g. how to impress on the target population the true impact of 'HIV not going away', since "neither has the common cold") - see 1c above
- c. **Version 1** was preferred for "**common language**" (e.g. got HIV/Haven't got HIV/Don't know) over the symbolism "HIV+/HIV-"). The group further reiterated that common language is required throughout any new adjusted model.
- d. There was active discussion about the use and framing (in campaigns gone by) of the terminology: "use condoms" or "use condoms every time" (as per our examples). The group was asked to consider if such words (or a potential reframing of such words), used in the context of shared responsibility (implied in the drafts), would change behaviour of those who



presently don't use condoms (always)? Was there another way to encourage condom use? None were sure due the changes in the natural history and social history contexts of the HIV epidemic. Queried whether a direct message about condom use is useful, or conversely may engender disengagement, the group seemed uncertain. The facilitator asked the group to take their time and further consider such an issue in their postal evaluation returns.

- e. The term "good sex" was placed in Version 1 to demonstrate the right of PLWHA to a satisfying healthy (safe) sex-life. There was little or no discussion which came from this, although it was interesting to see that one postal return received had something else to say about HIV which "can be contracted through bad, pitiful, bland, 'why did I bother' sex" as well*.

* *The Brisbane focus group also highlighted that they believed, in the majority, that HIV becomes a risk exactly during these situations, particularly where "low self-esteem" and vulnerability are in place, such as in poor choice behaviours or compromised by the disinhibition of drug and alcohol use (reported predominant in PLWHA Future's studies, and other sources of gay men's research).*

Brisbane Focus Group:

8 PLWHA were consulted at Brisbane on **Thursday 3rd November**, similarly as per the Nambour group. However, with this group, greater discussion occurred around the broader sets of questions lists at top of this report.

Summary of Discussion Outcomes (Brisbane):

- 1) There was fairly consistent and common agreement that perhaps one answer was to impress upon the urgency and impact of HIV, by listing (in a very factual way, without fear-based fashion) the numerous social and health deficits of becoming infected with HIV, so as to impress a sense of asking people to "think twice" about placing themselves at risk of HIV. For example: "relationship impact", "disclosure" (work and relationships), "cost of medications", "unpredictable health", "ongoing health considerations", "rejection from family and friends", "restriction in overseas travel". One participant dubbed the following slogans:
 - a. "An ounce of prevention, is worth \$30,000 ('pounds') of treatment" (no cure for HIV).
 - b. "HIV is no longer a DEATH sentence. It's a LIFE sentence"
- 2) Discussion took place that there is increasing and prevalent pursuits by HIV negative men actively seeking to be infected with HIV, dubbed "Bug Chasers" (particularly via the internet, and with serious - albeit irrational - intent). The group reflected that the reasons for this are due to ignorance of the impact of HIV and extreme lack of self-worth and self-confidence among many gay men who seemed to be almost "craving something to belong to" - a community - an 'inner-fold' - a sense of "belonging to something" that society does not freely offer to gay men in other circumstances in an open, socially accepting, and inviting sense on the whole (i.e. gay men experience minority exclusion generally,. In other words, gay men are afforded far less opportunity for wider

social involvement, integration, and acceptance than the non-gay men (or women) of our community, social, political, and religious environments, and HIV is perhaps being seen (albeit irrationally) as a way to connect and belong to an otherwise disenfranchised group). It was the view of the group that this attitude is either blatantly conscious denial (i.e. don't care about the risks) or an uneducated disregard to the impact and severity of HIV lifelong infection.

- 3) The group tended to agree (as did the Nambour group) that some form of new confrontational "scare tactics" need to be deployed, but NOT at the expense of stigmatising PLWHA. When queried how best to do this (and the potential stigmatising problems in doing so), there was little immediate answers. However, both groups (Brisbane and Nambour) tended to agree that the "grim reaper" (although attention grabbing) and other stigmatising campaigns such as those emanating from the US some few years back (showing graphic 'Crix Belly' and facial lipatrophy photographs, and diarrhea [person in nappy] etc., type imagery, are NOT helpful to the cause, but only result in further stigmatising of PLWHA.
- 4) There was a tendency for universal agreement in the group that the triggers for HIV infection occurring in individuals followed some prominent themes, being:
 - a. There was opinion that some short-lived or momentary lapses of self-worth or self-esteem, were triggers to spontaneous dismissal or denial of risk (in the 'heat of the moment'), and that unsafe acts against pre-established self-behaviour 'rules', or self-boundaries, incurred the dismissal of vulnerability. It was the view of the group that such triggers tended to cause a false sense on invincibility, or that rejection of vulnerability occurred in favour of taking risks (i.e. I've been safe to date and HIV hasn't got me - 'I might just take the risk and see'). It was felt by the group that these (as well as "defiance" and delusions of invisibility) may be one of the highest precursors to new HIV infection occurring. Some felt strongly that drugs and alcohol were significant contributory factors (given their high prevalence of use in the gay and PLWHA community) giving a risky sense of dis-inhibition, while others thought that dis-inhibition and risk taking was not always related to D&A but the above matters of lapses in cognitive thought and spontaneous risk taking were the triggers (with or without D&A involvement).

Note: Only a small number of written returns have been provided from both groups, and whilst those who did return evaluations provided additional input and notes, it is felt that the discussion groups have sufficient extracted the predominant views highlight in this report.



Appendix 1 - VERSION #1

I'm not Fucking Irresponsible

Got HIV	Haven't Got HIV	Don't Know?
<p>Be</p> <p>Fucking Responsible</p> <p>...use condoms</p>	<p>Be</p> <p>Fucking Responsible</p> <p>...use condoms</p>	<p>Be</p> <p>Fucking Responsible</p> <p>...use condoms</p>

**HIV hasn't gone away,
Neither has good sex**

Appendix 1 - VERSION #2

Don't Let Anyone Say You're Fucking Irresponsible

HIV+	HIV-
<p>Be</p> <p>Fucking Responsible by not transmitting HIV to your sexual partners</p> <p>USE CONDOMS EVERY TIME</p>	<p>Be</p> <p>Fucking Responsible by not contracting HIV to your sexual partners</p> <p>USE CONDOMS EVERY TIME</p>

**HIV may still be HERE,
BUT it won't get past ME**



Appendix 1

QPP HIV PREVENTION CAMPAIGN SUGGESTIONS SURVEY INSTRUCTIONS:

Please read the two (2) campaign DRAFT Texts supplied (themed "Fucking Responsible"). Try to ignore that they are not coloured posters or flyers and have no images/pictures (as yet), but just try to concentrate on the **words only**, and the way they are **constructed** (i.e. put together).

Below is a series of questions about these words and the way they are constructed, which we would appreciate your written answers and comments upon this form. We ask that you take the time to reflect on these samples and question, and use the reply-paid envelope provided to send back your responses*. Although we don't have any graphic images or pictures at the moment, we also ask some questions about them. **Be completely honest!**

Note: This survey is anonymous. We ask that you **do not** put your name on this form, as all responses will be held in the strictest confidence and will be used **ONLY** for the purpose of producing a campaign for the prevention of HIV in others. Be assured that we are asking your viewpoint because we believe that the best view points about prevention of HIV come from people who have experienced what it is like to get it.*

We thank you...

for taking the time to complete the following questions....

Question 1:

Which of the two versions do you **prefer**?

(please mark with "X"):

Version #1

OR

Version #2

OR

Neither

OR

Both

Question 1(a):

If there are words and phrases you **DO LIKE** in either of them, please explain **what and why**?

(please provide as much detail or explanation as you can):

Question 1(b):

If there are words or phrases you **DON'T LIKE** in either of them, please explain **what and why**?

(please provide as much detail or explanation as you can):

Question 1(c):

Regardless of whether you like, or dislike, or are indifferent to the two samples provided, do you have any **ALTERNATIVE SUGGESTIONS** for wording or phrasing you think should be included in a campaign?

(please provide as much detail or explanation as you can):

Question 2:

If you could tell people who **do not have HIV** what they need to know, or do, to **avoid getting HIV** what messages would they be? (list as many as you prefer, and be as creative as you like):

Question 3:

If you could tell people who **do have HIV** (i.e. PLWHA) what they need to know, or do, to **avoid transmitting HIV** what messages would they be?

(list as many as you prefer, and be as creative as you like):

Question 4:

Is there **anything else** you want to say about HIV prevention and/or strategies and methods for delivering prevention campaigns?

(please provide as much detail or explanation as you can):

Question 5:

Should this campaign have any photographs, images, sketches, art or pictures in it, and if so, what do you believe would be good, and how should they be used?

(please provide as much detail or explanation as you can. If you are posting this back, please feel free to include example of your suggestions):

Some 2005 HIV/AIDS data of interest

HIV notifications in Queensland rose by 9.5 per cent from 2004 to 2005 (i.e. from 137 to 150 cases) representing the highest annual total since cases were first reported in 1984.

There has been a significant upward trend in HIV notifications in Queensland since 2001 - that is, a 55 per cent increase from 2001 (97 cases) to 2005 (150).

The majority of HIV notifications in Queensland are gay men and other men who have sex with men. These groups remain most at risk. Within this population, the majority of men (79%) were aged 20-44 years. This group had the highest notification rates in 2005 and for the period 2001-2005.

The vast majority of HIV infections in 2005 could have been prevented through safe sex practices. Using condoms and lubricant remains the best defence against HIV.

At the end of 2005 there were 1,513 people living with HIV who were accessing care in Queensland. An estimated 927 people living with HIV in Queensland were eligible for antiretroviral treatments with sixty percent of these people accessing antiretroviral drugs in December 2005.