

# *Appendices*

# Appendix A

## Members of the Enquiry

---

The Enquiry was chaired by Mr Chris Puplick AM, assisted by members of the Statutory Board, Ms Suzanne Jamieson and Father Hugh Murray OAM.

Mr Chris Puplick is the President of the NSW Anti-Discrimination Board and NSW Privacy Commissioner. He was appointed President of the ADB in 1994.

Ms Suzanne Jamieson is a Senior Lecturer in Work and Organisational Studies at the University of Sydney. She has recently completed a doctorate in Women and Occupational Health Safety, and has done extensive research in gender and discrimination issues in the workplace.

Father Hugh Murray is a Catholic priest of the Vincentian Order. He has spent most of his life working in education. Before retirement, Father Murray spent several years as the Catholic Chaplain for people with HIV in the City of Sydney.

### Members of the Enquiry Steering Committee

Professor Bob Batey

Director, Gastroenterology Unit, John Hunter Hospital

Mr Jack Wallace

Executive Officer, Australian Hepatitis Council

Mr Stuart Loveday

Executive Officer, Hepatitis C Council of NSW

Professor Sue Kippax

Director, National Centre in HIV Social Research

Ms Maureen Steele

Community Advocacy Coordinator, NSW Users and AIDS Association

Ms Annie Madden

Executive Officer, Australian Intravenous League

Dr Ingrid van Beek

Director, Kirkeaton Road Centre

### Project Officer

Ms Julia Cabassi, a Legal Officer of the ADB, was the project officer responsible for managing the Enquiry.

Ms Cabassi is the principal author of the report.

# Appendix B

## Media coverage

---

The conduct of the Enquiry has provided an important opportunity to raise community awareness about hepatitis C related discrimination, and to promote the role of the ADB and compliance with anti-discrimination legislation. The Enquiry received considerable media attention, centred around the conduct of the public hearings in Sydney and regional centres. The coverage was generally well informed and provided an important opportunity to raise hepatitis C related discrimination issues in regional newspapers and on regional radio.

### Radio interviews

Many of the radio stations recorded two interviews, an introductory piece about the Enquiry hearing interview, and a round up of the day's events.

Radio 2GN, Goulburn

ABC 973, Wollongong

ABC Radio Newcastle

Radio 2HD

Radio 2NX

Radio 2NO FM

Radio 2GN News, Dubbo

ABC Radio Central West, Dubbo

Radio 2GN

Radio 2LM, Lismore

### Press coverage

*Goulburn Post*, pre and post Enquiry hearings coverage

*Illawarra Mercury*

*Newcastle Herald*

*Dubbo Daily Liberal*

### Television coverage

*The 7.30 Report* filmed at the Wollongong hearing and interviewed the President about the Enquiry. The story also examined the high risk of hepatitis C transmission in custodial settings, including interviews with prison activists and the NSW Department of Corrective Services. The report went to air on 14 June 2001. Prime Television filmed at the Wollongong hearing, and their package was broadcast through their rural network across the State. Prime Television also filmed at the Newcastle hearing.

# Appendix C

## Oral submissions

---

### Enquiry launch — 15 March 2001

Professor Bob Batey  
John Hunter Hospital, University of Newcastle  
Chair of the Hepatitis C Sub-Committee of the Australian  
National Council on AIDS, Hepatitis C and Related Diseases

Mr Stuart Loveday  
Executive Officer, Hepatitis C Council of NSW

Mr Paul Harvey  
Special Projects Officer, Hepatitis C Council of NSW

Ms Maureen Steel  
Community Advocacy Coordinator,  
NSW Users and AIDS Association

### Goulburn Public Hearing — 8 May 2001

Dr Michael Levy  
Director of Population Health, Corrections Health Service

Ms Alita O'Meara  
Public Health Nurse,  
Goulburn and Berrima Correctional Centre

Ms Jenni Somers  
Sexual Health Counsellor, Moruya Community Health Centre

Ms Sharon Medway  
Indigenous Sexual Health Worker,  
Southern Area Health Service

Ms Angela Trevaskis  
Sexual Health Counsellor,  
Queanbeyan Community Health Centre

Ms Lorraine Dubois  
Acting Sexual Health/HCV Coordinator,  
Southern Area Health Service

Mr Brian Callahan  
Area Methadone Service Manager, Southern Area Health  
Service (Drug and Alcohol)

### Wollongong Public Hearing — 9 May 2001

Mr Richard Carbury  
Unit Manager, Dennison Street Private Methadone Clinic

Ms Cheryl Wifton  
Service Manager, Contact Drug and Alcohol Service

Ms Jane Anderson  
Drug and Alcohol Counsellor,  
Contact Drug and Alcohol Service

Mr Mick Fernandez  
HCV Project Officer, Illawarra Area Health Service

Ms Karina Ramson  
Project Officer, HCV Study, University of Wollongong

Ms Mairi MacLeod  
Nurse Educator, Clinical Nurse Specialist,  
Illawarra Sexual Health Service

### Newcastle Public Hearing — 15 May 2001

Ms Marilyn Bliss  
AIDS and Infectious Diseases Coordinator,  
Hunter Area Health Service

Mr Michael Pope  
HCV Project Officer, Hunter Area Health Service

Ms Tracey Jones  
Clinical Nurse Consultant, John Hunter Hospital

Ms Gabrielle Murphy  
HCV Social Worker, John Hunter Hospital

Mr Keith King  
Needle and Syringe Program Coordinator,  
Hunter Area Health Service

Mr Ken Zulumovski  
Sexual Health Worker, Awabakal Aboriginal Medical Service

Ms Trish Tanner  
Acting Nurse Unit Manager, Newcastle Methadone Unit

### Dubbo Public Hearing — 16 May 2001

Ms Maggie Westman  
Acting AIDS Coordinator, Macquarie Area Health Service

Ms Fiona Baker  
Nurse Unit Manager, Methadone Management Program,  
Macquarie Area Health Service

Ms Maria Walsh  
Case Worker, Drug and Alcohol Unit,  
Macquarie Area Health Service

Mr David Ward  
Solicitor, Community Legal Service for Western NSW

Mr David Kelly  
CEO, Wellington Aboriginal Corporations Health Service

Ms Bedelia Skinner  
Needle and Syringe Program Coordinator,  
Macquarie Area Health Service

Mr Steve Gibson  
Aboriginal Health Coordinator, Macquarie Area Health Service

## **Lismore Public Hearing — Wednesday 23 May**

Ms Wendi Evans  
AIDS and Infectious Diseases Coordinator,  
Northern Rivers Area Health Service

Mr Scott Russell  
HCV Project Officer, Northern Rivers Area Health Service

Ms Marilyn Marks  
HIV, HCV and Sexual Health Educator,  
Grafton Community Health Centre

Mr Christian Gruft  
Needle and Syringe Program Coordinator,  
Western Cluster Primary and Extended Care Services (PECS),  
Northern Rivers Area Health Service

Ms Deb Woodbridge  
HCV Study Project Officer,  
Southern Cross Institute of Health Research

Ms Bernadette Monaghan  
HCV Study Project Officer,  
Southern Cross Institute of Health Research

Mr Robert Monaghan  
Sexual Health Educator, Bulgarr Ngaru Aboriginal Medical  
Service

Ms Yana Van der Jagt  
HCV and Needle and Syringe Program Coordinator,  
Mid North Coast Area Health Service

Ms Roslyn Hawkins  
Clinical Nurse Consultant, Sexual Health Clinic,  
Northern Rivers Area Health Service

The Hon. Dr Brian Patrick Victor Pezzutti  
Member of Legislative Council (NSW)

## **Sydney Public Hearings — 2 and 3 August 2001**

Dr Ingrid van Beek  
Director, Kirketon Road Centre

Ms Annie Madden  
Executive Officer, Australian Intravenous League

Dr Alex Wodak  
Director, St Vincent's Hospital Drug and Alcohol Service

Mr David Wallace  
Community Liaison Officer, Options Employment Service

Mr Michael Strutt  
Spokesperson, Justice Action

Mr Tony Hague  
Prison Aware

Mr John Murray  
Positive Justice

Dr Greg Dore  
National Centre in HIV Epidemiology and Clinical Research

Mr Michael Molesworth  
Managing Director, GeneralCologne Life Re Australia Ltd

Mr David Mico  
Senior Policy Manager,  
Investment & Financial Services Association

Mr Brian Sussman  
General Manager,  
Gerling Global Life Reinsurance Company of Australia  
Pty Limited

Dr Patrick O'Brien  
Development Manager, GeneralCologne Life Re Australia Ltd

Mr Gary Gahan  
Coordinator Hepatitis C Services Network (HepNet),  
North Sydney Area Health Service

Ms Sue Mason  
Clinical Nurse Consultant, HCV, Royal Prince Alfred Hospital,  
Central Sydney Area Health Service

Ms Sinead Sheils  
Clinical Nurse Consultant, HCV, Royal Prince Alfred Hospital,  
Central Sydney Area Health Service

Mr Brad Freeburn  
Drug and Alcohol Educator,  
Redfern Aboriginal Medical Service

Dr John Daniels  
Redfern Aboriginal Medical Service

Professor Michael Kidd  
Head of Department,  
Department of General Practice, University of Sydney

Ms Levinia Crooks  
Australian Society for HIV Medicine

Dr Gillian Deakin  
General Practitioner

Mr Stuart Loveday  
Executive Officer, Hepatitis C Council of NSW

Ms Margaret Gearin  
President, Hepatitis C Council of NSW

Ms Maureen Steele  
Community Advocacy Coordinator,  
NSW Users and AIDS Association

Mr Stephen Wye  
Editor, Users News, NSW Users and AIDS Association

## **Private hearings**

The Enquiry also conducted private sessions at each of the regional locations outlined above and held private hearings at:

Hepatitis C Council of NSW — 29 May 2001  
Kirketon Road Centre — 5 June 2001  
Goulburn Correctional Facility — 8 May 2001.  
Mulawa Women's Correctional Facility — 26 July 2001  
Joint Assessment Review Team Offices —  
Youth Drug Court Program — 27 July 2001.

The Enquiry heard evidence from 15 health workers and 45 individuals in these private sessions.

# Appendix D

## Written Submissions

---

Ageing and Disability Department of NSW  
AIDS Council of NSW Inc  
Australian Dental Association (NSW Branch)  
Australian Health Ethics Committee of the National Health and Medical Research Council  
Australian Hepatitis Council  
Australian National Council on AIDS, HCV and Related Diseases, HCV Committee  
Australian Research Centre in Sex Health and Society  
Central Sydney Area Health Service  
Combined Community Legal Centres Group (NSW)  
Corrections Health Service  
Council of Social Service of New South Wales  
Crookwell District Hospital  
Darwin Community Legal Service  
Department of Juvenile Justice  
Dr W. J. Kingswell  
Dr A. R. MacQueen  
DUNES Inc  
Far West Area Health Service  
Health Care Complaints Commission  
Hepatitis C Council of NSW  
Hepatitis C Council of SA  
Hepatitis C Council of WA  
Hepatitis C Helpline (Victoria)  
HIV/AIDS Legal Centre Inc  
Investment and Financial Service Association  
Mid North Coast Area Health Service  
Multicultural HIV/AIDS Service  
National Drug and Alcohol Research Centre  
New England Area Health Service  
Northern River Area Health Service  
Northern River Community Legal Centre  
Northern Sydney Area Health Service  
NSW Department of Corrective Services  
NSW Health Department  
NSW Users and AIDS Association  
Office of the Director of Equal Opportunity in Public Employment  
Options Employment and Training Service  
Phoebe House Inc  
Prison Aware  
Positive Justice Centre  
Professor Sandy Gifford  
Royal Australasian College of Physicians  
South East Health Area Health Service  
Southern Area Health Service  
Sussex Street Community Law Service (WA)  
Sex Workers Outreach Program  
TRAIDS  
Waikerie Medical Centre

**We also received 62 written submissions from individuals.**

# **Appendix E**

## **An Epidemic of Difference: A Social Analysis of Hepatitis C-related Discrimination**

**NATIONAL CENTRE IN HIV SOCIAL RESEARCH**

---

### **A. Introduction**

### **B. Background to the hepatitis C epidemic in Australia**

### **C. Discrimination and stigma**

C1. Social identity

C2. Fear of contagion and 'userphobia'

### **D. Method**

D1. Submissions from the health care sector

### **E. Misinformation and the confounding of hepatitis C and injecting drug use**

### **F. Themes of stigma and practice of discrimination**

F1. Disclosure

F2. The 'innocent' and 'guilty' victims of hepatitis C

F3. Discrimination of hepatitis C-related health care workers

F4. The tools of harm reduction: resistance to drug-related health services

F5. Access to hepatitis C and other health services

F6. Confidentiality

F7. Poor medical treatment and exclusion from health services

### **G. Affective responses to hepatitis C-related discrimination**

G1. Learned helplessness

### **H. Societal forms of hepatitis C-related discrimination and stigmatisation**

### **I. Conclusion**

### **J. References**

## A. Introduction

In November 2000, the President of the Anti-Discrimination Board of New South Wales (ADB), Mr Chris Puplick, announced a statewide Enquiry into hepatitis C-related discrimination. The Enquiry was launched in Sydney on March 15th 2001, with hearings conducted in Wollongong, Goulburn, Dubbo, Lismore and Newcastle throughout May 2001. Sydney hearings were held in June and August 2001. In addition to public hearings, the ADB invited written submissions from individuals and organisations.

The National Centre in HIV Social Research (NCHSR) was invited to assist in the analysis of submissions tendered to the ADB's Enquiry into Hepatitis C-related Discrimination by providing a sociological analysis of the central themes as they appear in both the written and oral submissions.

## B. Background to the hepatitis C epidemic in Australia

Prevalence studies of the hepatitis C virus in Australia place the number of people infected at between 130,000 and 234,000 (Law 1999; National Centre in HIV Epidemiology and Clinical Research 1998), approximately 90,000 of whom reside in NSW. Currently, hepatitis C is the most frequently reported notifiable infection in Australia (National Centre in HIV Epidemiology and Clinical Research 2000). Research indicates that the majority of people contract hepatitis C through sharing contaminated injecting drug use equipment (Crofts et al. 1993; Crofts et al. 1997; Freeman et al. 2000; Macdonald et al. 1996). Australia has an incidence of around 10,000 new hepatitis C infections annually with about 91% of new infections occurring among injecting drug users (Dore et al. 1996). Approximately 10% of all hepatitis C infections in Australia are the result of blood transfusions or the use of blood products prior to 1990 when screening was introduced (Hepatitis C Council of New South Wales 2000).

The combination of a significant pool of infected people and the long duration of illness associated with hepatitis C infection indicates that the overall health and economic costs to Australian society in the years ahead will be substantial (Wodak 1997). The growing public health significance of the epidemic is evidenced by the implementation of the National Hepatitis C Strategy 1999–2000 to 2003–2004, an initiative aimed at promoting and supporting treatment measures, support and care (Commonwealth Department of Health and Aged Care 2000).

The current epidemic of hepatitis C is often likened to that of HIV/AIDS, where specific populations and practices are linked to risks of infection. In Australia, HIV is commonly transmitted via unprotected anal intercourse and principally affects gay men living in highly visible and geographically focused urban gay communities. In Australia, hepatitis C is an epidemic that predominantly affects people who practice, or have practiced, injecting drug use. However, people who contracted hepatitis C from injecting drug use do not constitute a 'community' in the same sense as the gay community (Hulse 1997) and a tendency to liken this current epidemic with HIV/AIDS may obscure significant disparities.

Hepatitis C is an 'epidemic of difference'<sup>1</sup>. People who contracted hepatitis C from injecting drug use come from a broad range of backgrounds and include people who experimented with injecting decades before discovering their infection. Some of these people may have only injected once or twice, while others are current injectors, including those who are drug dependent. People who have ever injected in their life do not comprise a homogeneous group: they inhabit corporate boardrooms, the suburban family home, and the local football club, as well as park benches.

In addition, a significant minority of Australians contracted hepatitis C via non-injecting means, such as medical procedures, tattooing, skin-piercing, accidental household and workplace transmissions, or following mass vaccination programs in their country of birth. Evidently, people with hepatitis C are culturally and geographically diverse and perform a variety of social roles, which makes this epidemic, from a socio-cultural perspective, unique, multi-faceted and extremely complex. These differences affect the way people cope with hepatitis C infection, how they experience hepatitis C-related discrimination, and their power to respond to stigmatisation and discrimination. The following section defines discrimination and stigma and discusses these constructs in relation to social identity theory, a tool useful for understanding the processes involved in discrimination of people with non-normative values and lifestyle practices, and those living with a stigmatised chronic illness. This discussion provides a theoretical framework from which to view evidence tendered to the Enquiry.

## C. Discrimination and stigma

Discrimination refers to 'actions or practices that are carried out by members of dominant groups, or their representatives, which have a differential and negative impact on members of subordinate groups' (Feagin et al. 1978: 20–21). There are two major approaches to thinking about discrimination: the first involves the prejudice-causes-discrimination model which perceives discrimination as individualistic, overt, sporadic and episodic and presumes that individuals' attitudes and behaviour are causally linked. This approach focuses on individuals or small groups and their intentions and while valid in many contexts, this conceptualisation of discrimination has been critiqued for its assumption that attitudes and behaviour are always consistent (Merton 1970). Another approach to discrimination looks beyond personal rationalisations and motivations to social

<sup>1</sup>Courtesy of Dr Erica Southgate.

structures where discrimination is perceived to be overt or covert, routine and continual. This approach focuses on institutions and organisations where discrimination can be either intentional or unintentional (Feagin et al. 1978; Herdman et al. 1995; Henriques et al. 1984). It is useful to consider both approaches when thinking of discrimination.

Discrimination is associated with, and the enactment of, stigma. Stigma is a term used to 'refer to an attribute that is deeply discrediting' and a stigmatised person is someone who embodies 'an undesired difference' (Goffman 1968 p. 3). Social groups stigmatise individuals or groups of people who display difference from social norms and who identify with or enact behaviours that hegemonic groups consider deviant.

Stigmatisation is manifested through rules and sanctions directed towards affected people (Malcolm et al. 1998). It is a means by which communities defend against overt threats to cultural values and social control can be maintained through marginalising those people who exhibit particular traits (Malcolm et al. 1998; Gilmore et al. 1994). Stigmatisation involves the labelling of people as lacking conformity with the salient values enshrined within a culture, and the kind of behaviours that come to be stigmatised can vary widely between cultures (Fulton 1999; Pittam 2000). The stigmatising trait or value is often one that conflicts with an important cultural value that is being upheld by the majority in a community. By marginalizing certain groups and individuals, societies articulate important community values and define boundaries of accepted behaviours (Gilmore et al. 1994).

The burden of stigma often weighs heaviest on the poorest and most marginalised people in our community and this point reveals the political dimension of stigma, that is, powerful groups can enforce rules onto less powerful groups (Fulton 1999). The following explains the nature of social divisions as posited by social identity theory and discusses the categorisation of people with stigmatised diseases into social out-groups.

## C1. Social identity

**'If history teaches us anything at all, it teaches us that human beings have a powerful need to form groups and that the sacrificial victimisation of scapegoats is often an indispensable ingredient for maintaining social cohesion among the members of such groups.'** (Szasz 1987, in Gilmore et al. 1994 p. 1346)

Here, Szasz discusses the scapegoating of drug users within modern American society. People who represent difference to the majority in their values and beliefs and/or practices are often stigmatised, stereotyped and scapegoated as a means of preserving the safety and validity of the hegemonic group and the integrity of individuals who claim membership.

Social identity provides a theoretical framework to explain the propensity of people to stigmatise and stereotype, often erroneously (Henriques 1984), and to simplify and divide the world into the 'us' and 'them' binary. Specifically, social identity theory involves three basic assumptions: people categorise others into in-groups and out-groups; people are motivated to strive for a positive self-concept and gain a sense of self-esteem by identifying with a particular in-group; and people's self-concept partly depends on how they evaluate their in-group compared with other groups (Sears, Peplau and Taylor, 1991). This theory describes people's desire to belong to a 'superior' group, and to claim the psychological, social and material benefits obtained from such membership. By identifying with, for example, specific religious and socio-political groups, in-group norms, values and beliefs provide a structure from which individuals view the 'other'.

Apart from the stigmatising of specific behaviours and values, people experiencing illness may also be subject to stigmatisation (Lupton 1994c). Some diseases have a history of eliciting stigma and sick people are often labelled and excluded from a range of social contexts. Some diseases are perceived as a threat to the self or one's community. For example, people with a sexually transmitted infection (STI) or mental illness are at times stigmatised and may suffer discrimination as a result. Those affected are labelled as belonging to an out-group. This is seen as a method of preserving the physical and moral health of the community against the problems represented by the disease (Gilmore et al. 1994). When people with an STI are stigmatised, for example, the disease comes to represent all the 'suffering and evil' in society and people with the disease are positioned as an out-group representing 'societal shortcomings, inadequacies, unmet needs, or unrealised expectations' (Gilmore et al. 1994 p. 1346). People with a STI (or those presumed to have a STI) are judged, scapegoated and blamed by others for their own disease state as well as a range of other problems that exist among society.

HIV/AIDS has become one of the most stigmatised diseases of recent times and is characterised as a multiple epidemic, that is a viral epidemic as well as an epidemic of stigmatisation, scapegoating and discrimination (Gilmore et al. 1994). The early days of the epidemic saw calls from both individuals and some social institutions for people living with HIV/AIDS to be quarantined, to be excluded from participating in the work force and other social contexts, and to be identified as carriers of death and disease (Sontag 1989; Crimp 1987). These actions were aimed at maintaining a distance between the healthy, 'moral' majority and the threat of disease that was seen as a result of a deviant lifestyle and practices of a minority. Stigmatisation aimed to simultaneously identify and disempower those affected by HIV/AIDS and preserve hegemonic values.

The stigmatising, scapegoating and discrimination familiar to many people living with HIV/AIDS, has in some ways being replayed over the past decade, this time in the context of hepatitis C. If a condition is understood to be the result of an individual's own actions, then those affected are likely to be viewed adversely and discriminated against (Jones et al. 1984). Whereas gay men's sexual practice was construed to present a major threat to the preservation of social order during the

HIV/AIDS epidemic, the stigmatised villains and 'guilty' victims of the hepatitis C epidemic are injecting drug users.

## C2. Fear of contagion and 'userphobia'

Discrimination against people living with an infectious disease is often based on both rational and irrational fears of contagion (Kippax et al. 1991). Rational fears concern chronic illness and disease that results from infection with a transmissible virus. Irrational fears reflect exaggerated estimates of risk of contagion. These fears often lead people to avoid social interaction with those known or assumed to be infected and may lead to discrimination against people associated with risk groups and practices. Perceptions of risk are highly subjective. Individuals do not usually assess risk from an exclusively scientific standpoint, but in terms of personal and cultural values and beliefs (Kippax et al. 1991).

**'The panic and uncertainty that accompany epidemic disease may lead to a desperate search for explanations...Stigmatisation seems to provide a partial (although spurious) answer...the convenience of having an already despised or suspect group in the vicinity allows for quick attribution of causality and blame.'**  
(Turner et al. 1989, p. 391)

Because of the way society views illicit drug use and injecting drug users, people are socialised to hold certain beliefs about users and come to question, for example, their value as members of society, their ability to find and maintain employment, and their capacity to form relationships with family and others (Fulton 1999). Injecting drug users are assumed to be addicted and to have close ties with crime in order to finance their addiction. People who use drugs are often stereotyped as lacking social worth and a danger to the community because they are likely to spread their negative characteristics to others. This seems especially true if the user comes from a poor socio-economic background and injects heroin (Acker 1993; Jones et al. 1984; Fulton 1999).

'Userphobia', a term loosely defined as a fear and dislike of injecting drug users, describes a palpable distaste for anyone admitting to, or associated with, injecting. This loathing may be interpersonal and aimed at individual users, or systemic and focused on organisations such as methadone clinics and needle and syringe programs. Some individuals may be more userphobic than others. Userphobia informs many of the prejudicial beliefs and discriminatory practices leveled at people with hepatitis C by various sections of the community. At the core of userphobia is the division of people into 'guilty' and 'innocent' victims of hepatitis C. This division is apparent when people who acquired their infection through injecting drug use are held responsible for their own disease. Conversely, those people who contracted hepatitis C through non-injecting means are seen as the 'innocent' victims of the epidemic and not held responsible for their infection. A 'guilty' finding may be used to justify discriminatory treatment of an individual with hepatitis C infection.

Social identity theory is useful in understanding how people living with hepatitis C come to be positioned as belonging to an out-group. There is a strong association between injecting drug use and hepatitis C in the media, the minds of the general public and among social institutions like the health care system. Illicit drug use is one of the most stigmatised behaviours throughout the world, and users belong to some of the most marginalised populations that are often scapegoated and discriminated against (Gilmore 1996). In a society that emphasises rationality and values sobriety (Marr 1999; van Ree 1997), non-users may view illicit drug use as evidence for a moral, personal and/or biological inadequacy in those who 'choose' to use (Gilmore 1996). Additionally, because of the illegal status, drug users are positioned as criminals flouting the rules of society. If participation in an illegal activity is also synonymous with the transmission of blood-borne viruses and other negative health outcomes, including a compromising of human rationality (van Ree 1997), social identity theory suggests that those whom eschew these activities will act to distance themselves from people involved in order to preserve in-group safety and uphold in-group values. Boundaries are created to delineate the in-group containing rational, healthy, law-abiding citizens and those deviant 'others' who compromise their mental and physical health by choosing to use illicit drugs. Boundaries reaffirm hegemonic social values (ie. observation of the law and the prioritising of one's health) by excluding deviant ones (Gilmore et al. 1994), satisfies the in-group's need for security, and bolsters a collective self-concept and sense of esteem.

Recent responses to epidemic disease are often characterised by processes of stigmatisation and discrimination that further endanger the health of affected people (Kippax et al. 1991; Herdman & Kippax 1995). When the community and media think of people living with hepatitis C, there is a strong tendency to focus on the practice of injecting drug use as the cause of their infection. Indeed, for many, hepatitis C and injecting drug use have become synonymous.

## D. Method

The Anti-Discrimination Board sought input to the Enquiry from a broad range of community-based organisations, Area Health Services, relevant government departments, experts in the field, private sector institutions and individuals (see section 1.3 – 'Methodology' in the main report for a detailed account of the procedures used for collecting evidence). The Enquiry was advertised widely in the print and electronic media, and via two broadly distributed information fact sheets produced by the ADB and Hepatitis C Council of NSW. In response, oral and written submissions were received from a variety of individuals and organisations throughout Sydney and regional NSW. On receipt of a written submission, the ADB returned a letter of acknowledgment detailing the role of the NCHSR in the Enquiry. A two-week period was granted for people making written submissions to withdraw consent for their evidence to be used in the NCHSR analysis.

In total, one hundred and ten written submissions were received by the ADB. Eighty-two of these became a primary source of data for use in the NCHSR analysis. In addition, the author attended nine out of thirteen oral hearings held throughout New South Wales. Extensive notes were taken from both data sets (ie oral and written submissions). The submissions were analysed using a grounded theory approach (Glaser and Strauss 1970). The frequency with which preliminary concepts occurred was recorded, enabling the identification of emerging clusters of themes. The theoretical framework of stigma and social identity was used to interpret the findings. The analysis describes themes within the submissions that emerge as significant or important to individuals.

## **D1. Submissions from the health care sector**

A high proportion of submissions received by the Enquiry concerned health care workers. The methods of data collection may have influenced the extent of this evidence received by the Enquiry. The Enquiry was advertised among health care settings such as community health centers, needle and syringe programs, methadone clinics and other key health services. These settings provide a significant path to accessing people with hepatitis C and workers in the field who had information and direct experience of discrimination. The high proportion of submissions relating to discrimination from health care workers, to a certain extent, reflects the use of this avenue for advertising the Enquiry. Additionally, this evidence reflects the probability that people living with hepatitis C are more likely to disclose their hepatitis C infection in health care settings than in other community contexts. Therefore, health care is a key environment in which hepatitis C-related discrimination is likely to be enacted. Many instances of hepatitis C-related discrimination used in this report are taken from the health care sector as submissions pertaining to this context provided the most salient examples.

The following sections discuss the major themes that emerge as informing hepatitis C-related discrimination, beginning with: misinformation pertaining to hepatitis C infection; the confounding of injecting drug use and hepatitis C; and evidence of userphobia.

## **E. Misinformation and the confounding of hepatitis C and injecting drug use**

A submission to the Enquiry from the Hepatitis C Council of New South Wales (HCC of NSW) reported that hepatitis C-related discrimination occurs either because of 'a non-rational fear of infection' or the virus' association with injecting drug use and suggests that it is often hard to tell which is driving discrimination. Poor knowledge of hepatitis C infection among the general community, including the health care sector, was a major finding of the Enquiry. Many people confuse the hepatitises. A hepatitis C educator stated that there 'is a considerable amount of misinformation' concerning the virus within the community. Poor knowledge of the hepatitis C virus was reported among a variety of workplaces, such as insurance companies, funeral services and schools and among some health care workers, including GPs.

Submissions to the Enquiry highlighted how ignorance of hepatitis C appeared to underpin some of the negative attitudes and discriminatory practices that people encountered. A quote from a woman who attended a social gathering with friends, where the topic of discussion was hepatitis C and HIV/AIDS, highlights a positive person's reaction to community ignorance of the virus:

**'[I was] shocked at the attitudes of some of the people...I would not have told them that I had hep C or they would have stoned me, that's how they came across to me'.**

Ignorance and fear of the virus may explain why some people are excluded from participating in activities within their social networks when there is no risk to others, and why infection control procedures are sometimes implemented in inappropriate contexts.

Evidence was also tendered to the Enquiry suggesting hepatitis C-related discrimination was inextricably linked to discrimination of injecting drug users. The association of hepatitis C infection with injecting drug use has been reinforced by the media and appears to be so significant that in the minds of many health care workers, and indeed members of the public, hepatitis C and injecting drug use have become indistinguishable. According to one service provider:

**'People are automatically assumed to be current users when they disclose their [hepatitis C] positive status to health care workers.'**

The confounding of hepatitis C and injecting drug use reportedly underpins many instances of hepatitis C-related discrimination. Service providers and individuals claimed that hepatitis C-related discrimination, especially in health care settings, is informed by userphobia. According to a submission from a user, in the context of health care, either a disclosure of injecting drug use or a hepatitis C positive sero-status may result in poor treatment:

**'Once they [health care workers] find out you have hep C or are an addict, they treat you like shit.'**

Some health service providers claimed that there is a cultural norm of discrimination against injecting drug users existing among the health care system. Individuals and service providers maintain that some health care workers find it difficult to have positive attitudes towards injecting drug users. An ex nurse stated:

**'Some nurses practice punitive measures when they identify patients as being ex or current users.'**

Injecting drug use is a stigmatised practice and userphobia positions injecting drug users as an out-group with irrational values, needs and lifestyle practices foreign to those of mainstream society, as well as being considered a contagious threat to the health of the majority. Health workers were said to perpetuate values and beliefs that were 'unhelpful' to users and by association, people with hepatitis C. Many health care workers were reported to view illicit drug use as a criminal rather than a public health issue. Manifestations of discrimination are varied, however, one example given by workers from methadone clinics and needle and syringe outlets claimed that pain relief is difficult to get if the health care worker thinks that the patient is a user who is just 'shopping for Pethidine'. Some GPs and nurses were described as openly hostile to users and often dismissive in their treatment of users.

According to a methadone clinic worker, the label 'scum-bag junkies' is often applied to users in health care settings. Many non-users see illicit drug use as an 'evil' pursuit that stems from a moral and personal inadequacy whereby users cannot, or will not, resist taking drugs (Gilmore 1996). This socially pervasive interpretation positions drug users as self-indulgent, weak-willed and criminal. Health care workers' negative attitudes to drug users may be based on issues of morality and health, and reinforced on the grounds that injecting drug use is an illegal activity. A quote from a woman on a methadone maintenance program highlights the poor attitudes and treatment leveled at injecting drug users by some health care workers:

**'I present as a nice North Shore mum, but when I go to the methadone clinic.... staff are rude, unhelpful, badly informed, and their treatment of people who can't fight back is contemptible. They make fun of their clients, comment on their clothes and mental condition and generally act like they are infinitely superior. This is a private clinic. What the hell happens at public ones?'**

The stigmatisation and concomitant aggressive dislike of injecting drug users was so common in health settings that some service providers believed that injecting drug users only go to see a doctor 'when they absolutely must', and that they expected to experience discrimination from GPs and other health care workers. Individuals and service providers suggested that this self-limiting behaviour by users reduces the incidence of user-related discrimination, and contributes to an under-estimation of the severity of discrimination.

The fear and dislike of injecting drug users and ignorance about hepatitis C infection appears to be widespread. The equation of infection and injecting drug use can be regarded as so pervasive among the general community that it affects all. In the words of one user:

**'People are ... scared of you being a drug user ... because straightaway you're likely to have everything.'**

## **F. Themes of Stigma and Practice of Discrimination**

### **F1. Disclosure**

Disclosure emerged as a major theme in the Enquiry, and in the context of health care settings disclosure often resulted in a range of negative outcomes for people. People commented on 'a change' or 'a shift' that occurs among some health care workers following disclosure of hepatitis C sero-status. A submission from a user organisation states:

**'When you disclose your status [to a health care worker], you see a shift and they treat you differently, but what can you do about that?'**

Similarly, a man believes he is doing the right thing by disclosing to health care workers, however, when he does he notices that:

**'...the atmosphere changes, you know their body language changes and the way they sit back as if to put distance between themselves and me.'**

These experiences have caused these patients to rethink their habit of disclosing as they believe their interactions with health care workers would be less stressful if they did not disclose.

Reaction to disclosure of hepatitis C infection was not always so subtle. Often health care workers were reported to behave in a patronising and abusive manner, assuming infection occurred through injecting drug use regardless of patients' accounts. For example, when a patient with medically acquired hepatitis C objected to his doctor's assumption that his infection was the result of injecting drug use, his doctor retorted:

**'...all you junkies are liars.'**

Service providers supported observations by individuals that following a disclosure, health care workers often assume a history of injecting. These assumptions also occur in workplace contexts. Employees tell of their experiences with co-workers and employers following workplace disclosures of hepatitis C. Often rumours circulate throughout the work environment that position sero-positive people as 'heroin addicts' and these may be accompanied by innuendo regarding their sex life. Similarly, positive people were sometimes marginalised or completely excluded from friendship networks, rumours were circulated about their sexual practices and drug use, families behaved differently with loved ones, and relationships became very tense or completely broke-down. One woman wrote despairingly of the effects of disclosure on her relationship:

**'My husband of fourteen years never has sex with me now, and has lost all loving feelings towards me. I am a loving person and give love and need love [and] that has hurt...'**

Finally, disclosing a hepatitis C positive status to organisations like insurance companies and banks often resulted in poor outcomes for people. Life insurance policies and mortgage insurance were reportedly denied to those who had disclosed their positive sero-status. These outcomes exemplify a cross-section of people's reactions to the disclosure of an infection associated with a stigmatised practice.

Scambler and Hopkins (1986) discuss two different ways that people experience stigma. 'Felt' stigma involves the perceptions that people have about their own condition and the ways that others respond to this, and 'enacted' stigma describes the actual experience of discrimination. 'Felt' stigma describes a fear of discrimination that may cause people to behave in ways to reduce the possibility of 'enacted' stigma (Malcolm et al. 1998). In the context of hepatitis C, 'felt' stigma implies that people will often not disclose their positive sero-status and/or injecting drug use to those who may be in a position to discriminate against them for fear of negative consequences.

Whether discriminatory responses occur due to ignorance and/or a dislike of people who inject drugs, they reflect attempts to establish and maintain distance from the threat of disease and to uphold what are seen as important community values. The following describes a range of possible outcomes from disclosure, highlighting processes of stigmatisation and categorisation of people into out-groups.

## **F2. The 'innocent' and 'guilty' victims of hepatitis C**

It is apparent that communities make a distinction between 'guilty' and 'innocent' victims of some epidemics (Herek & Glunt 1988). Where an epidemic is associated with an already stigmatised population, blame for infection is attributed to the victims' inherent deviance and aberrant lifestyle. Because injecting is a stigmatised practice and seen as a voluntary behaviour, the community positions injectors as 'guilty' victims of hepatitis C, justifying their exclusion from society's concerns. Throughout the Enquiry, people living with hepatitis C repeatedly expressed concerns regarding the assumptions made by others relating to how their infection was acquired. It was common for health care workers, other service providers and people from the general community to label hepatitis C positive people as either ex or current injecting drug users, responsible for their own infection and therefore 'guilty' victims of the virus. A hepatitis C service provider claims that health care workers generally feel that people living with hepatitis C:

**'...only have themselves to blame and that they are less worthy of health care services because they are, or were, injecting drug users, even if fleetingly.'**

Similarly, this attitude was evident among people's friendship networks. Below an ex-user describes a 'friend's' reaction to her hepatitis C disclosure:

**'One 'friend' went so far as to say that those who contracted hep C through medical procedures or workplace injury are entitled to feel much more upset about having HCV than 'people like me'.**

Finally, a submission from a man with medically acquired hepatitis C implied that people are rational beings and must be held accountable for their own behaviour. Therefore, those with medically acquired hepatitis C should be put ahead of people who acquired the virus through injecting drug use when it comes to selecting people for places in treatment trials:

**'...drug user(s) should be at a lower level...everyone is responsible for their own action(s), drug users or otherwise.'**

## **F3. Discrimination of hepatitis C-related health care workers**

Claims were made at the Enquiry that health care workers discriminated against service providers who work in the hepatitis C and alcohol and other drugs (AOD) health services. Hepatitis C and AOD workers reportedly bear the stigma of their clients and were often assumed to be hepatitis C positive 'ex-junkies' by other health care providers. A worker starting a new job in the area of hepatitis C service provision claimed that a colleague remarked in an intimidating manner:

**'I suppose you have to have hep C to get that position'.**

Generally, health providers positioned AOD workers on the margins of health care. It was claimed that staff at needle and syringe programs (NSP) were 'often at odds' with non-AOD health care workers who see NSP clients as undeserving of health care. Similarly, a health care worker who acquired hepatitis C from a needle-stick injury was advised by his solicitor and doctor not to disclose his status to fellow workers for fear of discrimination.

## **F4. The tools of harm reduction: resistance to drug-related health services**

Related to health care workers' and the general community's ignorance of hepatitis C infection was the often cited poor understanding of the role and place of needle and syringe programs, methadone maintenance treatment and alcohol and other drug services in the public health system. In some centres, the media is claimed to manipulate hepatitis C issues to promote stigmatisation and discrimination, and media articles and reports do not mention the positive aspects of needle and syringe programs, methadone prescribing and alcohol and other drug services. Several methadone maintenance clients as well as

service providers reported discrimination and discussed the need for some health care workers and the community generally, to be re-educated about harm reduction and the benefits of needle and syringe programs and methadone maintenance treatment. In some regions, needle and syringe vending machines were vandalised. The suspects included local business people and community identities.

A worker from a methadone clinic reported aggravation from local business people who expressed their wish to see the clinic closed or moved out of their area. Similarly, a private methadone clinic was closed down in a regional centre due to agitation from the local community and in another region local business people have blamed a methadone clinic operating in the central business district for the downturn in local business. An aboriginal health worker indicated that it would be difficult to change attitudes in the aboriginal community about needle and syringe programs because they are seen as 'sending the wrong message'. Another worker believes that the Aboriginal Medical Service resists needle and syringe programs and education campaigns regarding injecting drug use because the 'older people' who sit on the boards do not engage with the issue of harm reduction. A service provider suggested that community ignorance and cynicism of harm reduction is reflected in the labelling of 'Fit-packs' as 'Party-packs' by some health care workers. Another health worker stated that a common attitude expressed by people in her Area Health Service is:

**'...we're not against harm minimisation, but not in our backyard'.**

## **F5. Access to hepatitis C and other health services**

Discriminatory attitudes and practices from the health care sector were having an effect on people accessing hepatitis C-related and other health services, according to service providers. Some groups of hepatitis C positive people, like injecting drug users and people from culturally and linguistically diverse backgrounds, are not accessing a range of health services that could assist them due to fear of (further) discrimination. Service providers and individuals cite people using non-disclosure as a means to prevent discrimination and this is thought to affect which services are accessed. Also, hepatitis C-related discrimination was having an effect on health service provision for hepatitis C positive people, as highlighted by a CEO of an Area Health Service:

**'...the ongoing discriminatory attitudes often held by health workers, including general practitioners, and those in the wider community hamper the further development of co-ordinated health and welfare services for people living with hepatitis C.'**

Some of these discriminatory practices concerned breaches of confidentiality and withholding of treatment.

## **F6. Confidentiality**

Within health contexts, the careless handling of confidential information about hepatitis C patients was a significant theme within the submissions. Consistent with a prediction of social identity theory, there appeared to be less concern for the rights to confidentiality of stigmatised patients than for other patients. Confidentiality was compromised through, for example: the use of colour-coded wrist-bands signifying hepatitis C to staff and anyone in the know; staff speaking loudly in a public ward about a patient's hepatitis C positive sero-status; and signs displayed above beds and easily legible to the public declaring 'Hepatitis C positive'. Breaches of medical confidentiality lead to relationship breakdown and personal information leaking into friendship networks, workplaces and among families.

Service providers cited particular difficulties among rural and smaller communities where the confidentiality of hepatitis C patients' health information was said to be hard to ensure as 'everyone knows each other'. A nurse reported that in rural settings, health care workers can often recognise hepatitis C positive patients through their descriptions and that this information is passed among other health care workers.

Confidential medical records were erroneously completed and carelessly mishandled by doctors and nursing staff according to several submissions. A patient who disclosed his hepatitis C sero-status to his doctor with an explanation that he had acquired the virus after a blood transfusion, some time later observed that his medical file indicated he had had a history of unsafe injecting practice. In another instance, a patient's file was marked 'hepatitis C positive' and left at the end of the bed where a friend observed it. This information was then passed around the patient's social network resulting in loss of friends and exclusion from this network. Some patients reported that their blood test results were given to them over the phone. Similarly, service providers reported that sex workers were given their test results in a careless manner that compromised their confidentiality.

## **F7. Poor medical treatment and exclusion from health services**

It was common among the submissions to hear reports of poor treatment by nurses, doctors and specialists of hepatitis C and injecting drug use patients in hospitals. Following disclosure of a positive sero-status patients were often placed last on the day's surgery list. This resulted in anger and frustration from hours spent waiting without food, sometimes in pain and often with no explanation. Examples were provided of health care workers using 'abusive, patronising, paternalistic and condescending' language, such as in the case of a psychiatrist who took away a methadone patient's right to be chemist-dosed, telling his patient that he wanted him 'on a leash, a tight leash like an animal'. A sero-positive patient admitted to hospital for

surgery was told by a nurse that she would be placed on 'the dirty list' and that 'her sheets would have to be burnt' when she left. A patient reported that he was not assisted to shave, was spoken to 'badly' and suffered bedsores when nurses avoided him after he had disclosed his hepatitis C positive status.

A number of people discussed their experience of being denied pain relief after disclosing their hepatitis C infection when presenting at hospitals and dentists. They believed that pain relief was denied because doctors assumed that the patients were injecting drug users. These assertions were supported by service providers from various Area Health Services in NSW. Hepatitis C patients found it hard to get pain relief if nursing staff or doctors knew the patient to be on a methadone maintenance program or a current injecting drug user.

Exclusion from medical treatment and health services was cited by individuals and service providers. Exclusion exemplifies the creation of boundaries that social identity theory predicts will occur when specific groups or practices are deemed incompatible or threaten hegemonic group values. Claims were made that some general practitioners and dentists refused to treat hepatitis C positive patients. A dentist reportedly stated that he 'did not want to see people with viruses' in his practice, while doctors at a newly opened medical practice advertised that they did not want to see alcohol and other drug clients at their surgery. Several people reported that doctors and dentists had been 'unhelpful' in providing treatment or information regarding hepatitis C once patients had disclosed their positive sero-status.

Similarly, people claimed they were denied access to needles and syringes from some hospital emergency department outlets. A large user organisation stated that current injecting drug users are sometimes denied access to combination treatments for hepatitis C because of a belief that they cannot comply with drug taking regimens. Also, claims were made of sero-positive people being 'rushed through' health services while others commonly complained about receiving no pre or post test counselling for hepatitis C blood testing.

## **G. Affective responses to hepatitis C-related discrimination**

The experience of discrimination can elicit a range of reactions and this was evident from the submissions to the Enquiry. Individuals and service providers attested to a significant degree of anger as a result of their experiences of discrimination. This was markedly apparent when discriminatory practices were encountered from the health care sector, particularly if it involved a doctor or a specialist. Patients described how they were often regarded with 'a complete lack of compassion' and expressed their anger and humiliation at being treated like 'untouchable(s)'. Some patients 'felt disturbed' at being ill yet considered by their doctor to be unworthy of medical treatment. Patients commented on their frustration at not being able to change their doctors' attitudes or educate their doctors about living with hepatitis C. As one man writes:

**'I felt frustrated, disappointed and angry and felt that the surgeon was not doing his job. I felt that I had been discriminated against [and] I felt like giving up on health care providers...I found the whole incident very distressing. It was hideous. I feel shattered. It's changed my whole life.'**

In contexts outside of the health care sector, the experience of discrimination created similar negative affective responses in people. Evidence highlighted the difficulties people had, following the loss of a loved one, in dealing with grief and achieving closure as a result of discriminatory practices carried out by some funeral service providers. Anger was directed at large private sector organisations for their attitudes to, and discriminatory treatment of, employees who had either disclosed their sero-status or were suspected of having a chronic infectious disease such as hepatitis C. People also discussed processes of self-reassessment and re-evaluation that occurred because of the stressful effects of discrimination on their close personal relationships. A man who had been refused life insurance because of his hepatitis C positive sero-status writes:

**'...my inability to provide financial security for my family has left me very worried about the future and totally demoralised...[my wife's] constant distress at my inability...has had a detrimental effect on my confidence, self-esteem and ability to be a good father.'**

Finally, a divorcee writes about her ex-husband's refusal to touch her following disclosure of her hepatitis C diagnosis. Here, she discusses her fear of further discrimination within future relationships:

**'...[hepatitis C] has devastated my life, I know I will never be able to have an intimate relationship with a man because I would be [too] scared to tell, and I could not lie.'**

### **G1. Learned helplessness**

Submissions contained evidence of a learned helplessness (Seligman et al. 1980) operating among injecting drug users. If stigmatised people have experienced poor treatment in the past, they may come to expect further discrimination and integrate these negative experiences into their sense of self. As in a state of learned helplessness stigmatised people who have experienced ongoing discrimination may be unmotivated or unable to seek redress. Evidence from a community legal centre stated that members of some marginalised groups, such as injecting drug users, are so used to discrimination they can no longer objectively perceive it when it occurs:

**'An act of discrimination on the basis of hepatitis C status may be difficult to discern for a person who is treated with a**

**lack of respect on an everyday basis as 'dirty', 'immoral' or 'subhuman' by fellow citizens.'**

A common attitude found among injectors, and discussed in submissions from a range of organisations, related to people's aversion to making formal complaints with regard to hepatitis C-related discrimination issues:

**'I'm sick and tired of not having complaints acted upon. I don't complain anymore.'**

**'Who would you complain to...and would they really care?'**

## **H. Societal forms of hepatitis C-related stigmatisation and discrimination**

It has been observed that in Australia hepatitis C policy was slow to develop when compared with the urgency that governments exhibited in their response to the HIV epidemic (Hulse 1997). One reason for this is the view that the virus is largely confined within injecting drug user populations and is regarded as unlikely to cross over into mainstream Australian society. Hulse argues that policy was slow to develop because injecting drug users are perceived by the health bureaucracy as disorganised and do not constitute a 'community' in the same sense as the gay community that helped to enable an efficient response during the early years of the HIV epidemic. He points out that power for making and informing public health policy concerning hepatitis C has shifted back to senior health bureaucrats and away from giving a role to 'affected' communities (Hulse 1997). It is likely that such bureaucratic stigmatisation endangers the development of relevant policy sensitive to the needs of a diverse population as represented by the 'hepatitis C community'. Bureaucratic apathy concerning this epidemic has contributed indirectly to hepatitis C-related discrimination (Hulse 1997). Denial by governments of the existence of an epidemic and those most affected by it may have contributed to increasing the isolation and stigmatisation of people living with hepatitis C while simultaneously discrediting their needs. The experience of HIV/AIDS in some countries of the world has illustrated how this occurs (Malcolm et al. 1998).

Injecting drug use is a most efficient vector of hepatitis C transmission, however, federal and State governments in Australia are reluctant to engage with the issue of drug law reform. Generally, voices seeking drug law reform as a means by which to reduce viral transmission and address a range of health related issues for people living with hepatitis C were notably scarce throughout the Enquiry. Calls for drug law reform were usually expressed as an aside or delivered as part of a 'wish-list', something that people would like to see happen but something they felt was years and possibly decades away. In the meantime, a key stakeholder in the field of alcohol and other drugs commented that current drug policy is exacerbating the risks for hepatitis C virus transmission. Some service providers and individuals suggested drug law reform as an option to reduce viral transmission as well as hepatitis C-related discrimination. A submission from a prisoners' advocacy organisation blames society's prohibitive stance on drug use as 'one of the leading risk factors to public health in NSW' because of the level of hepatitis C infection within prisons and the ease at which it can be transmitted in that context and in the wider community:

**'While so much has been achieved in the wider society to...lower [hepatitis C] infection rates, the prison system and its discriminatory practices is actually an institutional incubator threatening to undermine wider social policy, practice and safety.'**

This organisation suggested that by reducing the number of people receiving prison sentences for drug offences, the incidence of hepatitis C infection in society, as well as hepatitis C-related discrimination, would be reduced.

## **I. Conclusion**

This document provides an analysis of the central themes to emerge from the submissions tendered to the Anti-Discrimination Board of New South Wales' Enquiry into Hepatitis C-related Discrimination. In order to gain some understanding of the nature of hepatitis C-related discrimination, submissions to the Enquiry are viewed and discussed through the theoretical lens of stigma and social identity. The document highlights society's confounding of hepatitis C infection with injecting drug use and the influence that this has on the individual experience of discrimination. The analysis describes the experience of hepatitis C-related discrimination as evident from the submissions to the Enquiry. Poor knowledge of hepatitis C, disclosure, confidentiality, 'userphobia', and health care workers' discriminatory practices and attitudes are highlighted. The negative impacts of discrimination on individuals' sense of self and the implications this has for people accessing hepatitis C-related services are discussed. Finally, societal forms of hepatitis C-related stigmatisation and discrimination are highlighted with allusion to the role of drug prohibition in hepatitis C-related discrimination.

This interpretation of the submissions to the ADB Enquiry raises several important aspects regarding hepatitis C-related discrimination. Ignorance of hepatitis C and the confounding of the virus with injecting drug use create the context for discrimination.

The relatively recent discovery of the hepatitis C virus and its high prevalence among sub-sections of the general community establishes a set of dynamics for the perpetuation of misinformation regarding, for example, transmission risks, infectiousness and disease prognosis. While knowledge within the general community regarding hepatitis C is scant, evidence from the Enquiry

shows that even among health care workers hepatitis C is often a misunderstood virus. As predicted by stigma and social identity theory, some uninformed sections of the community are reacting to people living with hepatitis C in discriminatory ways in order to preserve their distance from risks of infection. Stigmatisation of those people living with hepatitis C, through labelling them as 'sick' and infectious, is deployed as a method of preserving the physical health of communities against the complications represented by the disease.

When people are assumed to have contracted hepatitis C infection from injecting drug use, an alternative set of dynamics are established with which to view hepatitis C-related discrimination. Judgments concerning an individual's moral and personal adequacy are made via a process of categorisation that positions people with the virus as 'deviant', that is, existing outside the boundaries of accepted normal social behaviour. This establishes an 'us' and 'them' binary where injecting drug users are perceived to belong to a homogeneous out-group that has a lifestyle informed by a value system inconsistent with, and inferior to, the majority of society. This out-group is characterised as having prioritised pleasure above physical health, compromised their rationality, and participated in illegal activities. Members of the out-group are viewed as a danger to themselves, those close to them and, indeed, the general community. People with hepatitis C are judged as 'guilty' victims and responsible for their infection, justifying discrimination by the non-using majority. The fear and dislike of injecting drug users helps explain why users: receive poor treatment from a variety of social institutions; may be denied pain relief in hospitals; have their rights to confidentiality in medical settings violated; receive increasingly under-funded services; may at times be totally excluded from health care; and are held personally responsible for their physical, moral and social impoverishment.

Many of the submissions to the Enquiry pointed to the health care system as a primary source of hepatitis C-related discrimination. Submissions from both individuals and health care workers highlighted instances of discrimination. Because people living with hepatitis C are more likely to disclose their positive sero-status to doctors, dentists, specialists and nurses than in other community contexts, health care is a key setting in which hepatitis C-related discrimination is likely to be enacted.

Continued discrimination and stigmatisation of people living with hepatitis C will obstruct efforts to prevent the further spread of the virus among the community. Hepatitis C-related discrimination is extensive and is a complex social problem that encompasses many secondary issues. Addressing community ignorance of the virus may assist in ameliorating some people's experiences of discrimination, however, increased knowledge alone will not be sufficient to address hepatitis C-related discrimination within all domains. As theory suggests, discrimination of people living with hepatitis C may serve a socially adaptive function for certain groups by reinforcing cultural norms and values that are at odds with people who belong to, or are perceived to belong to affected groups, such as injecting drug users. Legislative change may be the first step in a process to counter stigmatisation and discrimination of people living with hepatitis C. Law reform could pave the way for broader changes in the attitudes and social norms that currently inform discriminatory practice.

## J. References

- Acker, J. (1993). Stigma or legitimation: a historical examination of the social potentials of addiction disease models. *Journal of Psychoactive Drugs*, 25(3): 193–205.
- Burrows, B. & Bassett, B. (1996). Meeting the needs of people in Australia living with hepatitis C. National Hepatitis C Councils Education Reference Group. Canberra: Commonwealth Department of Health and Family Services.
- Commonwealth Department of Health and Aged Care. (2000). National hepatitis C strategy 1999–2000 to 2003–2004. Canberra: Publications Production Unit (Public Affairs, Parliamentary and Access Branch).
- Crimp, D. (1987c). AIDS: cultural analysis, cultural activism. (Ed) D. Crimp. Cambridge, Massachusetts: MIT Press: 3–16.
- Crofts, N., Louie, R., Loff, B. (1997). The next plague: Stigmatisation and discrimination related to hepatitis C virus infection in Australia. *Health and Human Rights*, 2(2): 86–97.
- Crofts, N., Hopper, J., Bowden, D.S., Breschkin, A.M., et al. (1993). Hepatitis C virus infection among a cohort of Victorian injecting drug users. *Medical Journal of Australia*, 159: 237–241.
- Crofts, N., Jolley, D., Kaldor, J., van Beek, I., et al. (1997). Epidemiology of hepatitis C virus infection among injecting drug users in Australia [Review]. *Journal of Epidemiology and Community Health*, 51(6): 692–697.
- Dolan, M. (1997). *The hepatitis C handbook*. London: Catalyst Press.
- Dore, G. & Kaldor, J. (1996). HIV and HCV: Contrasting epidemics. *Today's Life Science*, Oct: 30–32.
- English, R. & Foster, G. (1997). *Living with hepatitis C*. London: Robinson.
- Feagin, J.R. & Feagin, C.B. (1978). *Discrimination American Style*. New Jersey: Prentice Hall, Inc.
- Freeman, A.J., Zekry, A., Whybin, L.R., Harvey, C.E., et al. (2000). Hepatitis C prevalence among Australian injecting drug users in the 1970s and profiles of virus genotypes in the 1970s and 1990s. *Medical Journal of Australia*, 172(12):588–591.
- Fulton, R. (1999). The stigma of substance use: a review of the literature. Centre for Addiction and Mental Health, Toronto, Canada. <http://sano.afr.org/stigma/litrev.htm>

- Gilmore, N. & Somerville, M.A. (1994). Stigmatisation, scapegoating and discrimination in sexually transmitted diseases: overcoming 'them' and 'us'. *Social Science and Medicine*, 39(9): 1339–1358.
- Gilmore, N. (1996). Drug use and human rights: privacy, vulnerability, disability, and human rights infringements. *Journal of Contemporary Health, Law and Policy*, 12: 355–447.
- Glaser, B.G. & Strauss, A. (1970). *The discovery of grounded theory*. New York: Aldine.
- Goffman, E. (1968). *Stigma. Notes on the management of spoiled identity*. Harmondsworth, England : Penguin.
- Henriques, J. (1984). Social psychology and the politics of racism. In J. Henriques, W. Hollway, C Urwin, C. Venn & V. Walkerdine (Eds.), *Changing the Subject*. London and New York: Methuen: 60–89.
- Hepatitis C Sub-Committee. (1998). Australian National Council on AIDS and Related Diseases. Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia. National Centre in HIV Epidemiological and Clinical Research, The University of New South Wales.
- Hepworth, J. & Krug, G.J. (1999). A socio-cultural perspective on the effects of a new virus on a community's health. *Journal of Health Psychology*, 4(2): 237–246.
- Hepworth, J. & Krug, G.J. (1997). Hepatitis C and policy implementation: ethics as a dialogic process for resource allocation. [Editorial]. *Australian and New Zealand Journal of Public Health*, 21(1): 4–7.
- Herdman, E. & Kippax, S. (1995). Institutional discrimination: critical ethnography of HIV/AIDS related discrimination in a hospital setting. HIV/AIDS & Society Publications: Macquarie University, Sydney.
- Herek, G.M. & Glunt, E.K. (1988). An epidemic of stigma: public reactions to AIDS. *American Psychologist*, 43(11): 886–891.
- Hulse, G.K. (1997). Australia's public health response to HIV and HCV: a role for 'affected' communities. *Drug and Alcohol Review*, 16: 171–176.
- Jones, E.E. (1984c). *Social stigma: the psychology of marked relationships*. New York: W.H. Freeman.
- Kippax, S., Tillet, G., Crawford, J. & Cregan, J. (1991). Discrimination in the context of AIDS: disease and deviance. Macquarie University AIDS Research Unit: Sydney.
- Law, M.G. (1999). Hepatitis C Virus Projections Working Group. Modelling the hepatitis C epidemic in Australia. *Journal of Gastroenterology and Hepatology*, 14(11): 1100–1107.
- Lupton, D. (1994c). *Moral threats and dangerous desires: AIDS in the news media*. London: Taylor and Francis.
- MacDonald, M., Crofts, N. & Kaldor, J. (1996). Transmission of hepatitis C virus: Rates, routes and cofactors. *Epidemiological Review*, 18(2): 137–148.
- Malcolm, A., Aggleton, P., Bronfman, M., Galvao, J., Mane, P. & Verrall, J. (1998). HIV-related stigmatization and discrimination: its forms and contexts, *Critical Public Health*, 8(4): 347–370.
- Marr, D. (1999). *The high price of heaven*. St. Leonards, NSW: Allen and Unwin.
- Merton, R.K. (1970). Discrimination and the American Creed. In P. Rose (Ed.) *The Study of Society*, second edition. New York: Random House.
- National Centre in HIV Epidemiology and Clinical Research. (2000). HIV/AIDS, Hepatitis C and Transmissible Infections in Australia Annual Surveillance Report 2000. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW.
- Pittam, J. & Gallois, C. (2000). Malevolence, stigma, and social distance: Maximizing intergroup differences in HIV/AIDS discourse. *Journal of Applied Communication Research*, 28(1): 24–43.
- Scambler, G. & Hopkins, A. (1986). Being epileptic: coming to terms with stigma. *Sociology of Health and Illness*, 8: 26–43.
- Sears, D.O., Peplau, L.A. & Taylor, S.E. (1991). *Social psychology* (7<sup>th</sup> edition). Englewood Cliffs, New Jersey: Prentice Hall.
- Seligman, M. & Weiss, J.M. (1980). Coping behaviour: learned helplessness, physiological change and learned inactivity. *Behavior Research and Therapy*, 18(5): 459–512.
- Sontag, S. (1989). *AIDS and its metaphors*. New York: Farrar, Straus and Giroux.
- Turner, C.F., Miller, H.G. & Moses, L.E. (Eds.) (1989). AIDS: sexual behaviour and intravenous drug use. Committee on AIDS Research and the Behavioural, Social and Statistical Sciences, Commission on Behavioural and Social Sciences and Education, National Research Council. Washington D.C.: National Academy Press.
- van Ree, E. (1997). Fear of drugs, *The International Journal of Drug Policy*, 8(2): 93–100.
- Wodak, A. (1997). Hepatitis C: Waiting for the Grim Reaper [Editorial]. *Medical Journal of Australia*, 166: 284–285.
- Wood, C. (1997). Living with hepatitis C. *Connexions*, N.S.W. Drug and Alcohol Authority. Darlinghurst, NSW: 14–17.

# Appendix F

## Extracts of Legislation

This Appendix provides extracts of legislation referred to in this report.

### Anti-Discrimination Act 1977 (NSW)

#### 4 Definitions

*disability* means...

- (b) the presence in a person's body of organisms causing or capable of causing disease or illness...

*services* includes:

- (a) services relating to banking, insurance and the provision of grants, loans, credit or finance,
- (b) services relating to entertainment, recreation or refreshment,
- (c) services relating to transport or travel,
- (d) services of any profession or trade,
- (e) services provided by a council or public authority,
- (f) services consisting of access to, and the use of any facilities in, any place or vehicle that the public or a section of the public is entitled or allowed to enter or use, for payment or not.

#### 49A Disability includes past, future and presumed disability

A reference in this Part to a person's disability is a reference to a disability:

- (a) that a person has, or
- (b) that a person is thought to have (whether or not the person in fact has the disability), or
- (c) that a person had in the past, or is thought to have had in the past (whether or not the person in fact had the disability), or
- (d) that a person will have in the future, or that it is thought a person will have in the future (whether or not the person in fact will have the disability).

#### 49B What constitutes discrimination on the ground of disability

(1) A person (*the perpetrator*) discriminates against another person (*the aggrieved person*) on the ground of disability if, on the ground of the aggrieved person's disability or the disability of a relative or associate of the aggrieved person, the perpetrator:

- (a) treats the aggrieved person less favourably than in the same circumstances, or in circumstances which are not materially different, the perpetrator treats or would

treat a person who does not have that disability or who does not have such a relative or associate who has that disability; or

(b) requires the aggrieved person to comply with a requirement or condition with which a substantially higher proportion of persons who do not have that disability, or who do not have such a relative or associate who has that disability, comply or are able to comply, being a requirement which is not reasonable having regard to the circumstances of the case and with which the aggrieved person does not or is not able to comply.

(2) For the purposes of subsection (1) (a), something is done on the ground of a person's disability if it is done on the ground of the person's disability, a characteristic that appertains generally to persons who have that disability or a characteristic that is generally imputed to persons who have that disability.

(3) For the purposes of, but without limiting, this section, the fact that a person has a disability of or relating to vision, hearing or mobility has, or may be accompanied by, a dog which assists the person in respect of that disability, is taken to be a characteristic that appertains generally to persons who have that disability, but nothing in this Act affects the liability of any such person for any injury, loss or damage caused by the dog.

(4) A reference in this section to persons who have a disability ("the particular disability") is a reference to persons who have the particular disability or who have a disability that is substantially the same as the particular disability.

#### 49C What constitutes unjustifiable hardship

In determining what constitutes unjustifiable hardship for the purposes of this Part, all relevant circumstances of the particular case are to be taken into account including:

- (a) the nature of the benefit or detriment likely to accrue or be suffered by any persons concerned; and
- (b) the effect of the disability of a person concerned; and
- (c) the financial circumstances and the estimated amount of expenditure required to be made by the person claiming unjustifiable hardship.

#### 49D Discrimination against applicants and employees

(1) It is unlawful for an employer to discriminate against a person on the ground of disability:

- (a) in the arrangements the employer makes for the

purpose of determining who should be offered employment, or

(b) in determining who should be offered employment, or  
(c) in the terms on which the employer offers employment.

(2) It is unlawful for an employer to discriminate against an employee on the ground of disability:

(a) in the terms or conditions of employment which the employer affords the employee, or

(b) by denying the employee access, or limiting the employee's access, to opportunities for promotion, transfer or training, or to any other benefits associated with employment, or

(c) by dismissing the employee, or

(d) by subjecting the employee to any other detriment.

(3) Subsections (1) and (2) do not apply to employment:

(a) for the purposes of a private household, or

(b) where the number of persons employed by the employer, disregarding any persons employed within the employer's private household, does not exceed 5, or

(c) by a private educational authority.

(4) Nothing in subsection (1) (b) or (2) (c) renders unlawful discrimination by an employer against a person on the ground of the person's disability if taking into account the person's past training, qualifications and experience relevant to the particular employment and, if the person is already employed by the employer, the person's performance as an employee, and all other relevant factors that it is reasonable to take into account, the person because of his or her disability:

(a) would be unable to carry out the inherent requirements of the particular employment, or

(b) would, in order to carry out those requirements, require services or facilities that are not required by persons without that disability and the provision of which would impose an unjustifiable hardship on the employer.

(5) For the purposes of subsection (3) (b), a corporation is taken to be the employer of the employees of any other corporation which, with respect to the firstmentioned corporation, is taken to be a related corporation within the meaning of the Corporations Law.

In relation to discrimination in employment, see also sections 49E–49K, covering discrimination against commission agents, contract workers, in partnerships, by local government councillors and industrial organisations, qualifying bodies and employment agencies.

## 49L Education

(1) It is unlawful for an educational authority to discriminate against a person on the ground of disability:

(a) by refusing or failing to accept his or her application for admission as student; or

(b) in the terms on which it is prepared to admit him or her as a student.

(2) It is unlawful for an educational authority to discriminate against a student on the ground of disability:

(a) by denying him or her access, or limiting his or her access, to any benefit provided by the educational authority; or

(b) by expelling him or her; or

(c) by subjecting him or her to any other detriment.

(3) Nothing in this section applies to or in respect of:

(a) a private educational authority; or

(b) a refusal or failure to accept a person's application for admission as a student by an educational authority where the educational authority administers a school, college, university or other institution which is conducted solely for students who have a disability which is not the same as that of the applicant.

(4) Nothing in subsection (1) (a) or (2) (b) renders it unlawful to discriminate against a person on the ground of disability where, because of the person's disability, the person requires services or facilities that are not required by students who do not have a disability and the provision of which would impose unjustifiable hardship on the educational authority.

(5) Nothing in subsection (2) (a) renders it unlawful to discriminate against a person on the ground of disability where, because of the person's disability, the person requires the benefit to be provided in a special manner and the benefit cannot without unjustifiable hardship be so provided by the educational authority.

## 49M Provision of goods and services

(1) It is unlawful for a person who provides, for payment or not, goods or services to discriminate against a person on the ground of disability:

(a) by refusing to provide the person with those goods or services; or

(b) in the terms on which he or she provides the person with those goods or services.

(2) Nothing in this section renders it unlawful to discriminate against a person on the ground of the person's disability if the provision of the goods and services would impose unjustifiable hardship on the person who provides the goods and services.

## 49N Accommodation

(1) It is unlawful for a person, whether as principal or agent, to discriminate against a person on the ground of disability:

(a) by refusing the person's application for accommodation, or

(b) in the terms on which the person is offered accommodation, or

(c) by deferring the person's application for accommodation or according the person a lower order of precedence in any list of applicants for that accommodation.

(2) It is unlawful for a person, whether as principal or agent, to discriminate against a person on the ground of disability:

- (a) by denying the person access, or limiting the person's access, to any benefit associated with accommodation occupied by the person, or
- (b) by evicting the person, or
- (c) by subjecting the person to any other detriment.

(3) Nothing in this section applies to or in respect of the provision of accommodation in premises if:

- (a) the person who provides or proposes to provide the accommodation or a near relative of that person resides, and intends to continue to reside, on those premises, and
- (b) the accommodation provided in those premises is for no more than 6 persons.

(4) Nothing in this section applies to the provision of accommodation in premises where special services or facilities would be required by the person with a disability and the provision of such special services or facilities would impose unjustifiable hardship on the person providing or proposing to provide the accommodation whether as principal or agent.

(5) Nothing in this section applies to the provision of accommodation to persons who have a particular disability by a charitable body or other body that does not distribute its profits to members.

(6) Nothing in subsection (2) (a) renders it unlawful to discriminate against a person on the ground of disability where, because of the person's disability, the person requires the benefit to be provided in a special manner and the benefit cannot without unjustifiable hardship be so provided by the person who provides the accommodation.

#### **49Q Superannuation, insurance**

Nothing in this Part renders unlawful discrimination against a person on the ground of disability in the terms or conditions appertaining to a superannuation or provident fund or scheme or with respect to the terms on which an annuity, a life assurance policy, an accident or insurance policy or other policy of insurance is offered or may be obtained, where:

- (a) the terms or conditions:
  - (i) are based upon actuarial or statistical data on which it is reasonable to rely, and
  - (ii) are reasonable having regard to the data and any other relevant factors, or
- (b) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the terms or conditions are reasonable having regard to any other relevant factors, and the source on which the data referred to in paragraph (a) is based is disclosed to the Tribunal, where the Tribunal so requires, and any other relevant factors to which regard has been had as referred to in paragraph (a) or (b) are disclosed to the Tribunal, where the Tribunal so requires.

## **50 Victimisation**

(1) It is unlawful for a person (*the discriminator*) to subject another person (*the person victimised*) to any detriment in any circumstances on the ground that the person victimised has:

- (a) brought proceedings against the discriminator or any other person under this Act,
- (b) given evidence or information in connection with proceedings brought by any person against the discriminator or any other person under this Act,
- (c) alleged that the discriminator or any other person has committed an act which, whether or not the allegation so states, would amount to a contravention of this Act, or
- (d) otherwise done anything under or by reference to this Act in relation to the discriminator or any other person, or by reason that the discriminator knows that the person victimised intends to do any of those things, or suspects that the person victimised has done, or intends to do, any of them.

(2) Subsection (1) does not apply to the subjecting of a person to a detriment by reason of an allegation made by the person if the allegation was false and not made in good faith.

## **54 Acts done under statutory authority**

(1) Nothing in this Act renders unlawful anything done by a person if it was necessary for the person to do it in order to comply with a requirement of:

- (a) any other Act, whether passed before or after this Act,
- (b) any regulation, ordinance, by-law, rule or other instrument made under any such other Act,
- (c) an order of the Tribunal,
- (d) an order of any court, not including an order or award of a court or tribunal having power to fix minimum wages and other terms and conditions of employment, or
- (e) (Repealed)

(2) (Repealed)

(3) Except as provided in this section, this Act has effect notwithstanding anything contained in:

- (a) the *Co-operation Act 1923*,
- (b) the *Financial Institutions (New South Wales) Act 1992*,
- (c) the *Friendly Societies (NSW) Code* or the *Friendly Societies (NSW) Regulations*,
- (c1) the *Co-operatives Act 1992*,
- (d), (e) (Repealed)
- (f) the *Registered Clubs Act 1976*,

or any instrument of whatever nature made or approved thereunder.

# Disability Discrimination Act 1992 (Cth)

## 4 Interpretations

**disability**, in relation to a person, means...

- (c) the presence in the body of organisms causing disease or illness; or
- (d) the presence in the body of organisms capable of causing disease or illness; or...

**services** includes:

- (a) services relating to banking, insurance, superannuation and the provision of grants, loans, credit or finance; or
- (b) services relating to entertainment, recreation or refreshment; or
- (c) services relating to transport or travel; or
- (d) services relating to telecommunications; or
- (e) services of the kind provided by the members of any profession or trade; or
- (f) services of the kind provided by a government, a government authority or a local government body.

## 5 Disability discrimination

(1) For the purposes of this Act, a person (**discriminator**) discriminates against another person (**aggrieved person**) on the ground of a disability of the aggrieved person if, because of the aggrieved person's disability, the discriminator treats or proposes to treat the aggrieved person less favourably than, in circumstances that are the same or are not materially different, the discriminator treats or would treat a person without the disability.

(2) For the purposes of subsection (1), circumstances in which a person treats or would treat another person with a disability are not materially different because of the fact that different accommodation or services may be required by the person with a disability.

## 11 Unjustifiable hardship

For the purposes of this Act, in determining what constitutes unjustifiable hardship, all relevant circumstances of the particular case are to be taken into account including:

- (a) the nature of the benefit or detriment likely to accrue or be suffered by any persons concerned; and
- (b) the effect of the disability of a person concerned; and
- (c) the financial circumstances and the estimated amount of expenditure required to be made by the person claiming unjustifiable hardship; and
- (d) in the case of the provision of services, or the making available of facilities — an action plan given to the Commission under section 64.

## 15 Discrimination in employment

(1) It is unlawful for an employer or a person acting or purporting to act on behalf of an employer to discriminate against a person on the ground of the other person's disability or a disability of any of that other person's associates:

- (a) in the arrangements made for the purpose of determining who should be offered employment; or
- (b) in determining who should be offered employment; or
- (c) in the terms or conditions on which employment is offered.

(2) It is unlawful for an employer or a person acting or purporting to act on behalf of an employer to discriminate against an employee on the ground of the employee's disability or a disability of any of that employee's associates:

- (a) in the terms or conditions of employment that the employer affords the employee; or
- (b) by denying the employee access, or limiting the employee's access, to opportunities for promotion, transfer or training, or to any other benefits associated with employment; or
- (c) by dismissing the employee; or
- (d) by subjecting the employee to any other detriment.

(3) Neither paragraph (1)(a) nor (b) renders it unlawful for a person to discriminate against another person, on the ground of the other person's disability, in connection with employment to perform domestic duties on the premises on which the first-mentioned person resides.

(4) Neither paragraph (1)(b) nor (2)(c) renders unlawful discrimination by an employer against a person on the ground of the person's disability, if taking into account the person's past training, qualifications and experience relevant to the particular employment and, if the person is already employed by the employer, the person's performance as an employee, and all other relevant factors that it is reasonable to take into account, the person because of his or her disability:

- (a) would be unable to carry out the inherent requirements of the particular employment; or
- (b) would, in order to carry out those requirements, require services or facilities that are not required by persons without the disability and the provision of which would impose an unjustifiable hardship on the employer.

In relation to discrimination in employment, also see Sections 16–21, covering discrimination against commission agents, contract workers, in partnerships, by registered organisations under Workplace Relations Act, qualifying bodies and employment agencies.

## 22 Education

(1) It is unlawful for an educational authority to discriminate against a person on the ground of the person's disability or a disability of any of the other person's associates:

- (a) by refusing or failing to accept the person's application for admission as a student; or
- (b) in the terms or conditions on which it is prepared to admit the person as a student.

(2) It is unlawful for an educational authority to discriminate against a student on the ground of the student's disability or a disability of any of the student's associates:

- (a) by denying the student access, or limiting the student's access, to any benefit provided by the educational authority; or
- (b) by expelling the student; or
- (c) by subjecting the student to any other detriment.

(3) This section does not render it unlawful to discriminate against a person on the ground of the person's disability in respect of admission to an educational institution established wholly or primarily for students who have a particular disability where the person does not have that particular disability.

(4) This section does not render it unlawful to refuse or fail to accept a person's application for admission as a student at an educational institution where the person, if admitted as a student by the educational authority, would require services or facilities that are not required by students who do not have a disability and the provision of which would impose unjustifiable hardship on the educational authority.

## 24 Goods, services and facilities

(1) It is unlawful for a person who, whether for payment or not, provides goods or services, or makes facilities available, to discriminate against another person on the ground of the other person's disability or a disability of any of that other person's associates:

- (a) by refusing to provide the other person with those goods or services or to make those facilities available to the other person; or
- (b) in the terms or conditions on which the first-mentioned person provides the other person with those goods or services or makes those facilities available to the other person; or
- (c) in the manner in which the first-mentioned person provides the other person with those goods or services or makes those facilities available to the other person.

(2) This section does not render it unlawful to discriminate against a person on the ground of the person's disability if the provision of the goods or services, or making facilities available, would impose unjustifiable hardship on the person who provides the goods or services or makes the facilities available.

## 25 Accommodation

(1) It is unlawful for a person, whether as principal or agent, to discriminate against another person on the ground of the other person's disability or a disability of any of that other person's associates:

- (a) by refusing the other person's application for accommodation; or
- (b) in the terms or conditions on which the accommodation is offered to the other person; or
- (c) by deferring the other person's application for accommodation or according to the other person a lower order of precedence in any list of applicants for that accommodation.

(2) It is unlawful for a person, whether as principal or agent, to discriminate against another person on the ground of the other person's disability or a disability of any of the other person's associates:

- (a) by denying the other person access, or limiting the other person's access, to any benefit associated with accommodation occupied by the other person; or
- (b) by evicting the other person from accommodation occupied by the other person; or
- (c) by subjecting the other person to any other detriment in relation to accommodation occupied by the other person; or
- (d) by refusing to permit the other person to make reasonable alterations to accommodation occupied by that person if:

- (i) that person has undertaken to restore the accommodation to its condition before alteration on leaving the accommodation; and
- (ii) in all the circumstances it is likely that the person will perform the undertaking; and
- (iii) in all the circumstances, the action required to restore the accommodation to its condition before alteration is reasonably practicable; and
- (iv) the alteration does not involve alteration of the premises of any other occupier; and
- (v) the alteration is at that other person's own expense.

(3) This section does not apply to or in respect of:

- (a) the provision of accommodation in premises if:
  - (i) the person who provides or proposes to provide the accommodation or a near relative of that person resides, and intends to continue to reside on those premises; and
  - (ii) the accommodation provided in those premises is for no more than 3 persons other than a person referred to in subparagraph (a)(i) or near relatives of such a person; or
- (b) the accommodation is provided by a charitable or other voluntary body solely for persons who have a particular disability and the person discriminated against does not have that particular disability; or

(c) the provision of accommodation in premises where special services or facilities would be required by the person with a disability and the provision of such special services or facilities would impose unjustifiable hardship on the person providing or proposing to provide the accommodation whether as principal or agent.

## 46 Superannuation and insurance

(1) This Part does not render it unlawful for a person to discriminate against another person, on the ground of the other person's disability, by refusing to offer the other person:

- (a) an annuity; or
  - (b) a life insurance policy; or
  - (c) a policy of insurance against accident or any other policy of insurance; or
  - (d) membership of a superannuation or provident fund; or
  - (e) membership of a superannuation or provident scheme;
- if:
- (f) the discrimination:
    - (i) is based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and
    - (ii) is reasonable having regard to the matter of the data and other relevant factors; or
    - (g) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.

(2) This Part does not render it unlawful for a person to discriminate against another person, on the ground of the other person's disability, in respect of the terms or conditions on which:

- (a) an annuity; or
  - (b) a life insurance policy; or
  - (c) a policy of insurance against accident or any other policy of insurance; or
  - (d) membership of a superannuation or provident fund; or
  - (e) membership of a superannuation or provident scheme;
- is offered to, or may be obtained by, the other person, if:
- (f) the discrimination:
    - (i) is based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and
    - (ii) is reasonable having regard to the matter of the data and other relevant factors; or
    - (g) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.

# Public Health Act 1991 (NSW)

## 17 Protection of identity

(1) A medical practitioner must not state the name or address of a patient:

- (a) in a certificate sent to the Director-General under section 14 in relation to a Category 5 medical condition, or
- (b) except as may be prescribed, in a written or oral communication made by the medical practitioner for the purpose of arranging a test to find out whether the patient suffers from a Category 5 medical condition.

(2) A person who, in the course of providing a service, acquires information that another person:

- (a) has been, or is required to be, or is to be, tested for a Category 5 medical condition, or
- (b) is, or has been, infected with a Category 5 medical condition,

must take all reasonable steps to prevent disclosure of the information to another person.

(3) Information about a person that is of a kind referred to in subsection (2) may be disclosed:

- (a) with the consent of the other person, or
- (b) in connection with the administration of this Act or another Act, or
- (c) by order of a court or a person authorised by law to examine witnesses, or
- (d) to a person who is involved in the provision of care to, or treatment or counselling of, the other person if the information is required in connection with providing such care, treatment or counselling, or
- (e) in such circumstances as may be prescribed.

(4) A medical practitioner or other person who fails to comply with the requirements of this section is guilty of an offence.

Maximum penalty: 50 penalty units.

Schedule 1 of the *Public Health Act* provides that a Category 5 medical condition is HIV or AIDS.

# Public Health Regulation 1991 (NSW)

## Definitions — Regulation 18....

**“List ‘A’ disease” means any one or more of the following conditions:**

- Acquired Immunodeficiency Syndrome (AIDS)
- Acute viral hepatitis (unspecified)
- Hepatitis B
- Hepatitis C
- Hepatitis D
- Human immunodeficiency virus infection (HIV infection)
- Meningococcal disease
- Rabies
- Tuberculosis;

**“List ‘B’ disease” means any one or more of the following diseases:**

- Anthrax
- Creutzfeldt-Jakob disease
- Diphtheria
- Plague
- Smallpox
- Yellow fever
- Any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Congo-Crimean fevers);

## Regulation 28 Removal of bodies from body bags

(1) An undertaker may remove from a body bag a body which the undertaker has no reason to believe is infected with a List “A” or List “B” disease for the purpose of:

- (a) embalming the body; or
- (b) preparing the body for viewing, transport, burial or cremation; or

(c) transferring the body to a coffin.

(2) An undertaker may remove from a body bag a body which the undertaker has reason to believe is infected with a List “A” disease for the purpose of:

(a) preparing the body for viewing, transport, burial or cremation; or

(b) transferring the body to a coffin.

(3) After an undertaker has embalmed or prepared a body, the undertaker must place it in a coffin or in a new body bag approved by the Director-General.

Maximum penalty: 10 penalty units.

(4) A person must not remove from an outer body bag required under clause 26 (2) a body which the person has reason to believe is infected with a List “B” disease.

Maximum penalty—subclause (4): 10 penalty units.

## Regulation 29 Body viewing

An undertaker may make available for viewing by mourners a body which the undertaker has no reason to believe is infected with a List “B” disease.

(2) However, an undertaker who makes an unembalmed body available for viewing:

(a) must not remove the body from refrigeration for a period longer than is necessary for making it available for viewing; and

(b) unless the body is to be buried or cremated immediately, must replace the body under refrigeration after the viewing; and

(c) must not allow the body to remain unrefrigerated for a period exceeding 8 hours in any day.

Maximum penalty: 5 penalty units.

An undertaker is to refuse or terminate the viewing of a body if the undertaker has reason to believe that the viewing will be, or will become, prejudicial to public health or amenity.

An undertaker must not make available for viewing a body which the undertaker has reason to believe is infected with a List “B” disease.

Maximum penalty—subclauses (3) and (4): 10 penalty units.

# Appendix G Reference List

- Andriulli, A., Mangia, A., Niro, G. and Caturelli, E. 2001 To biopsy or not biopsy (letter to the Editor), *Hepatology*, Vol. 34, 438–439.
- Australasian Society of HIV Medicine *HIV/ Viral hepatitis - A guide for primary care*, 2001, Sydney.
- Australian Hepatitis Council 2001 *Hepatitis C Anti-Discrimination Strategy 2001–2004*, Canberra.
- Australian Hepatitis Council 2001 *The Australian media guide to hepatitis C*, Canberra.
- Australian National Council on AIDS, Hepatitis C and Related Diseases 1999 *Talking sexual health: National framework for education about STIs, HIV/AIDS and blood borne viruses in the Secondary Schools*, Commonwealth of Australia, Canberra.
- Australian National Council on AIDS and Related Diseases and Intergovernmental Committee on AIDS and Related Diseases 1998 *HIV Testing Policy*, Commonwealth Department of Health and Aged Care, Canberra.
- Australian National Council on AIDS, Hepatitis C and Related Diseases and Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases 2001 *National Hepatitis C Testing Policy* (Draft), Commonwealth Department of Health and Aged Care, Canberra. [Due for release by the end of 2001].
- Awofeso, N., Harper, S. and Levy, M. 2000 Prevalence of exposure to hepatitis C virus among prison inmates 1999, *Medical Journal of Australia*, Vol. 172, 94.
- Bauman, A. and Chen, J. 2000 NSW Hepatitis C media campaign evaluation 2000 — *Report 1, Results of the impact of the hepatitis C campaign in NSW from cohort and independent sample population surveys*, Australian Centre for Health Promotion, Sydney (unpublished).
- Burrows, B. and Bassett, B. 1996 *Meeting the needs of people in Australia living with hepatitis C*. National Hepatitis C Council's Education Reference Group, Commonwealth Department of Health and Family Services, Canberra.
- Cabassi, J. 2001 *Barriers to access and effective use of anti-discrimination remedies for people living with HIV and HCV*, ANCAHRD Occasional Paper No. 1, Canberra.
- Carey, W.D., Saadeh, S. and Barnes, D. 2001 To biopsy or not biopsy (letter to the Editor), *Hepatology*, Vol. 34, 439.
- Commonwealth Department of Health and Aged Care 2000 *Hepatitis C: informing Australia's national response*, Canberra.
- Commonwealth Department of Health and Aged Care 2000 *National Hepatitis C Strategy 1999–2000 to 2003–2004*. Canberra, Publications Production Unit.
- Commonwealth Department of Health and Aged Care 2001 *National hepatitis C resource manual for health care workers*, Canberra.
- Crofts, N. 1997 A cruel and unusual punishment, *Medical Journal of Australia*, Vol. 166, 116.
- Crofts, N., Louie, R. and Loff, B. 1997 The next plague: Stigmatisation and discrimination related to hepatitis C virus infection in Australia, *Health and Human Rights*, Vol. 2, No. 2, 87–97.
- Department of Corrective Services 1996 *HIV/AIDS communicable diseases and health promotion — Policies and procedures and management guidelines*, Sydney.
- Department of Education and Training 2001 *Prevention of transmission of hepatitis*, Sydney.
- Department of Labour 2000 *Managing health and safety risks in New Zealand mortuaries*, Wellington, New Zealand.
- Dolan, K. 2000 *Surveillance and prevention of hepatitis C infection in Australian prisons: A discussion paper*, Technical Report No. 95, National Drug and Alcohol Research Council, University of NSW, Sydney.
- Dolan, K. 2001 Can hepatitis C transmission be reduced in Australian prisons? *Medical Journal of Australia*, Vol. 174, 378–379.
- Dolan, K., Topp, L. and MacDonald, M. 1999 *Needle and syringe programs — A review of the Evidence*, Australian National Council on AIDS, Hepatitis C and Related Diseases, Canberra.
- Dolan, K., Wodak, A. and Hall, W. 1998 A bleach program for inmates in New South Wales: an HIV prevention strategy, *Australian and NZ Journal of Public Health*, Vol. 22, No. 7, 838–840.
- Dolan, K., Wodak, A. and Hall, W. 1999 HIV risk behaviour and prevention in prisons: a bleach programme for inmates in New South Wales, *Drug and Alcohol Review*, Vol. 18, No. 2, 139–143.

- Dore, G. 2000 Natural history of hepatitis C virus infection, *Hepatitis C: informing Australia's national response*, Commonwealth Department of Health and Aged Care, Canberra.
- Dore, G., Kaldor, J. and McCaughan, G. 1997 Systematic review of role of polymerase chain reaction in defining infectiousness among people infected with hepatitis C virus, *British Medical Journal*, Vol. 315, 333–337.
- Elmar Jaeckel, M.D., Markus Cornberg, M.D., Heiner Wedemeyer, M.D., Teresa Santantonio, M.D., Julika Mayer, M.D., Myrta Zankel, D.V.M., Giuseppe Pastore, M.D., Manfred Dietrich, M.D., Christian Trautwein, M.D., Michael P. Manns, M.D. and the German Acute Hepatitis C Therapy Group, Treatment of Acute Hepatitis C with Interferon Alfa-2b, *The New England Journal of Medicine*. < content.nejm.org> The article was published on line early because of its potential clinical implications. The article is to be published in the November 15, 2001 issue of the Journal.
- Freeman, A., Dore, G., Law, M., Thorpe, M., Von Overbeak, J., Lloyd, A., Marinou, G. and Kaldor, J. 2001 Estimating progression to cirrhosis in chronic hepatitis C, *Hepatology* (in press).
- Gifford, S., O'Brien, M., Banwell, C. and Bammer, G. 2001 *Survey of women living with hepatitis C in Victoria and ACT*, Deakin University, Australian Research Centre in Sex Health and Society, La Trobe University, National Centre for Epidemiology and Population Health, Australian National University.
- Haber, P., Parsons, S., Harper, S., White, P., Rawlinson, W. and Lloyd, A. 1999 Notable cases — Transmission of hepatitis C within Australian prisons, *Medical Journal of Australia*, Vol. 171, 31–33.
- Hepatitis C Council of NSW 2001 *Hepatitis C — What you need to know*, Edition 4, Sydney.
- Herdman, E. and Kippax, S. 1995 *Institutional discrimination: Critical ethnography of HIV/AIDS related discrimination in hospital settings*, NCHSR, Sydney.
- Heywood, M. and Altman, D. 2000 Confronting AIDS: Human rights, law, and social transformation, *Health and Human Rights — An International Journal*, Vol. 5, No.1, 149–179.
- Hopwood, M. and Southgate, E. (under review) Living with hepatitis C: a sociological review, *Australian Journal of Social Issues*.
- House of Representatives, Standing Committee on Family and Community Affairs 2000 *Health is Life — Report on the Inquiry into Indigenous Health*, The Parliament of the Commonwealth of Australia, Canberra.
- Intergovernmental Committee on AIDS Legal Working Party 1992 *The Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS*, Department of Health, Housing and Community Services, Canberra.
- Lenton, S., Tan-Quigley, A. 1997 *Fitpak Study: A survey of 'hidden' drug injectors with minimal drug treatment experience*. Perth, Western Australia: National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology.
- Levy, M. 1999 Australian prisons are still a health risk, *Medical Journal of Australia*, Vol. 171, 7–8.
- Lindsay, J., Smith, A. and Rosenthal, D. 1999 Uncertain knowledge: a national survey of high school students' knowledge and beliefs about hepatitis C, *Australian and New Zealand Journal of Public Health*, Vol. 23, 135–140.
- Maher, L. and Dixon, D. 2001 The cost of crackdowns: Policing Cabramatta's heroin market. *Current Issues in Criminal Justice*, Vol. 13, No. 1, 5–22.
- Mann, J. 1996 Health and human rights: Broadening the agenda for health professionals, *Health and Human Rights — An International Journal*, Vol. 2, No. 1, 1–5.
- Meihubers, S., Godwin, P. and Rotem, A. 1998 Blood-borne virus related discrimination in dental services, *Australian Health Review*, Vol. 21, No. 3, 92–103.
- Mhloyi, M. 1995 Health and human rights: An international crusade, *Health and Human Rights — An International Journal*, Vol. 1, No. 2, 125–127.
- National Centre in HIV Epidemiology and Clinical Research 2001 *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia — Annual Surveillance Report 2001*, NCHECR, University of NSW.
- National Centre in HIV Social Research and Australian Research Centre in Sex Health and Society 2001 (in press) *Hepatitis and health: A survey of high school students in New South Wales*.
- Nelles, J. and Fuhrer, A. 1995 *Drug and HIV prevention the Hindlebank Penitentiary. Abridged Report of the Evaluation Results*. Swiss Federal Office of Public Health, Berne.
- NSW Government, *NSW Drug Summit 1999 — Government Plan of Action*, July 1999, Sydney.

- NSW Health Council 2000 *A Better Health System for NSW*, NSW Government.
- NSW Health Department 1992 *Guidelines for counselling associated with HIV antibody testing*, Circular 92/20.
- NSW Health Department 1993 *HIV/AIDS and confidentiality: A guide to legal requirements*, Circular 98/100.
- NSW Health Department 1999 *Health care workers infected with HIV, hepatitis B or hepatitis C*, Circular 99/88.
- NSW Health Department 1999 *Infection Control Policy*, Circular 99/87.
- NSW Health Department 1999 *Review of the Public Health Act 1999 — Issues Paper*, Better Health Centre, Sydney.
- NSW Health Department 2000 *New South Wales Hepatitis C Strategy 2000–2003*, Better Health Centre, Sydney.
- NSW Health Department 2001 *A Framework for Building Capacity to Improve Health*, Better Health Centre, Sydney.
- NSW Law Reform Commission 1999 *Review of the Anti-Discrimination Act 1977 (NSW)*, Report 92, Sydney.
- NSW Medical Board 1997 *Medical practitioners & blood borne viruses — HIV, hepatitis B and hepatitis C*, Sydney.
- NSW Ministerial Advisory Committee on Health Services in Smaller Towns 2000 *Report to NSW Minister for Health: Framework for Change*, NSW Government.
- NSW Ministerial Advisory Committee on Privacy and Health Information 2000 *Panacea or Placebo? Linked electronic health records and improvements in health outcomes*, Report to the NSW Minister for Health, Sydney.
- Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS 1998 *HIV/AIDS and Human Rights International Guidelines*, United Nations, New York and Geneva.
- Parliament of NSW Legislative Council Standing Committee on Social Issues 1998 *Hepatitis C: The neglected epidemic*, Report No. 16, Sydney.
- Premier's Drug Advisory Council, *Drugs and Our Community*, Report of the Premier's Drug Advisory Council, Victoria, March 1996.
- Rosenthal, D., Haste, B., Mitchell, A. and Ollis, D. 2000 *Teaching about hepatitis C: A national survey of secondary school teachers*, Monograph series No. 18, Australian Research Centre in Sex, Health and Society, La Trobe University.
- Royal Australian College of General Practitioners 1999 *Hepatitis C: A management guide for general practitioners*, *Australian Family Physician*, Vol. 28, Special Issue, S13–S195.
- Royal Australian College of General Practitioners *Enhanced Primary Care: Standards and Guidelines for the Enhanced Primary Care Medicare Benefits Schedule Items*.
- Saadeh, S., Cammell, G., Carey, W.D., Younossi, Z., Barnes, D. and Easley, K. 2001 *The role of liver biopsy in chronic hepatitis C*, *Hepatology*, Vol. 33, 196–200.
- Sievert, W. 2000 *Hepatitis C treatments and issues*, *Hepatitis C: informing Australia's national response*, Commonwealth Department of Health and Aged Care, Canberra.
- Spinzi, G. and Minoli, G. 2001 *To biopsy or not biopsy (letter to the Editor)*, *Hepatology*, Vol. 34, 438.
- Tarantola, D. 2000 *The shifting HIV/AIDS paradigm: 20 years and counting*, *Health and Human Rights — An International Journal*, Vol. 5, No. 1, 1–6.
- Tomasevski, K. 1994 *Prison health law*. *European Journal of Health Law*, Vol. 1, 327–341.
- Victorian Institute of Forensic Medicine 2000 *Mortuary autopsy work instructions*, Version 1, last authorised on 14 July 2000.
- Walker, B. 2001 *Inquiry Into the post-mortem and anatomical examination practices of the Institute of Forensic Medicine — Report*, Government of NSW, Sydney.
- Wilcher, G. 2000 *Funeral practices*, *The Hep C Review*, Winter Edition, No. 33, 4.
- WorkCover Authority NSW 1995 *Code of Practice: HIV and other blood-borne pathogens in the workplace*.

# Appendix H

## Summary of recommendations by department or agency

Agency	Recommendations
<b>NSW Government</b>	
NSW Government - general	29, 45, 65, 74, 79
NSW Government - legislative amendments	7, 30, 48, 52, 64, 70, 75, 76, 78
NSW Health	2, 3, 5, 8, 9, 10, 11, 18, 19, 31, 32, 34, 42, 49, 55, 56, 68
NSW Ministerial Advisory Committee on Hepatitis	2, 5, 6, 8, 10, 16, 17, 23, 35, 67, 68, 72
WorkCover Authority of NSW	26, 50, 51
NSW Attorney-General's Department	77
NSW Anti-Discrimination Board	27, 73
NSW Department of Corrective Services	33, 34, 36, 37, 38, 39, 41, 43, 44,
NSW Corrections Health Service	33, 34,
NSW Department of Education and Training	57, 58, 60, 61, 63
NSW Police Service	69
<b>Area Health Services</b>	4, 12, 13, 14, 18, 20, 21, 34,
Central Sydney Area Health Service	53, 54
<b>Australian Dental Association (NSW Branch)</b>	15
<b>National Review of Nursing Education</b>	22
<b>General practice</b>	24
<b>Pre-service tertiary training/educational institutions</b>	25, 59, 62
<b>HREOC</b>	46, 47
<b>Hepatitis C Council</b>	73
<b>NAAA</b>	73

# Acknowledgments

---

The Anti-Discrimination Board would like to thank all those who have participated in this Enquiry. In particular, the ADB is especially grateful to the many people who had the courage to share their own, often painful and difficult, experiences of discrimination. The ADB recognises that this report is immeasurably richer for their contribution.

The Anti-Discrimination Board would also like to acknowledge the contribution of the following people to the work of this Enquiry.

## **President and Enquiry Chair**

Mr Chris Puplick

## **Enquiry Panel Members**

Fr Hugh Murray

Ms Suzanne Jamieson

## **Members of the Enquiry Steering Committee**

Professor Bob Batey

Mr Jack Wallace

Mr Stuart Loveday

Professor Sue Kippax

Ms Maureen Steele

Ms Annie Madden

Dr Ingrid van Beek

## **Project Officer and principal author**

Ms Julia Cabassi

## **Media co-ordination**

Ms Anna Cooper

## **Para Legal Officers**

Ms Amanda Andreazza

Ms Sarah Ellison

## **Editorial advice**

Mr Chris Puplick

Ms Maggie Smyth

Mr Chris Ward

Mr Tim Leach

Ms Ruth Sheard

## **Library**

Ms Anna Forsyth

## **Social analysis of Enquiry evidence**

National Centre in HIV Social Research

Professor Sue Kippax

Mr Max Hopwood

## **Design**

Deborah Kelly Communication Arts

## **Finished Art**

Helen Drew

## **Printing**

Agency Printing (Aust) Pty Ltd