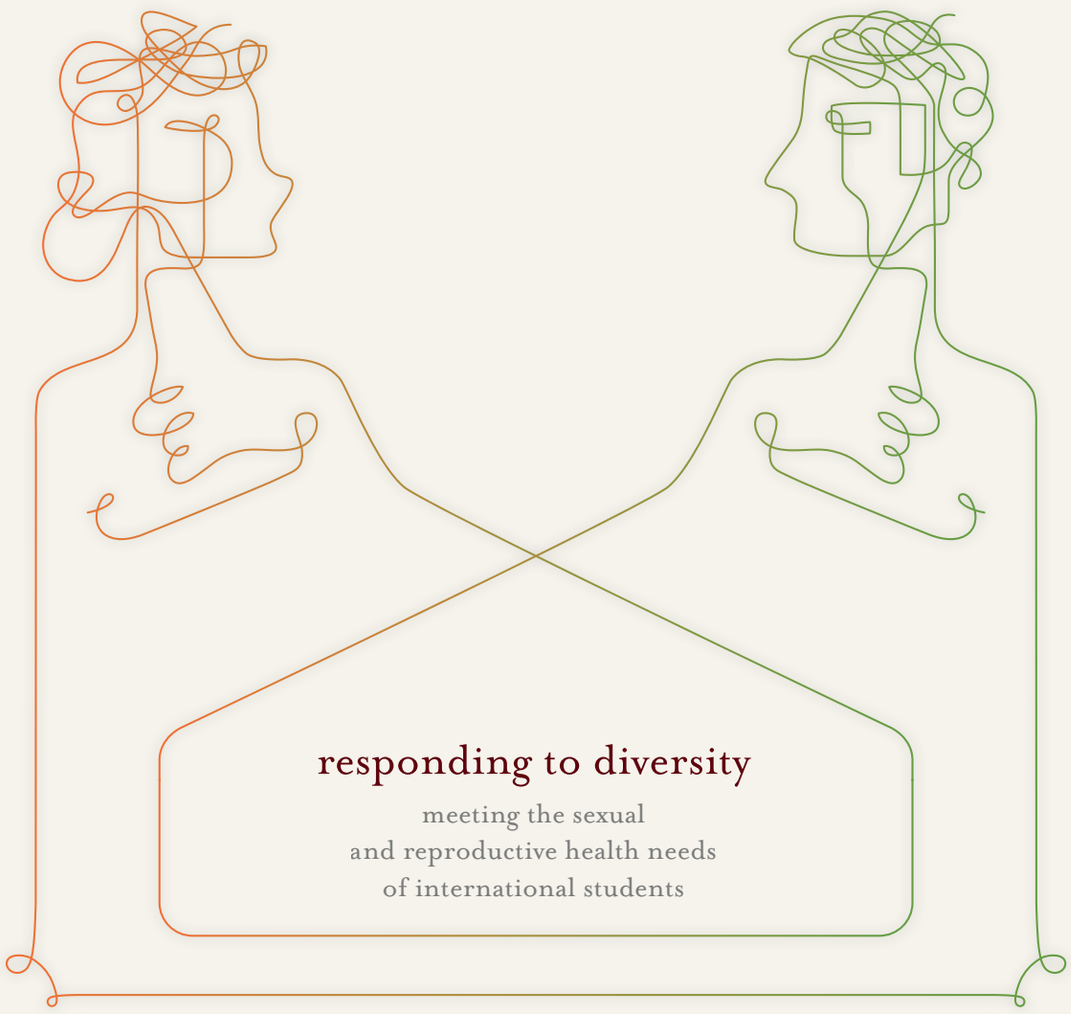

responding to diversity

meeting the sexual
and reproductive health needs
of international students

multicultural health
& support service

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contents

executive summary

what's the problem?

With rapid growth in Victoria's international student (IS) population, service providers have registered alarm about unplanned pregnancy in heterosexual students and HIV infection in same sex attracted international students.

what's the cause?

We argue these outcomes are the end result of unmet need for sexual and reproductive health (SRH) education in the IS population. IS receive little or no SRH education in their countries of origin and upon arrival in Australia.

IS strongly prefer to seek help and information through close friends and family before turning to the Internet, and they access services like counselling as an absolute last resort. There is a mismatch between this preference and the Victorian response to their needs, which has concentrated on developing websites and services for individuals and small groups – services that are vitally important for students in crisis but offer little in terms of prevention and early intervention.

what do students need?

All students need knowledge, skills and opportunities enabling them to achieve SRH and wellbeing; form close friendships and diverse social networks; negotiate the kind of sex and relationships they want; solve problems for themselves and 'share help' with their friends; and access affordable, convenient, confidential and culturally responsive care and support.

Most students are 'active/connected' in their response to life challenges, and only need 'baseline' messages consistent with adult education principles, not comprehensive SRH education. Vulnerable students have additional needs. The drivers of vulnerability ('higher risk of risks') are personal, social, cultural and systemic in nature. A significant minority of students are avoidant in problem solving or adventurous in risk-taking.

Social isolation can reduce access to information, support and referrals to services. Vulnerability results from one-size-fits-all approaches to student orientation and SRH service provision, which fail to respond to the diversity of needs and adaptation styles in the international student population. Understanding the drivers of vulnerability allows us to target an effective and coordinated population health response to the SRH educational needs of international students.

how should we respond?

The size of the population (around 150,000) and its rate of turnover (35% per year) overwhelm the capacity of BBV/STI and sexual health funded agencies to meet their needs on a sustainable basis.

A whole-of-government, evidence-based, partnership approach is needed, in which DH-funded agencies develop materials and training enabling education providers, who use them to deliver baseline SRH education themselves to all students. Partnership with education providers presents its own challenges: large institutions are difficult to engage, while smaller providers are extremely numerous and respond mainly to regulatory signals.

In the short to medium term, we recommend the pilot development and evaluation of a best practice evidence-based model for delivery of baseline messages by education providers using creative audiovisual materials. In the longer term, this model may be proposed for inclusion as a minimum standard in the policy regime governing the provision of Educational Services for Overseas Students (ESOS).

key findings

in this section:

what's the problem?

Health practitioners and service providers working with international students have expressed concern about their sexual and reproductive health and wellbeing.

Main areas of concern around **heterosexual students** are:

- reported high rates of terminations of pregnancy, later in the course of pregnancy when surgical intervention is required and potential complications are more serious;
- infection with bacterial STI, particularly Chlamydia, combined with low rates of asymptomatic screening creating increased risk of pelvic inflammatory disorder and possible infertility;
- students presenting to clinicians with low levels of knowledge around their bodies, the basics of sexual reproduction, correct condom use and contraceptive options, sexual negotiation and healthy relationships.

Main areas of concern around **same sex attracted students** are:

- rates of HIV infection among male international students, some being diagnosed in Victoria and others returning home undiagnosed;
- low awareness of asymptomatic screening, post-exposure prophylaxis, and negotiated safety;
- sexual activity before students arrive in Australia, sometimes in sexual cultures where sexual adventurism (group and 'chemical' sex) and intergenerational partnerships are more common;
- vulnerability to unwanted sex and HIV/STI infection during casual sex and regular partnerships, caused by lack of skills and confidence around sexual and relationship negotiation.

what's the cause?

We are not doing enough to meet international students' sexual and reproductive health needs:

- international students receive very little sex education in countries of origin and what little they do receive is ineffective, yet few education providers in Australia provide sexual and reproductive health promotion for international students on arrival or commencement of their studies;
- the government response to international students' needs has focused heavily on creating websites and funding new services, yet students report they prefer to solve problems with help from close friends and family, and access services in particular as a last resort;
- where health promotion activities have addressed sexual and reproductive health needs, they have relied on low-reach, high-intensity strategies that favour students who are proactive and health-conscious and have little impact on students who most need the intervention;
- the policy and research agenda has given low priority to international students' personal health and wellbeing, and failure to record visa status has made them invisible in surveillance and quality of service data, leading to missed opportunities to build evidence around their needs.

what do they need?

(For further detail on this section see Ch 5 "Crafting an effective and coordinated response").

high-level needs

All students need knowledge, skills, attributes and opportunities enabling them to:

1. achieve sexual and reproductive health and wellbeing
2. negotiate the kind of sex and relationships they desire
3. form close friendships and cosmopolitan social networks
4. solve problems for themselves and 'share help' with their friends
5. access affordable, convenient, confidential, and culturally responsive care/support

heterosexual students

Most students need (knowledge, skills, attributes and opportunities):

- starting points for information and further enquiry to meet their own health and support needs
- awareness of services available, how to access them, and what to expect
- a combination of contraceptive strategies that works for them, including coaching and resources to increase their confidence in the safety of hormonal contraception and ability to use condoms correctly and consistently
- emergency contraception and non-surgical options for pregnancy termination
- understanding of their health insurance entitlements (equivalent to Medicare)
- exposure to norms including the value of prevention, early intervention and screening

Vulnerable students may also need:

- 'coaching' in life skills needed to meet friends and solve problems
- structured opportunities for social contact, networking and community engagement
- opportunities to identify and discuss cross-cultural differences in values/expectations
- early identification by teaching and support staff when things are going wrong
- supported referral to access relevant services/opportunities

what do they need? (cont'd)

same sex attracted students

Most students need (knowledge, skills, attributes and opportunities):

- Understanding of HIV transmission pathways and how risk does and does not work
- Effective, personalised combination of HIV prevention strategies (including condoms, risk reduction, status knowledge, STI testing and treatment, and post-exposure prophylaxis) and the behavioural skills, confidence and motivation to use them
- Negotiated safety protocol for unprotected sex in relationships
- Ability to identify and negotiate personal desires and limits in sexual encounters and relationships, and to avoid HIV infection, unwanted sex
- Awareness of SSA-friendly services for sexual health, social connection and counselling
- Ability to manage who knows what about their sexual attraction and relationships
- Opportunities to learn about and discuss cultural differences around friendship, relationships and community as experienced here and in their countries of origin
- Health promotion and service delivery that responds to culturally-specific attitudes and understandings they bring to sex and relationships (and related risks/harms)
- Opportunities to experience and engage in community that aren't diminished by racism or dependent on 'coming out' as a condition of entry

Vulnerable students' needs may vary:

- students whose vulnerability comes from loneliness may make chaotic attempts at connection, increasing their risk of unwanted sex, exploitation, emotional harm and HIV infection – these students may need one-on-one coaching and counselling-type interventions, as well as more structured social and learning opportunities, such as workshops;
- other students may be vulnerable because their adventurous, active and gregarious approach to life can facilitate greater risk-taking in sexually adventurous spaces – creating a need for advanced prevention skills and knowledge made available through peers and mentors.

how should we respond?

This section summarises a comprehensive action plan presented in this report (see Ch 5).

- Victoria needs an effective and coordinated population health response to unmet sexual and reproductive health needs among international students.
- A whole of government approach including Department of Health will give fuller recognition and more effectiveness in response to the health and wellbeing needs of international students.
- The population of international students is notable for its size, high rate of turnover, temporary residence, internal diversity and widespread distribution across metro and regional Victoria. This places some important constraints on the strategies we can use in response to their needs:
    - Sustainability is key. The high rate of replacement in this population (around 34% per year) means that activities must be continual and ongoing to reach newly-arriving students.
    - Reach and intensity of interventions must be carefully targeted and optimised according to adult education principles and the drivers of vulnerability in this population. The majority of the population only needs basic messages to help recognise and demand information and services to meet their needs; a smaller proportion need more intensive intervention.
    - Prevention, early intervention, and screening in the absence of symptoms are essential messages that must be disseminated to the wider population at scale.
    - There are currently very few media or settings allowing for effective mass communication with international students. Developing these channels is a priority for health promotion.
    - There is insufficient capacity in the sexual and reproductive health sectors to provide in-person education sessions to reach even a fraction of newly-arriving students each year.
- Conditions in the operating environment pose their own challenges:
    - The tertiary education sector in Victoria is sizeable and very diverse. There are a small number of huge institutions with considerable administrative hierarchy and functional separation which made them very difficult to contact and involve in this project. Smaller 'private colleges' are simpler in structure but too vast in number to engage ourselves.
    - The discourse (conceptual vocabulary) of higher education is export market-oriented, with a particular sensitivity and resistance to anything that might appear negative in overseas markets.This is not favourable to an evidence-based population health response to sexual risks.
- In the long term, the only sustainable way to reach this population is a partnership approach between health promotion agencies, education providers, government and non-government agencies, and providers of Overseas Student Health Cover (OSHC) insurance. Working back from this aim:
    - Research and advocacy are needed to persuade larger education providers of the value of health promotion and population health approaches and partnerships, and the need to meet sexual and reproductive health needs in their international student cohort;
    - Small providers of vocational and technical education (so-called 'private colleges') offer the bare minimum services required to maintain their accreditation, and reaching students in this setting may only happen when health education is required under the ESOS regime;
- In the short to medium term we need to develop, pilot and evaluate creative multimedia approaches that can be delivered in a variety of settings and formats and covering key messages, and to commence building partnerships, communication channels and awareness of the issue.

how do we know?

We undertook a needs analysis using qualitative research and rapid assessment methodologies to identify and evaluate the sexual and reproductive health needs of international students and to see if we could substantiate the concerns expressed about them (see 'What's the problem?' above).

background

The project began as a proposal in partnership between People Living with HIV/AIDS Victoria Inc and the Multicultural Health and Support Service (a program of the Centre for Culture, Ethnicity and Health).MHSS was funded by the Victorian Government Department of Health, Prevention and Population Health Branch, Sexual Health and Viral Hepatitis Team, to look at STI acquisition and unplanned pregnancy in heterosexual students and HIV/STI risk and infection among same sex attracted students.

methods

- We undertook two focus groups with international students, male (n=8) and female (n=13).
- In-depth interviews were conducted with same sex attracted students purposively recruited to illustrate key aspects of risk and vulnerability (n=3) and one heterosexual female student.
- We interviewed key informants (n=20) from clinical and social service providers at universities, TAFE colleges, government and non-government agencies.
- An inclusive literature search was conducted, including published peer reviewed articles, 'grey' literature such as conference papers, consultation reports, monographs and policy/advocacy documents, media articles, and resource materials for international students.
- Data were analysed using an adapted grounded theory methodology (Glaser & Strauss, 1967) following the outlines of rapid assessment and response (WHO, 2002).
- Guidance on project design and ethics was provided by a reference group of interested experts from the higher education, OSHC insurance and sexual and reproductive health sectors.

research questions

1. What knowledge of sexual health and BBV/STI prevention do students have on arrival?
2. Where do students look to access information and services in metro and regional Victoria?
3. What models of best practice exist for building BBV/STI education into student orientation?
4. What are potential barriers to international students accessing education and services?
5. How common is the experience of BBV/STI infection among the population?
6. Other questions as advised by the project reference group or emerging from initial research:
    - What attitudes toward and knowledge about contraception are common in China?

limitations

Our methodology and its limitations are discussed further under "Methodology" below.

- This report presents qualitative research looking in-depth at the experiences of a small number of participants. It is not designed to support generalisations to the whole population, or to quantify the rate of particular events such as HIV infection or unplanned pregnancy.
- We did not ask heterosexual students questions about their sexual practices, and this made it impossible during the analysis to know whether their reported information and help-seeking had any impact on risk-taking and health outcomes.

glossary

"coming out"
explicitly disclosing same sex attraction or gay/bisexual identification to others

BBV
blood-borne virus (such as HIV or hepatitis B/C)

CALD
culturally and linguistically diverse

evidence-based practice
the philosophy of basing health practice on rigorous published research from as high as possible on a hierarchy of evidence sources; the randomised controlled trial is at the top

HIV
human immuno-deficiency virus

health needs
capacity to benefit from a health intervention

homonegativity
a more conceptually-sound alternative to "homophobia", referring to sexual stigma against gay/bisexual people

homophily
seeking sameness and avoiding difference in friends and partners ("birds of a feather")

LGBTI / GLBTI
people who are lesbian, gay, bisexual, transgender and intersex

MHSS
Multicultural Health and Support Service, a program of the Centre for Culture, Ethnicity and Health

MSHC
Melbourne Sexual Health Centre

MSM
Men who have sex with men

n= (number)
the number of participants in a study

OSHC
Overseas Student Health Cover – insurance all international students must purchase here

PEP / post-exposure prophylaxis
a 28-day course of anti-HIV medication that can prevent infection from taking hold if commenced within 72 hours of exposure

PLHIV / PLWHA
Person/People Living with HIV (or HIV/AIDS)

population
a conceptual grouping of individuals according to some shared attribute for epidemiological purposes, which may not exist as a social group or community in the 'real world'

risk
the probability of an event occurring, such as HIV infection; sometimes used to refer to practices where that probability is increased

SEA
South East Asian

SOPV
sex on premises venue, such as a sauna or sex club where MSM may meet to have sex

SSA
same sex attracted

STI
sexually transmitted infection

VAC / GMHC
Victorian AIDS Council/Gay Men's Health Centre

vulnerability
"risk of risks" -- a social factor applying to a population leading to more of its members encountering or tending towards risk

introduction

Since 1996, international education has grown to become Australia's third largest export market. The change was driven by innovation in Commonwealth policy on education, immigration and trade. More than a decade passed before impacts of the change at local and State government levels began to receive attention, quite literally at street level, as a series of assaults on international students in public spaces provoked outraged media coverage locally and in students' countries of origin.

This threatened Australia's export market reputation, and the reputation of Melbourne as a safe and livable multicultural city, and so kicked off a process of policy review and regulatory reform. Growing awareness of international students' needs and experiences has led to responses at every level of government, culminating in the Council of Australian Governments (COAG) *International Student Strategy for Australia 2010–2014* and substantial reform of the Educational Services for Overseas Students (ESOS) regime.

Yet little consideration has been given in that process to international students' personal health and wellbeing. In the health, social and community services sectors, the rate of growth in numbers of international students has outpaced our understanding of their needs and experiences before arriving in Australia, during their studies here, and when they apply for permanent residence or return home (or migrate elsewhere). People working face to face with international students, providing advice, counselling and clinical services, have sought in various ways and forums to 'sound the alarm'.

The initial funding submission for this project certainly had that intention. In a partnership submission with People Living with HIV/AIDS (PLWHA) Victoria, we raised concerns about HIV infection among same sex attracted (SSA) male international students. We were subsequently asked to look at terminations of pregnancy and sexually transmitted infections (STI) among heterosexual male and female students as well. At first we proposed to go straight into service delivery, but our funders suggested undertaking a health promotion needs analysis first. This has turned out to be extremely good advice.

Although we talk about 'sexual and reproductive health', there is a world of difference between sexual health and reproductive health, and between HIV infection and unplanned pregnancy, and finally, between the social structure and lived experience of heterosexual and SSA student groups. In an earlier draft, we compared the two groups in chapters divided by topic area, but this made for difficult reading and added little value, so we have separated our findings by group, reporting on heterosexual students in Ch 1 and SSA students in Ch 2.

Later chapters develop the common themes of information-seeking and problem-solving that emerge (with key differences) from both chapters. The final chapter outlines a blueprint for a population health strategy responding to diversities of sexuality, problem-solving and social connectedness existing among international students in Victoria.

Responding to diversity is the key to avoiding deficit accounts and pathologising representations. The intensities of need reported by counsellors and clinicians are not made up – they are real, and deserve a response.

But this perspective is partial. It describes one piece of the puzzle: the individuals who show up at clinics and services with problems. It does not represent the students who are successfully seeking information and solving problems on their own. Equally importantly, it doesn't reflect those students who need help but aren't seeking it until crisis develops.

This is not just a problem of representational fairness and accuracy. Our choice of educational messages and strategies is heavily influenced by our understanding of the population and its health needs. The strategic value of recognising health-protective strengths and assets is that we don't spend resources trying to build them up from scratch in people who already have them. It lets us focus our efforts on reaching those students who do need more intensive intervention and support.

This report suggests that personal differences in how people learn, form social connections and solve problems mean they have different needs for health promotion, support and social activities. When these needs are unmet or a situation arises that challenges a student's ability to respond and adapt, they may be vulnerable to subsequent, more serious negative health outcomes.

The dimensions of these personal differences are well-enough known to be predictable. We are not suggesting that students should be screened on arrival, but that these differences within the population should be taken into account when planning an appropriate mix of health promotion strategies.

The aim of this report is to present a considered and evaluative synthesis of;

- findings from our own qualitative research enquiries,
- published and 'grey' literature including quantitative studies and service usage data,
- practice knowledge from student service and support providers, and
- concepts and approaches from health promotion and population health.

To the research purist this may seem like a messy mixture, but there is strong precedent for this approach in the field of HIV prevention, where rapid assessment methodologies have been developed to allow practitioners to build and assess knowledge about new and emerging problems.

Our focus is less on quantifying the incidence and prevalence of a disease or problem and more on identifying what gaps in knowledge and skills are contributing to it, and what approaches will work best for addressing these gaps. As a result, this report is strongest on health promotion and population health concepts. Taking its recommendations forward will require the involvement and guidance of people who better understand how to advocate for policy reform in the higher education sector.

Sensational media coverage 'worked' to draw attention to international student safety and security, because the threat of reputational damage in export markets gave the issue visibility and priority within a policy context that normally excludes such concerns. However, in the tabloid and talkback media, migrants are already stigmatised with the suspicion of being bearers of disease, so that media advocacy to prioritise unplanned pregnancy and BBV/STI-related health needs would inevitably backfire.

Instead, our findings challenge policy-makers to figure out how the unmet health needs and the broader wellbeing of international students can be included within a whole-of-government and population health response that recognises them as community members, not just consumers.

methodology

overview

Our approach in this project combines rapid assessment methods and grounded theory analysis. Qualitative research methodologists have debated how to assess rigour in 'generic' qualitative research as defined by 'lack of allegiance to an established qualitative approach', and argue that

> *at a minimum, researchers employing a generic approach must explicitly identify their disciplinary affiliation, what brought them to the question, and the assumptions they make about the topic of interest. In their report, investigators must also demonstrate congruence between the questions posed and the generic approach employed. (Caelli, Ray & Mill, 2003, p5)*

This chapter aims to answer the questions posed by the quote above. Positionality questions (what brought us to the topic and our disciplinary affiliations) are answered first, in the Author's Note, before the our disciplinary assumptions are set out under Research Context. Finally, we detail the methods used and the limitations of our findings.

author's positionality

Our findings are based on judgments I have made, upfront in the writing or behind the scenes in the analysis, about how our participants' perspective has influenced what they say. This is an integral part of the grounded theory methodology adopted for the project, and it has a particular strength in settings where people have strong interests and disciplinary or discursive differences that shape and constrain their perspectives and accounts.

However, the ability to make those judgments and express them in writing gives me considerable power. I have done my best to be fair and accurate, but this can only mitigate the problem; it can never be avoided altogether. To hide or deny my own perspective is to claim it is objective and complete and limits readers' ability to make the same judgment of my work.

From my time at the University of Melbourne, and through the gay community, I have made many friends, now resident here or overseas, who were international students. These relationships sensitised me to the problem of unmet needs for information, support and social connection experienced by international students during their time in Melbourne.

I know three current or former international students, young gay men, who have become HIV positive: two after leaving Australia, both in relationships, and one, while studying here, through casual sex. From an epidemiological perspective, two of these men literally would not count in Victoria, since they were infected and diagnosed overseas, but from a health promotion perspective, I believe they represent a missed opportunity – during their time studying in Victoria, we failed to reach them with activities communicating information and skills to protect against preventable infection.

From a legal perspective, once students hit eighteen years of age, they are adults and responsible for themselves. From an educational perspective, I believe we can recognise that tertiary study is a transitional period, and educators and institutions are responsible for students' growth and wellbeing. From these beliefs, you can guess at my values and how they shape the perspective taken here.

During my time working in health promotion, I have had a dual, unacknowledged role, unpredictable in its dimensions and demands, as a source of information and support for friends and friends-of-friends tackling problems relating to sexual and mental health, sexuality, identity and community in their lives. The men who seroconverted talked to me in this role, and would never have made contact with the organisations I have worked for.

As health educators and community workers, we are not out to rescue people. We talk about behaviour change, but it's only ever an indirect, aggregate outcome of work that is more immediately focused on resourcing our target communities. Individual community members can take it or leave it. We aim to provide information they can use to make informed choices, and skills they can use to put their choices into practice, and to reshape their social environment to support healthy practices.

This leads into the next section of this chapter, setting out the conceptual framework that informed our collection of data, qualitative analysis and the development of recommendations.

conceptual framework

This project aims to assess **health needs** within a **vulnerable populations** framework structured by **social connectedness**. In this section these concepts are explained in detail.

If you prefer to skip this section, the key terms are briefly defined in the Glossary.

1) health needs

A health need refers to **capacity to benefit from a possible intervention** (NICE, 2006).

Assessing health needs involves making pragmatic judgments about the relevance and efficacy of proposed solutions when defining the problem. The definition we adopt comes from an approach that was originally developed to help prioritise competing demands for costly treatments within local NHS trusts in the United Kingdom. Although our funding arrangements are different, we face similar questions about how to target our interventions to achieve maximum effect given the resources available and the size of our target audience.

A health needs approach is also solution-focused and responsive to assets and strengths existing in the population, making it preferable to depicting international students as ridden by problems, issues, pathology and deficits.

Our analysis does not start from the assumption that all citizens need perfect knowledge of sexual and reproductive health. We assume they need knowledge relevant to the risks, harms and challenges they are likely to encounter, and this is captured in the element of capacity to benefit.

2) vulnerable populations

In an influential article, health policy researchers Frohlich & Potvin (2008:218) compare the concepts of risk and vulnerability, defining the latter as a socially and culturally produced 'risk of risks'. They note the problem of inverse care law, where "the availability of good medical care tends to vary inversely with the need for it in the population served" (Hart, 1971) or in other words, those who most need an intervention are typically the least able to make use of it.

Applied to the normal distribution of exposures to risk within a population, the problem is that intervention shifts the majority of the population towards lower risk but leaves the vulnerable untouched, increasing health disparity and the concentration of risk exposure.

For extremely common morbidities such as heart disease, small risk reductions multiply across large numbers of people to result in large reductions in overall mortality. The concern then, following Frohlich and Potvin's vulnerable populations approach, is one of access and equity – making sure that people don't miss out on opportunities to improve their health.

HIV is **not** an extremely common condition in Australia. Outside of a high-prevalence context, infection does not result from the lifetime accumulation of small risks, as do diabetes and hypertension. Instead, it depends upon a complex chain of causation, including intentional and accidental incidents, acts and omissions,

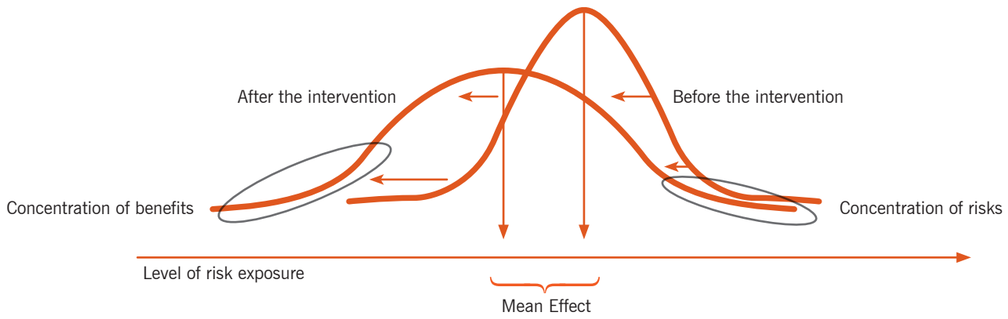


Figure 1. Illustration of a potential increase in the variation of risk following a population-approach internvention

Source. Adapted from Rose
Note. Arrows depict the shifting of the curve after a population-level approach.
Circles indicate where the variation in risk is most flagrant

practices, dispositions, attitudes and expectations, and social connections.

The mechanisms of infection are routinely described as risk factors, but this is not quite accurate; while the mechanisms of infection obviously predict its occurrence, behavioural surveillance suggests that a plurality of the gay population practice these risk behaviours without becoming infected.

Without the necessary risk context, i.e. the presence of HIV in a sexual partner or collectively its prevalence in a sexual network, individual risk behaviour will not produce infection.

This makes it particularly important to reach individuals in whom the combination of personal factors and social positioning puts them at risk for HIV infection, and to intervene in any systemic factors moving them toward that position (what access and equity scholars call the 'social gradient') or preventing them from developing contextually-sensitive protective personal dispositions.

Social and cultural conditions are directly relevant to HIV infection outcomes in a population, and vulnerability is an essential concept for understanding how someone moves from 'vulnerable' to 'at-risk'. To reduce overall infections it is necessary to reduce the number of people and amount of time spent in the at-risk category.

Vulnerability is a technical concept. Its meaning in common usage suggests fragility and emotionality, and this dual meaning can mislead by suggesting a mental picture of 'warning signs' to look out for among students.

In fact, students who express their emotions easily and reach out for help – showing vulnerability in the everyday meaning of the term – probably have less difficulty solving problems than students who bottle up their emotions and hide their problems, trying to 'tough it out'. It is important to keep in mind that vulnerability comes from different sources and may not be immediately apparent or obvious at first glance.

3) social connectedness

In our findings in this study and earlier work, and in the literature we reviewed, we learned that social connectedness and social methods of problem-solving are generally assets for health, and that social isolation, loneliness, and keeping problems hidden are the drivers of vulnerability to the risks and harms faced by international students.

Our starting point is a typology developed by Rosenthal, Russell & Thomson (2006) to organise and interpret results from a large survey of international students at the University of Melbourne (see Fig 2). The typology relates three concepts together:

1. social connectedness
2. stress and distress
3. personal style of adaptation

In the typology, a majority of students (59%) display a 'positive and connected' style, 34% were 'unconnected and stressed' and 7% were 'distressed and risk-taking'. It is worth noting this formulation encodes two progressions in sequence – from connected to unconnected, and from stressed to distressed. The two poles are 'positive' adaptational style and 'risk-taking'.

Although Marginson et al (2010) criticise the typology as 'pathologising', their own report confirms that loneliness exerts strong influence on international students' health and wellbeing.

Our approach in this study has sought to test and flesh out the typology with qualitative detail, and to examine the relationship between its component elements and sexual and reproductive health needs. The next section details the methods and principles we followed for data collection and analysis.

❊ data collection

Data was obtained in a number of ways:

- an inclusive literature search for published, peer reviewed articles; 'grey' literature, such as conference papers, consultation reports, monographs and policy/advocacy documents; media articles; and resource materials for international students;
- focus groups with international students, both male (n=8) and female (n=13);
- in-depth interviews with international students to develop illustrative case studies, male (n=3) and female (n=1);
- key informant interviews with clinical and social service providers at universities, TAFE colleges, and other agencies (n=20);
- the Double Trouble consultation forum (n=60; see Reeders, 2010) and a further consultation (n=12) held with international student advisers taking part in an ISANA state conference;

Figure 2.

- ongoing advice and feedback were received through a reference group comprised of interested and experienced experts.

Student participants were recruited through ads placed in online classifieds and university student careers websites. Ethical oversight was provided by reference group members, and where issues were raised they were resolved by negotiation and consensus.

Informed consent was obtained verbally and confirmed in writing from students, and student participants received $25 to cover the costs of their travel and participation.

We undertook 'member checking' (checking back) with key informants, sending them draft notes via e-mail to review and revise for accuracy and confidentiality. In general we do not name key informants or identify their institutions.

❊ qualitative analysis

This project combined methods and principles from grounded theory (Glaser & Strauss, 1967) and rapid assessment (WHO, 2002).

The grounded theory (GT) approach is:

> *a qualitative research method that uses a systematic set of procedures to develop an inductively derived theory about a phenomenon (Strauss & Corbin, 1990:24)*

The method was developed so that the findings it produced could match the rigour and validity then claimed for quantitative research. Unlike classical scientific method, grounded theory takes an inductive approach:

> *That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (Strauss & Corbin, 1990:23)*

The four central criteria for judging the applicability of a theory to a phenomenon are:

1. *fit* – faithful to the everyday reality of the substantive area, and carefully induced from diverse data
2. *understandability* – makes sense both to experts in the area and interested outside observers
3. *generality* – it is abstract enough and includes sufficient variation to apply in multiple contexts related to the phenomenon
4. *control* – it enables planned and effective action in relation to the area or phenomenon studied (Strauss & Corbin, 1990:23)

The main difference between GT and generic qualitative research is in the depth of analysis.

Many qualitative approaches use coding to 'break down and into' data for analysis. In GT the analysis is an ongoing process documented in 'memos'. It seeks to discover relationships and differences among codes, building them into 'concepts' and 'categories'.

As the analysis proceeds, 'theoretical sampling' occurs, where further interviews are conducted to answer questions that have emerged.

> *The goal is to develop a theory explaining the process occurring in the phenomenon being studied (Corbin & Strauss, 2008:87-89).*

In this report, in relation to the phenomenon of vulnerability and risk-taking in sexual and reproductive health, we describe the process of problem-solving by international students in terms of the social and personal influencing their information- and health-seeking preferences and 'sharing help' with friends.

GT aims to develop substantive theory covering a single area in-depth, which may be further developed into formal theory (abstract enough to apply across multiple areas or domains) (Glaser & Strauss, 1967). It recommends continuing to collect data until new data would add little to the theory, a point called 'theoretical saturation' (Morse et al, 2002).

However, substantive theory development was not our aim in this project; instead, we wanted to generate enough evidence to propose coordinated and effective interventions. This meant the cut-off point for data collection and desired end-point of analysis were different.

To find these points, we adapted the assessment and intervention development modules from the World Health Organisation Rapid Assessment and Response (RAR) framework (WHO, 2002). RAR is defined as:

> *a comprehensive assessment of a public health issue in a particular study area, including the characteristics of the health problem, population groups affected, settings and contexts, health and risk behaviours, and social consequences. It identifies existing resources and opportunities for intervention, and helps plan, develop and implement interventions. (WHO, 2002)*

RAR is a community-based alternative to university-based social research, developed for use with rapidly-emerging issues or populations where a timely response is necessary. RAR often paves the way for more formal research by generating evidence for funding proposals and raising awareness that it is needed.

In our project the GT and RAR approaches are complementary. GT offered guidance for the inductive analysis recommended by RAR, while the RAR focus on building enough knowledge for intervention provided a practical alternative to theoretical saturation as the cut-off point for interviewing.

The WHO (2002) *Technical Guide on RAR* (TG-RAR) sets out a comprehensive approach using a RAR team and extensive consultation and desk review activities for assessment.

(To view the guide, visit: http://www.who.int/docstore/hiv/Core/Contents.html)

In this project we did not adopt the team-based approach. We convened a reference group of key informants, who contributed their perspectives and expertise, but its members were all busy people and we did not feel we could ask them to commit the time and direct involvement the team approach demands.

In accordance with our project proposal, the data collection and analysis were undertaken by the project worker and the RG provided oversight and guidance.

We used the assessment modules set out in the TG-RAR to develop questions for focus groups, interviews with students and key informants, and consultation through the International Education Association (ISANA).

In this report, chapters 3-5 address the questions set out in the TG-RAR modules on context (at 8.3), population and setting (8.4), health issues (8.5) and social consequences (8.7) before suggesting an action plan (10).

The TG-RAR offers minimal guidance on the strategies and methods available for health promotion intervention, and we have supplemented this gap by referring to the Victorian Government Department of Health Primary and Community Health *Integrated Health Promotion Resource Kit* (DHS, 2008).

The RAR approach recommends using the action plan to commence immediate service delivery, which can be evaluated using an action research approach to further test the findings and recommendations. Rather than move straight into service delivery, the next step for this project is to raise awareness and set the issue on the agenda, to build consensus between major players, and to seek funding for the interventions proposed.

congruence

Caelli, Ray & Mill (2003) recommend that qualitative researchers demonstrate congruence between their research questions and their choice of methods of enquiry and analysis. So why did we combine GT and RAR approaches?

In key informant interviews, it was clear that some informants were engaged in structures and processes, ideological and institutional, that were highly influential on their scope of action, and so complex they defied analysis here. For an excellent discussion of these imperatives, see Forbes-Mewett's (2011) discussion of 'McDonaldization' in mainstreaming international student services.

It was also clear some respondents had an agenda for how this project should represent international students' needs and whether they were being met. We have not treated key informants as experts or oracles except in their area of direct involvement. As we discuss in the Double Trouble report, many assumptions and myths circulate whenever discourses like sex, gender, race, and nationality intersect. Everyone has their own, necessarily partial perspective, and as in that project, our goal here was to assess 'what do we know, *and how do we know it*'.

This is where GT added value to our project. A key tenet of GT is that 'the full range of possible interrelationships between macro/micro conditions is not always visible to individual research participants' (Corbin & Strauss, 2008:92). The complex and time consuming 'back end' process of GT involves constant comparison between the accounts and concepts elicited in order to discern relationships and patterns of variation amid the differences.

limitations

The small sample size means that care must be taken in interpreting our findings. The findings are not intended to be generalised to the entire student population. Rather, they are intended to illustrate the dimensions and diversity of needs in the population, and suggest to an audience of practitioners which health promotion strategies may be appropriate in response. Similarly, the methodology in this report does not allow us to quantify the incidence and prevalence of STI, unplanned pregnancies and terminations.

We have done further interviews and literature searches where the analysis and our reference group members recommended it, in order to fill gaps in our findings that were relevant to action and planning – such as attitudes towards contraception, and developing a case study with one of our heterosexual focus group participants to add personal detail to that chapter.

In this report, we have described in broad outline the needs and harms, and in finer detail the relevant personality, social and cultural factors, and patterns of communication within our target community – enough knowledge for health promotion planning. We hope that our findings in this report may help pave the way for more precise epidemiological research.

The project worker and author's identity as a gay man and work experience in gay men's health may bias the analysis towards the needs and lived experience of same sex attracted students. It is never possible to wholly eliminate bias, so we have drawn attention to its possible influence by including the 'author's note' (above).

Compared to our chapter on heterosexual students, there is more fine detail in the chapter on same sex attracted students, particularly around their sexual practices and risk-taking.

As in all MHSS projects, we convened an expert reference group. In between meetings, we used e-mail to seek feedback and guidance on planning documents. We followed this process for the interview and topic schedule.

During this process, one participant consulted with their colleagues and fed back concern about the fact that we planned to ask heterosexual students questions about their sexual practices and risk-taking. Their concern was that such questions would be embarrassing and possibly distressing to heterosexual students.

Although we engaged in dialogue over this feedback, we felt it was important to maintain a good relationship with this stakeholder and ultimately accepted this limitation. In hindsight, it would have been better to refer this issue for discussion at a meeting of the full RG.

When we commenced data analysis, it slowly became clear that not asking about sexual risk practices had made it impossible to evaluate the impact of gaps in the health knowledge and service awareness and usage of heterosexual students. Obviously they are related, but we rely on the findings of other studies to suggest the ways in which they are connected.

The heterosexual and homosexual enquiries were conducted as separate studies, and are presented in separate chapters. This reduces opportunities for comparison between the two cohorts, but an earlier draft attempting this comparison proved more confusing than useful.

1 heterosexual students

❊ overview

This chapter is divided into four sections. The first two sections look at sex education and social attitudes to contraception in international students' countries of origin. The third looks at where international students look for information and support while in Australia. The fourth looks at research and conceptual frameworks for understanding their social connectedness.

In focus groups and interviews with heterosexual students, we were able to get a good picture of where students look to access information and support, but eliciting information about their sexual and reproductive health knowledge was substantially more difficult. Our participants, although keen to help and happy to talk about their lives, seemed to lack the confidence and vocabulary they needed to talk about sex, even with a same-gender facilitator. To compensate we undertook further research (literature search and in-depth interview-based) to add detail to what we gleaned from focus groups.

❊ findings

sex education pre-arrival

our participants' experience

Almost unanimously, students who took part in focus groups and interviews reported having received minimal sexual and reproductive health education prior to arrival. One third of students had received no sexual or reproductive health education whatsoever. Others recalled isolated classes on reproductive anatomy, undertaken during general science or biology classes.

Students from China said their teacher instructed them to read a chapter from a textbook, while female students from Singapore and Malaysia had received school visits from salespeople from sanitary pad companies who conducted sessions about menstruation.

One female student from Singapore said she had received a single class encouraging a 'just say no' approach to casual sex, smoking and drug-taking, depicting STI infection as punishment for immoral behaviour.

At the time we interviewed them – for most, more than a year after their arrival – heterosexual students were unaware of the existence of emergency contraception, and were also unaware of the need for regular STI testing. They were also unaware that untreated STI can cause pelvic inflammatory disorder (PID) and infertility.

Staff members at a number of clinical service providers mentioned seeing some international student patients presenting repeatedly for terminations of pregnancy. At one university-operated provider, a patient from China presented three times in eight months and was quite resistant to learning about alternative forms of contraception. Among international students generally, said a nurse at the same clinic, condoms are the preferred contraceptive option.

Asked about attitudes to contraception in China, key informants reported that mistrust of doctor-prescribed options is common, attributing it to media coverage of adulterated hormone therapy and the reported practice of doctors implanting IUD (intra-uterine devices) with their cords cut so

they can only be removed by a doctor. Patients must then 'apply to conceive', and the IUD will only be removed if their application is successful.

It is therefore not surprising that condoms are popular. They are a widely-accessible, relatively inexpensive, user-controlled contraceptive option. They have the added benefit of preventing STI transmission, but this is offset by lack of knowledge about their correct use and low rates of consistent condom use (especially in relationships). Condoms are effective when used in concert with regular STI testing and a backup contraceptive option such as the Pill or emergency contraception, and clinical service providers report this is frequently not the case with the international students they see.

other studies

Smith et al (2003) undertook a UNAIDS-funded study of how education systems in the Asia-Pacific included HIV/AIDS in school-based sex education policy and curricula. They surveyed 150 key informants in 2000, and while educational policies are likely to have changed since then, their findings largely accord with the experiences of sex education described by our focus group participants. As discussed under Attitudes to Contraception (above), young people may have been taught the principles ("use a condom"), but lack skills-based education – step-by-step instruction, situated in the social context in which sex happens – and this matches the findings of the sex education policy survey.

> *The tendency (is) to locate knowledge concerning HIV transmission in science-based areas of the curriculum, where skills-based work tends to be under-developed, reflect(ing) the fact that biological and medical knowledge is emphasised in the vast majority of education policy documents. Detail about more skills-focused issues such as harm minimisation or specific sexual risk practices, including the dangers of unprotected penetrative sex, is typically absent. Where policy does stray into consideration of the social, cultural and personal context, abstinence and fidelity are stressed, with official documents frequently talking of 'desirable health values', 'healthy and responsible behaviour' and 'family values'.* (Smith et al, 2003:9)

All countries included the following in their secondary school curricula:

- Transmission modes of HIV
- HIV/AIDS and STD scientific knowledge (eg. What is HIV? Consequences of infection)
- Avoiding HIV and STDs, stressing sexual abstinence and fidelity (condoms are mentioned in a small number of countries)
- Contraception within marriage
- Human reproduction and anatomy
- Puberty—psychological and physiological changes (begun in primary school) (Smith et al, 2003:12)

The gaps in that list are significant. For heterosexual students, it doesn't mention regular STI screening, sex other than vaginal intercourse, or the link between untreated STI and potential infertility. For homosexual students, it doesn't mention anal or oral sex as transmission routes, and it doesn't mention the need for regular STI screening. In the absence of any mention of routine screening, our focus group and interview results suggest that education about symptoms/consequences leads students to believe that symptoms are an inevitable and reliable sign of STI infection. With this belief in mind, screening for asymptomatic STI would not make sense.

Mcrae (2007) and a team of student researchers from the community development program at Cambridge International College surveyed 1155 students, comprising 555 from Cambridge and 600 students from RMIT and Victoria University. 431 students (37.3%) had not received any sexual health education as part of their primary or secondary school education, and this included the majority of students of Indian nationality. Of great concern is their finding that 772 (66.8%) had never heard of Chlamydia, which may be asymptomatic (or cause only vague symptoms) and can lead to PID and possible infertility.

Song et al (2005) surveyed 1185 first-year students recruited from a stall during student Orientation week in 2002 and 2003 at the University of New South Wales. They did not ask if students were local residents or international students; rather they asked about country of birth. Overseas-born students were slightly older, less likely to have had sexual intercourse (defined as vaginal intercourse) and had consistently poorer sexual health knowledge and HIV awareness.

In that study, the knowledge items tested were not those a sexual health educator would want to ask about – for instance, the authors were very concerned about whether international students knew whether Australia or 'their home country'

had higher HIV prevalence, even though this is not something a member of the public in any country is likely to know; they did not ask any question about the need for regular STI testing.

Because they decided against asking for visa status, they may have wrongly included overseas-born but Australian resident/citizen students as 'overseas students'. They stated that location of primary and secondary education is what matters to HIV/STI knowledge, but then claimed birthplace represents that more precisely than citizenship or country of residence, as if students never migrate before primary or secondary education. Further, the stall bore a banner saying "STUDENT SURVEY – HIV/AIDS knowledge and sexual behaviour", likely to deter students who felt embarrassed talking about sex. Therefore it is likely the study overestimates international students' sexual health knowledge.

attitudes towards contraception

Social attitudes towards contraception in countries of origin – particularly China – came up as an issue during focus groups, in-depth and key informant interviews for this project. Some of the claims made were quite serious: for instance, that students feared deliberate sterilisation or accidental infertility resulting from use of hormonal contraception. For this reason we undertook further in-depth and key informant interviews and a select (English language) literature search on the issue.

our participants

May (not her real name) is a postgraduate student who transferred her studies to Australia to be with her boyfriend, after several years in a long-distance relationship conducted online, over the phone and in person during vacations.

She noted the lack of systematic education about sex and reproductive health, resulting in a reliance on information learned from media reporting and friends:

> *We don't really have, uh, you know, the education regarding having sex in China. So all this information we just pick up in pieces, based on friends, or the media.*

Media reporting of contraception often emphasised the risks of morning-after contraception:

> *Based on what I saw in the media, people are not really aware there is a birth control pill you can take for long term – they're normally talking about morning after pill, and there's a lot of negative report on that, where people have the baby out of your womb, it's really dangerous, and people cannot conceive any more due to that pill. (female, 26yo, China)*

Despite being highly informed and proactive about health, she initially had quite strong reservations about using hormonal contraception:

> *I took the long term birth control pill before. When I first took it I was very cautious if it was going to have any impact on my reproduction ability… so I read through every message on the piece of paper, just to make sure.*

May is relatively adventurous and very proactive about seeking health information; other students may require more reassurance in person before they accept oral contraceptives as a safe alternative or adjunct to condom use.

other studies

In 2009 an article in the China Daily ("Abortion statistics cause for concern", 30 July) reported concern at the more than 13 million surgical abortions performed in registered clinics each year, with many more taking place in unregistered clinics. A further 10 million terminations are induced pharmaceutically. Abortions were attributed to lack of knowledge of contraceptive options:

> *Wu Shangchun, a division director of the National Population and Family Planning Commission's technology research centre, told China Daily that research shows nearly half of the women who had abortions had not used any form of contraception.*

Zheng et al (2001) undertook a qualitative study (FGD n=146; KII n=58) of sexual behaviour and contraceptive attitudes and practices among young unmarried female migrant workers in five major urban centres in China. Compared to international students, migrant workers in China are likely to come from poorer, rural families; however, there are important ways in which they are similar, including their separation from family and community support networks, and the temporariness of their position. Both migrant workers and international students are sojourners, making up itinerant populations which present a particular challenge for health promotion work.

> *When young people live with their parents, they usually behave more conservatively. When they leave their parents and live alone or with other young people, they feel freer and more able to do what they like. This*

is a time when they are most likely to be influenced by their peers and the surrounding milieu. 'We felt free after we left our families. Nobody watches us and we have more freedom.' (Zheng et al, 2001:121)

Indeed, an article by Michelle Tsai in the news magazine Slate (4 Nov, 2009) reports a liberalisation of attitudes toward premarital sex in China, albeit unaccompanied by sexual health promotion focusing on the essential skills young people need in order to use contraception effectively:

The first time Hu Jing tried to have sex with her college boyfriend, there was a technical difficulty. 'We knew we had to use a condom,' she said. 'But we didn't know how.' (...) Even though Chinese culture has become increasingly liberal, traditional values endure. As a result, there's a gap between how open people are about sex and how informed they are, and stories like Hu's are more common than you might expect. (Tsai, 2009)

Zheng et al (2001) found that young women did not plan for sex and saw contraception as being out of their control, and the counsellors and clinicians we interviewed for this needs analysis confirmed this finding holds true for international students in Melbourne as well.

[I]n all five cities, most sexually active, young, unmarried women migrant workers had never used contraception when having sex. (...) Some interviewees said that sexual activity was usually unplanned, and they did not have time to think about contraception or did not have contraception with them. But many informants in all five cities said that the main reason why sex was unprotected was that young women wanted to please their partners.

'He would not agree to use condoms, I had to follow because I loved him. I was very concerned about getting pregnant but I had no other choice, so it was like placing a bet.'

'I wanted to make sure that I was fertile, so did my boyfriend. We tried and I got pregnant.' (Zheng et al, 2001)

China has a 'one child policy' for population control, with intense clinical and bureaucratic surveillance of and intervention into the reproductive lives of its women, so it may seem paradoxical that young women have so little knowledge of birth control. The paradox can be explained by reference to cultural differences in the Chinese conception of adulthood, where young persons are not seen as adult until they marry. Birth control is seen as an important topic for discussion between married women only.

[A]lthough some women knew that condoms and the pill were sold in stores, almost all of them believed that family planning service stations were not a place for them to go, because family planning was 'married women's business'.

Since sexuality is considered an embarrassing topic for unmarried people, only married women talk about contraception and exchange experience and information with each other. Hardly anybody mentions contraception to unmarried women, not even to their own children. (Zheng et al, 2001:125)

Indeed, some women in Zheng et al's study linked the biological onset and timing of fertility with marriage rather than puberty and menstruation.

When asked when a woman is most likely to fall pregnant in her cycle, both married and unmarried women in the Guiyang FGDs could not give a correct answer. A 23-year-old married woman answered: 'I've never heard about that. I think a woman will get pregnant soon after she gets married.'" (Zheng et al, 2001:125)

Even though sexual health education in China focuses mainly on the biology of reproduction, respondents overall had very poor understanding of this process and their bodies.

Not only did most of the unmarried women have very limited knowledge of contraception, but many were also not clear about basic aspects of reproduction. A 20-year-old unmarried woman who had just had an induced abortion thought that it was 'just bad luck' to get pregnant after (occasionally) having sex without using contraception for two years. In her mind, fate controlled conception; she had never thought of using a contraceptive when having sex. In all five cities, in fact, there were young women who knew almost nothing about why pregnancy occurred and had therefore never taken any preventive action. (Zheng et al, 2001:124)

As a result, use of abortion was commonplace:

According to the family planning doctors, more young migrant women came for induced abortions, at younger ages and later in pregnancy (this last because they did not recognise they were pregnant earlier), and some of them had more than one induced abortion. (...) Most women we interviewed who had unprotected sex did not think it would hurt them to have one or two induced abortions, since they were young and healthy. (Zheng et al, 2001:124)

Clinicians and counsellors interviewed for our needs analysis expressed concern about low levels of knowledge and repeat use of termination, possibly instead of contraception, among young female international student clients. According to figures kept by a large OSHC provider, termination is most common among students in their first year of study in Australia. Clinicians also report that international students typically present later in the course of their pregnancy, when termination requires a more invasive procedure with increased risk of complications.

sources of information and support

The answer to this question was consistently the same across focus groups and interviews with students, and there was a substantial disconnect between the answer they gave and the approach taken by education providers to meeting their information and support needs.

Students said their number one source of information and support was close friends. This was followed by parents, followed by information-seeking on the Internet, and finally, the absolute last resort was accessing institutional services.

Counselling was viewed with a particular scepticism, as many students felt accessing a counselling service necessarily implied they had some kind of mental problem.

The two biggest sources of information and emotional support for participants in our study were 'close friends' and 'housemates'.

Given this friends-and-family-first approach to problem-solving, it was not surprising that a nurse from a university-operated health service made the following observations:

- Students with depression are presenting 'late', in other words, when the condition is quite advanced. Students with anxiety often present with 'chest pain' or stomach ache, which is either attributed to poor diet or anxiety once all the possible physical causes have been ruled out.
- Patients often have an expectation of pharmacological solutions to social and emotional problems, such as depression/anxiety. Where a doctor might talk to them about sleep hygiene, making friends and so forth, the patient just wants a pill for it.

We did not ask heterosexual students the kind of in-depth questions about their sexual practices that would be needed to evaluate whether their social connectedness was related to BBV/STI risk-taking or the risk of unplanned pregnancy.

our participants

Given that close friends are the primary source of advice and support for international students, it is clear how loneliness can translate into vulnerability and knowledge deficit. In our focus groups, unless they were college students, participants were mainly friends with other international students, and these friendships were often close and mutually supportive – the 'bonding' friendships described in the ISS report. Friendships with housemates were seen as both mandatory ("you have to be friends with them") and genuine ("like family to me, because you stay for more than a year together").

Making friends with locals was seen as difficult.

It depends on your alcohol intake, I would say. (laughter) The more you drink the easier it gets... to be friends with them, in a way. Because they socialise in bars, so, if you can't even get into the bar, making friends would be a problem. (female, 21yo, Malaysia)

It's hard to make friends in class. Even sometimes we seldom talk, like, we just listen in class, after that we go to different classes, that's it, go home, and we live very far from each other." (female, 26yo, China)

I think it's about stepping out of my comfort zone, you know, being Malaysian, there are many other Malaysians here, best friends who I've had for like 10-20 years, they're here as well, so I just need to be able to tell myself to not hang out with them so much and hang out with people I've just met, so yeah, that's... We all tend to do what we're comfortable with, that's what I think. (female, 22yo, Malaysia)

Participants did not see the difficulty as being due to racism in Australia. They preferred an explanatory framework in which friendship grows out of common interests, which they just did not share with locals.

I just feel I do not really have anything to talk to them... what they talk, I do not feel interested in, so the conversation isn't going anywhere. And... I don't know if just like

background's different or if it's culture, just they're working and I'm still not working, I don't know if it's those factors or just because... like I'm not really good at talking. I don't know. (female, 26yo, China).

I guess because we don't have the common topics... sometimes they talk about going to club, what they did on the weekend, or that I went to friend's party or I went to club or like that – I don't go along to them, so I don't think it's good for me to talk to them about those stuff. (female, 25yo, China)

It's the accent thing for me as well, it took me a long time to get used to it. It didn't really affect me (emotionally) it was more like nodding and pretending I understood it. But the more I listened to them talk the more I got used to it. Cos most of them're from the country, so... (female, 20yo, Brunei)

I think it depends on the person that you're meeting too. At college 60-70% of people are from the country and some of them are quite open to meeting people from overseas and other cultures, while some have not been exposed to it so much, so, um... it's variable. (female, 22yo, China)

Having common interests. Some friends it's easy to understand each other but for others maybe different culture, different background, maybe not so easy to understand. (female, 19yo, Viet Nam)

Students from Malaysia and Singapore found it really easy to build their social networks in Melbourne, because there were such large populations of students from their countries here. Often they knew people from their high school or even primary school in Melbourne, not always from the same year level but frequently from year levels above them.

By contrast, May found it more difficult to meet people and make friends:

I find that just the social circle is so small... at home I would hang out with my friends and they would bring their friends and we would all know each other... but here, I only start with a few friends – I don't even have classes so I only meet some people during the seminar and nobody would start talking about what's your project about and what you're working on, nobody would start with common things like study and then going somewhere else like okay how about we just have a coffee afterwards and talk something else or how about we hang out and go to the movie? And you start with very tiny circle so it's really hard to have some kind of radiation to other people. (female, 26yo, China)

Other students pointed to the importance of friends from their countries of origins:

I guess there's a network here and you tend to hang out with people from your own country and it just gets bigger because everyone gets to know each other in Melbourne Uni where there are so many Singaporeans. (female, 22yo, Singapore)

These close networks were important, because they were the first line of support when things went wrong.

People who you have a lot in common with, so you share common ground. It's easier to relate and you know that the other side will relate to you as well. (female, 21yo, Malaysia)

Just, people who you know will be such a pillar... you don't need to have known them for long, some people you've just met them for say a year and you feel the connection to them and you know you matter to them just as much as they matter to you? (female, 21yo, Malaysia)

I will talk to my housemate because she know me very well, we have been living together a long time. (female, 22yo, Hong Kong)

Close friends are people I can get comfortable around with. We don't need to have a lot in common, I've got a really close friends and we're like fighting all the time, yeah just we care about each other, feel comfortable, that's it. (female, 19yo, Viet Nam)

Although students in our focus group expressed a clear preference for receiving advice and support from friends, those students who found it difficult to make friends were also the ones who made the most use of institutional support services, and this is an encouraging finding. However, they also placed the most weight on intimate relationships as a source of support, and this may leave them vulnerable when those relationships break up. As Rosenthal, Russell & Thompson (2006) found:

When relationships are not running smoothly, they can be a source of distress for students. (...) The stronger students' level of distress about relationships, the stronger their level of cultural stress, general stress, perceptions of drug use, alcohol use, and engagement in gambling and smoking. (...) Students who are most distressed (rating of 3) have a significantly lower sense of connectedness, and significantly higher level of anxiety, stress and depression than those who have little distress; they also have a significantly stronger experience of abuse and associated distress. (p81, citations omitted).

other studies

The ARC-funded study by Marginson et al (2010), released as a report titled International Student Security (hereafter "ISS report") focused quite extensively on loneliness and social connectedness and their impact upon international students' health and wellbeing.

We will not reprise their discussion here, except to note that we made essentially the same findings in this project and the Double Trouble report (Reeders, 2010).

The common findings were that:

- housemates are a common source of essential emotional support and information about health and wellbeing – in the social network analysis of the ISS report, they are described as "mini-hubs", or switching points for knowledge transfer;
- students who feel socially and emotionally lonely are at greater risk of distress and mental health problems, although they often present to clinical services with vague and somatised (ie. physical) symptoms;

Rosenthal, Russell and Thompson (2006) used a reply-paid, mail-out survey of one-third of the international students enrolled at the University of Melbourne to achieve a 43.9% response rate (n=979). They found overall wellbeing varied closely with connectedness:

The majority of students, 59 per cent, exhibit a positive, connected style of adaptation; these students have a sound sense of well-being. A substantial minority of students, 34 per cent, are unconnected and stressed in their approach, while a very small group, 7 per cent, have a distressed and risk-taking mode of adaptation. The latter two groups of students are the ones whose well-being is in need of strengthening. With appropriate support, these students could have much more satisfying and productive experiences as university students in Australia. (Rosenthal, Russell & Thomson, 2006:10)

Cultural adaptation and loneliness are major challenges to the health and wellbeing of international students. Mcrae (2007:15) found 70.9% reported loneliness and/or depression and identified a major need for additional or more prominent student counselling services. However, as the ISS Report puts it, "Australian educational institutions cannot compensate in quasi-affective fashion for social and emotional lacunae (gaps) in the private sphere." They cite research showing international students would rather speak to parents, older friends or other students than to academic or counselling staff about emotional problems (Leong & Sedlacek, 1986; Gonzales, 2001) and the more serious the problem, the more students felt unable to communicate about it or reluctant to seek help (Bradley, 2000).

According to the ISS Report, "students' willingness to use counselling was correlated to the willingness of service providers to 'use non-traditional ways of acquiring knowledge' and their 'understanding and ability to deal with racism'" (Boyer & Sedlacek, 1989). Unless it was culturally competent in this way, counselling can "invoke its own set of stress-creating intercultural tensions, in other words enhancing or even creating the very 'problem' the treatment is meant to solve" (Marginson et al, 2010:176).

❊ social network structure

Our participants clearly identified close friends and family as their primary source of information and support. This makes it necessary to ask about the social structure of the international student population – including topics such as the diversity within friendship groups – and whether or not they constitute a community for health promotion purposes.

The ISS Report found most international student friendships are 'bonding' (friendship with 'like' students) rather than 'bridging' (with students from more diverse backgrounds and experiences) in nature (Marginson et al, 2010:326-7). These close networks – what one counsellor described as 'ethnic clustering' – are an important source of social and emotional support; students in these networks 'exhibit better psychological and physiological wellbeing particularly during periods of high stress' (Sarason et al, 1997). They may also be "unstable and volatile, especially in the early days (as) relationships and networks develop and alter quickly" (Marginson et al, 2010:361).

As the ISS Report puts it, however, these networks "can also constrain action inside enclosures" (362). Bonding linkages increase the speed and ease of information transmission within a social network, while bridging linkages may increase exposure to novel information/perspectives,

although they may operate less efficiently for information transfer due to lower intimacy and translational costs. As cited in the report, "when information-seeking is the goal, novel, unfamiliar people are often the best sources" (Carstensen, 1995:152-3). Accordingly, a number of students interviewed for the ISS Report "were uneasy about same-culture networks, in which all connections led back to the same hubs and where the density of connections multiplied. These students preferred the extensivity of connections with its larger learning potential" (p355).

In the **Double Trouble** report, we identified lack of social connectedness – often influenced by experiences of discrimination – as a major factor in the vulnerability of CALD MSM to poorer health and wellbeing. There, it had a double effect, creating risk in 'time in crisis' and decreasing the protective effect of friends and family. In this needs analysis, it is clear that another factor – network homogeneity – operates to isolate sexual and reproductive health in particular from the overall health-protective effects of social connectedness. Students whose friendship networks are wholly comprised of other international students may not be exposed to information and referrals to clinical and community-based SRH messaging and services. It may not be safe to assume they 'catch up' with local-born or less recent migrant Australians in sexual and reproductive health knowledge.

Reliance on friends as a primary source of information and support is by no means unique to international students. Warwick et al (2003) interviewed 77 gay/bisexual and other same-sex attracted men aged under 25yo from a range of ethnicities living in London, to find out what they identified as their health needs and issues, and what strengths and capacities they possessed that asset-based health promotion could call upon. Participants were asked to identify the first and most recent situations that made them 'stop and think' about AIDS, HIV and sex.

For both (first and most recent) occasions, informal conversations with friends and family far outnumbered more structured discussions (such as those in education, group work or counselling). (…) [R]espondents did not often mention HIV/AIDS awareness campaigns and leaflets as things that had made them stop and think – only four respondents mentioned these… (…) More often, young gay and bisexual men had been made to 'stop and think' about HIV and AIDS through face-to-face encounters. (p221-5).

The Australian researcher Michael Hurley has developed the concept of 'cultures of care' to describe the ways in which sexual health knowledge is transformed into culturally appropriate language and forms and then circulated through community media and discourse in a particular setting – the HIV treatments media accessible in the gay community in Australia. Building on this work, Reeders (2009) sought to articulate a concept of 'community based prevention' to describe the community-level programs that underpinned Australia's successful response to the HIV/AIDS epidemic, in contrast to public health interventions elsewhere, which focused on individual psychology and behaviour.

A key factor in both concepts is the extent to which community members themselves take up and discuss the messages and objectives of a community health campaign. Both also depend upon the existence of a community as a site for circulation and audience concentration point for maximising reach. (It is less clear whether the concept is useful where it depends upon first creating a community.) But as Rosenthal, Russell & Thomson (2007) point out based on their 2006 study, there are practical steps universities can take to improve social connectedness between international and local students:

> *The challenge for universities is to develop programs that strengthen international students' sense of connectedness and thus their well-being. These programs might include: mentoring or 'buddy' schemes in which local students take a role in assisting and supporting an individual student; providing better orientation for international students on enrolment and continual monitoring of their well-being; or simply the provision of Faculty-based activities which bring together international and local students. Universities can also assist by encouraging small study groups where students have the opportunity of forming social and communal networks through regular contact in a comfortable context. There is also greater scope for universities to use the experiences of international students who do feel positive and connected in the host culture to outline to new international students the approaches, skills and experiences that allowed them to feel connected and accepted. (p81)*

It is clear from the analysis in this section that service creation and promotion are not in themselves sufficient to prevent the development of problems in sexual and reproductive health. What has to happen instead is improving baseline knowledge of the need for regular testing, multiple contraceptive use, early intervention, and the existence of services; and encourage international students to share their knowledge and support their friends.

2 same sex attracted students

Important note: the 'categories' (sections) developed in chapters 1 and 2 emerged from our data analysis, and the chapters are therefore structured differently.

overview

We wanted to know whether the typology offered by Rosenthal, Russell & Thomson (2006) could predict exposure to HIV infection risk, and whether it could be used to help in targeting different kinds of health promotion activity. As discussed in the conceptual framework ("Methodology", above) HIV infection is an uncommon event, resulting from a complex chain and combination of causal and contributing factors. Longitudinal case studies with purposively sampled participants offered the most appropriate method for capturing these nuances. We undertook one main interview with each of the participants and a number of shorter follow-up conversations over 12-18 months.

Our enquiry and analysis in this project builds on the findings and recommendations of an earlier project, *Double Trouble: the health needs of culturally diverse men who have sex with men* (2010). In that consultation, originally intended for service providers, we had an unexpectedly large turnout of culturally and linguistically diverse (CALD) men who have sex with men (MSM) community members, most of whom were international students. Indeed, participants cautioned that international students, since they form a 'visible cohort', might be overrepresented in our discussion as a sector about the needs and experiences of CALD MSM. Readers who are interested in same sex attracted male international students are invited to read that report alongside this chapter.

our participants

Rajan (gay male, early 20's, South Asian) fit the 'distressed and risk-taking' segment. When he first made contact with the project worker, he was a hairdressing student at an inner-city private college, preparing to apply for PR (permanent residence). He lived in a gay household and suffered terribly from inter-housemate rivalry and bullying, but he was unable to move out due to a debt he owed his chief tormentor. He felt helpless and suffered depression, which was not relieved by medication.

Ivan (gay male, 22, South East Asia) fit the 'isolated and stressed' segment. He studied at a major university with a campus in his home country, and came to Melbourne for the final year of his degree. He lived with zero privacy in the lounge room of an apartment with two gay international students around his age, and the one who came from his home country was his closest friend in Melbourne. He had very little sexual health knowledge and awareness of services, but had not sought to expand his knowledge while in Melbourne.

Alan (gay male, 24 years, China/Hong Kong) breaks out of the typology. He has a 'positive, connected' adaptational style, which facilitates considerable risk-taking. Alan's friendship network was very diverse, comprising both international and local students, white and Asian, university and workmates from the hospitality sector. Through these connections, Alan learned and passed on knowledge about STI testing services, but they also facilitated other kinds of learning and self-expression, such as adventurous sex and drug-taking.

sexual health knowledge

Our participants reported the same lack of school-based sexual health education, but had all since acquired better knowledge of HIV and STI through the Internet and from friends in their countries of origin and in Australia.

They were aware that HIV antibody testing has a 3-month window period, knew that gay men should get tested every 6-12 months, and could distinguish different types of STI.

However, at the time of interviewing, they were all unaware of the existence and availability of PEP (post-exposure prophylaxis, a 28-day course of anti-HIV medication that can prevent infection if started within 72 hours of exposure to HIV).

They were also unaware of precautions they could take before having sex without condoms in a relationship, such as the 'negotiated safety' protocol identified by social research (Kippax et al, 1993) and later operationalised in a campaign with the strapline "Talk, Test, Test, Trust".

Ivan, for instance, had poor health knowledge and an avoidant coping style. He described his housemate as a 'health freak', recounting an occasion where his housemate had unprotected sex and called him in a panic, so Ivan told him "You already did it, so what's the point of harping on about it now?"

He had never tested for HIV or STI, had never heard of PEP, was unaware of any gay community organisation, media or services, and was only vaguely aware (via his housemate) of a 'clinic in Carlton' (likely to be Melbourne Sexual Health Centre).

Ivan believed that he 'would know' if he needed to get an HIV test, thinking he would 'feel sick, headache, etc' if he was exposed to HIV. However, if he had to pay upfront for the HIV test or the consultation, he said he would reconsider it, joking that he was a poor student.

unwanted sex

Although he was very concerned about HIV infection and conscientious about condom use, Rajan reported experiencing unwanted sex on multiple occasions. Twice he was pressured into receptive anal sex without condoms by the same man, who followed him around at a licensed bar and SOPV (sex on premises venue).

A third time did not involve penetrative sex and occurred during a job interview for a massage service, and although he reported this to the police, they did not take him seriously and charges were never laid.

The problem of unwanted sex is discussed in the Double Trouble report as one of the major harms faced by culturally diverse MSM, and in Rajan's case it coincided with HIV infection risk.

negotiating sex and relationships

Ivan had just broken up with a 21yo Australian male he had been seeing for a month. During that time they saw each other every day and had unprotected sex, even though Ivan knew his partner was non-monogamous. They had not discussed HIV testing together. The romantic narrative of falling in love against your own will explained it best for Ivan:

> *You hang out every day for a couple of months, you have to have some kind of feelings for him... It's just like, hmm... at the very beginning you know that it's not serious, so I just kept telling myself that I shouldn't develop too much feelings for him, but it just kinda happened, because you just can't control your feelings for someone.*

Ivan had some quite serious risk factors for HIV acquisition, with low skills for negotiating condom use in casual encounters, and no understanding of negotiated safety.

> *And when you have sex with someone, who takes the lead?*
>
> *— Usually the other guy.*
>
> *Why is that?*
>
> *— I think it's just your role in bed, like, top or bottom. Most top are more like dominant, they're more like active, so they usually take the lead. But you just kinda go with the flow, I don't think there's a particular thing who initiate stuff.*
>
> *What about condoms?*
>
> *— Nobody really asks if they can use a condom or not... it's like we don't really talk about it, it just happens, wearing a condom, it's a must kinda thing. Whenever there isn't, it usually just happen, when the mood is right... you just want to go with the flow and you just couldn't be bothered to look for a condom and put it on or whatever.*

This shows the importance of what Laumann & Gagnon (2005) have called 'sexual scripts', as well as the challenge of negotiating sex and dating in 'post-paradigmatic' societies, where there are

no longer widely-shared narratives setting out roles and expectations.

By comparison, for Alan what seemed to matter was sexual history within a given relationship. He practices unprotected sex with casual partners and in relationships, often because an early episode of unprotected sex has set a precedent for it to continue in future.

> *I normally use condoms, yes. I would say 90% of the time, I do use condoms. But sometimes you know when you're on drugs, or you know when the guy's really hot, he's like 'let's go raw, I really want to try that with you' and you're just like 'whatever, let's just do this once', and you know… so I would say 90%. I normally have this thing in my mind that let's play safe, but definitely not 100%.*
>
> *(So you're* mostly *committed to it?)*
>
> *Yep. At least I'm trying to.*
>
> *(And with partners, when you've stopped using condoms together, have you been to get tested beforehand?)*
>
> *No. Um… the first one, I'm pretty sure he's clean because he doesn't have much sex experience, he doesn't really do casual sex, so um… mm… we both get tested afterwards and we were fine and I wasn't really worried at all, at the first time, you know. At the very beginning you don't really do much things anyway, you know?*
>
> *The second one, we had sex in the club toilet, that was the first time, and we didn't use a condom.. And the second time, he didn't… he didn't… he didn't initiate it (condom use) and I didn't say 'you should use one', I mean, we didn't use a condom at the first time anyway, so fuck it, he's hot, so we just keep carry on like that. So I only been with him for like four month, so that wasn't really a long time, and after we broke up I went to check it and I was okay, so I guess that was all good.*
>
> *Then, um, the last boyfriend, that was really tricky. So yeah, the first time, it was all like steamy sex, we used a condom at the beginning and then he said 'can I fuck you raw?' and I was like 'Okay', so we took it off and just did it raw. From that point we just didn't use a condom again. --Why did you say 'Okay'?-- Cos I was all excited, and I was like he's hot, and he'll probably be okay… Sometimes you just have those stupid thoughts in your mind and like, okay… (smiling)*

In Alan's mind, he chooses carefully, using rules of thumb on a case by case basis, which guys he will have unprotected sex with.

> *I'm gonna ask him so what's your status, when was the last time you got tested. And I won't ask him through MSN, I'm going to ask him face to face, because I want to hear the answer from him. And you know, if then, you know, if he, if he says 'I'm all good' then we can go ahead… If some people is really dodgy then I wouldn't even do anything with them.*

adventurous sex

In the Double Trouble consultation, a number of consultation participants expressed the belief that international students are 'virgins until Australia' who experience Australia as a land of sexual freedom, 'like a kid in a candy store'. While there are certainly some students who are less adventurous, this cannot be said of all international students, and those who do take more risk have quite substantial unmet sexual health needs.

Ivan and Alan, two men from different countries with totally different social backgrounds and personalities, had both used illicit drugs (including for sex with partners they met online) before arrival in Australia. Both said drug-taking was something their school educations had discouraged, but that it was common among young people in major cities in South-East Asia. Both had taken drugs in Australia, as well. Ivan compared the cultures 'there' and 'here':

> *In Malaysia they have 'houseparty' every week; that's like the culture – we're different there… Houseparty here (in Australia) just means like you have food and drink, and get piss-drunk. Houseparty there, they call it 'extension party', because all the clubs close at 3AM, so after 3 o'clock you go to houseparty. You might have a little bit of drinks there, but mostly just pills, and all different kinds of pills.*
>
> *(And how long do they go for?)*
>
> *Until the next day… Usually, around lunchtime, maybe eleven, twelve? Because it's not too safe taking pills in clubs in Malaysia – they have a lot of raids – it's safer if you have small, like 10-15 people at home. Because, you would be surprised, there are a lot, a lot, a lot of people who take pills.*
>
> *(And do people have sex in those parties?)*
>
> *Yeah, sometimes. You just have the group of people who take chem all the time and that's*

the group of people who do sex on chems. You know who are the ones who, like, there's a group of people who does it. And I fall kinda in-between... (laughs)

And you have to know that pills in Malaysia are so much better than pills in Melbourne. It's so shit here. I get drunk a lot here, though. Pick up drinking quite a bit. I think there's a big drinking culture or you could say problem here. I think I pick up that!

Alan has an extensive history of illicit drug use, although he had toned it down somewhat:

Well, I don't have pills any more – the last time would have been New Year's... and I had about four and I really had fun but the coming down was really bad. It's more the emotional stuff, it really gets me, and it took me about a week to recover. I was sitting in the toilet crying and I was seeing stuff and I was tripping, so that was really bad. That was the worst coming down I've had for years, so I was like, that's it, I don't want to do pills anymore. And the funny thing is, normally people get really bad coming down from coke, but I've never had bad coming down from coke. So now I just do it, after exam, at home, with friends. Or I smoke marijuana every now and again – so just weed or coke.

In the past, drug use had a significant impact on his studies:

When you're coming down you don't want to go to lecture, I didn't even want to go out, just stay in bed, I'd take valium and sleep for the whole day. (...) Every time, my plan was, you know, 'I'll stop on Saturday night, have Sunday to recover' then Monday I'll go to class!' But the thing always ends up that I'll be in bed Monday and Tuesday, show up on Wednesday, start partying again and that's just how it goes.

sources of information and support

Rajan was the first person to agree to be interviewed for this project, but the very last interview we undertook, over a year later. He connected through an MSN Live account created for the project, and every time the project worker came online, he would update us on how things were going, and through this connection the service became a significant source of information for him. Over time, he reached out to access services, including the Young & Gay and Insomnia groups at the Victorian AIDS Council, a GP at the Centre Clinic, and a counsellor at Drummond Street Services, and these have helped him with assertiveness and addressed the underlying issues that had left him feeling 'stuck'.

He also sought advice and support from the head of his household, a white gay man in his fifties who had deliberately sought (unsuccessfully, in Rajan's case) to create a safe space for gay male international students. Although a majority of students rely on close friends from the same age and cultural group – what the ISS report calls 'bonding' friendships – Rajan made effective use of less intense, more diverse 'bridging' friendships, and gay community-based services, to create a patchwork of practical and emotional support. He represents a success story for community based services: the intense needs client who required informal case management to get him through a prolonged adaptational challenge impeded by emotional crisis.

The current response by education providers to the health and wellbeing needs of international students is to create or further advertise the institutional services available, either through the institution or in the nearby vicinity. Rajan attended a small private college but through his 'bridging friendships' within the gay community he was nonetheless able to find services when he needed them, and as such, he is the best-case scenario. A heterosexual person in the same position would have a harder time, since there are few equivalent organised communities with traditions of mentorship and word-of-mouth education, apart from church groups, which are popular among South-East Asian students but are unlikely to facilitate knowledge transfer around sexual health and contraceptive options.

Ivan was ambivalent about the possibility of finding work and applying for PR (permanent residence) in Australia, and his primary connection to the social scene here was via his best friend, another international student from his home country.

He is like the one friend I can have a heart-to-heart with, that's my housemate. (He's) the reason I didn't move out [despite the lack of privacy] – I was just thinking I would crash in the living room until I found a better place, but I feel really comfortable staying there, even though there's like no privacy, but that's okay because they're cool with it.

Following our primary interview, the project worker provided Ivan with information to fill the gaps in his sexual health knowledge, and followed up afterwards to find out what action he had taken. He had attended Melbourne Sexual Health Centre

and tested HIV-negative, and was waiting out the window period to find out if this had changed during his relationship. He was also found to be susceptible to hepatitis A & B and was part-way through the vaccination schedule. He had also put the phone number for the PEP Infoline in his phone.

Alan's major source of information and support was his mostly-gay friendship network:

My main gay friends are locals, and I have some friends from uni as well, they're more like internationals, and the people from work, they're kind of mixed together – local and internationals. I spend more time with my gay friends. I don't know why – I guess we have the same interests and more common topics and we can pretty much talk about everything, so it's just more convenient I guess.

Of all the students interviewed, Alan had the best knowledge of sexual health and services available in Melbourne. He knew about the window period, he knew about acute infection and what symptoms to look out for, and he went to Melbourne Sexual Health Centre every 5-6 months for testing.

He was, however, unaware of PEP and unaware of negotiated safety. Given that his sexual repertoire includes using drugs for sex, Alan qualifies as 'sexually adventurous' (Kippax, Prestage et al), and therefore also needs more knowledge about HIV transmission efficiency and harm reduction strategies for unprotected sex, as well as an opportunity to reflect on the meaning of an HIV-negative test result, since repeated negative test results seem to him to confirm that the risks he's taking are not unreasonable.

social network structure

Alan's sexual health knowledge comes mainly from friends, and the diversity of his social network, comprised of a few intense 'bonding' friendships and a larger network of 'bridging' friendships, facilitates word-of-mouth information flow and informal peer education.

Me and my gay friends, we talk about everything – we talk about sex, and STD, and all that – and it just came up over the course of the conversation. And it was, 'oh, you know, there's a sex clinic, it's free, on Swanston St' and blah blah blah. I was actually very surprised – I have a friend, he's 29yo, a Melbournian, he's lived here for his whole life, and I was the one who told him about it!

Both cross-cultural and ethnocentric sexual preferences helped structure the friendship networks in which Alan was connected, and this had implications for information sharing.

(Among) my white friends, 50% of them are 'rice queens' and the other ones just pretty much do everything. And my Asian friends, about half and half, half only stick with Asians, they're 'sticky rice', and the other half they okay with things.

It was not possible to recruit an interviewee who was 'sticky rice' – a slang term referring to Asian men who prefer Asian partners. So it was useful to ask Alan whether these men do have sex in 'closed sexual networks', an assumption made by gay community sector and clinical service providers that was questioned in the Double Trouble report.

(The 'sticky rice' guys, do you think they know the sexual health centre?)

Yeah, they definitely.—Why definitely?—Because it came up. Like after clubbing, the second day, we go out for brunch, it came up in our conversation and also when I go to some people's – it's funny, I went to a friend's house and I saw his (MSHC) card lying on his table, the card with his number, and I told him you should really put the card into your drawer or something!

Alan himself had sex with people from that network, and also shared his sexual health knowledge with them, acting in effect as a bridge between their social and sexual network and local-born, white Australian networks. However, he was deeply ambivalent about a particular dynamic he perceived within their social circle, centred on gossip:

I think that's pretty much what people do – you know, gay guys... Especially, I think, the sticky rice, like 'gaysians', that's what they do, create stories, and you know. Who slept with who, who has been going out, and obsession thing about all this stuff.

(Really? Even though you're all friends?)

Yeah! Yeah. They really ugly... they just talk about everything. Like, okay, say you know, because, they're all a group of friends, and if someone doesn't hang out with them today, if they go out for lunch, they gonna talk about that guy, for sure. The "gaysian circle", it's like that. But with my (other) friends, if they talk bad things about me behind my back, I'd be really upset – and they wouldn't do that. We just talk about other people...

Ivan also experienced the effects of gossip in his relationship with a young white man, who kept a distance from him in gay venues and refused to publicly acknowledge their relationship, which he found confusing and hurtful.

> *I tried to ask him – cos he's still young, just like 21. What he told me was like, 'if your friends see you with Asian, they'll say "Ohh, you're with an Asian."' I don't know what that means among that group of friends, but I feel like he was a bit... condescending.*

Ivan put a lot of mental energy and effort into managing the impact of 'stereotype threat' (anticipation of being stereotyped) upon his perceived chances of meeting a partner.

> *It's this funny thing... like, Friday night, went to the Peel. Friday night just generally (has) more Asians. Now I know a lot of Asian friends. And we find that if we hang out more with them, it's generally harder to get pick up. Because you'll be seen like, 'Oh, he's part of the Asian group'. So if you don't hang out with them you'll be alone and it's different. I like to hang out with this white friend, he's a really nice guy. One of the reasons I like hanging out with him, you're seen that you're with a white guy, (so) you don't fall into that typical gay Asian kinda group.*
>
> *(Is there a stereotype that Asian guys hang out together?)*
>
> *Not really I guess... but then, you know, you soon find out that among gay Asian people, 'oh, hey, he doesn't like Asian, he likes white guys'. Then they will stop hitting on you and stuff like that. I know a lot of people who like Asian would hit on me, and I was like... 'uhhhh, I like white...' and they say 'Okay!' Then we'll become like friends -- which is pretty cool actually.*

By comparison, Alan didn't perceive or experience racism much – perhaps helped along by drugs and also by his more outgoing and adventurous personality.

> *I reckon when I'm on stuff it's easy to pick up, because you just want more, and I think the drugs really boost your confidence, you're more talkative and so... yeah.*
>
> *(Have you ever encountered racism, either online or in clubs?)*
>
> *There are a few people, but they're not in my face. So... (they're) not really, not that offensive... Well I guess, you know, I wouldn't say that's racism. That's just personal preference. They're not attacking me... I think some Asian guys are really self-conscious, you know, they just have this question mark in their head all the time. Sometimes you just talk to people and they will never say "You're Asian, I don't want to talk to you!"*

coming out

We interviewed a counsellor who worked at a university counselling service and was the international student liaison for that service. He counsels about 250 students per year, of whom about 25% are international students. Each year, 10-20 of these present with issues relating to same sex attraction, and of these, 4-5 are directly about 'coming out', while the rest are focused on sexuality more generally, including sexual health and relationships. One student from Singapore struggled with feeling under pressure to 'come out' to his family, until the counsellor pointed out that that 'coming out' to himself was equally valid and meaningful.

As we found in the Double Trouble report, CALD MSM experience pressure in both mainstream culture and gay community spaces to 'come out', but often it works better if they can wait and use strategies such as 'coming home' (Chou, 2001) to negotiate a more tacit and gradual integration of their same sex attraction into family and community life.

Both the counsellor we interviewed for this project, and Mark Camilleri from the FPV Youth Action Centre (interviewed in the Double Trouble report) had worked with students facing catastrophic consequences from families reacting badly to discovering their sexuality.

Alan 'came out' to his mother with very little pre-planning, through Skype (online voice chat), and this did not go well at all:

> *I thought there would be crying and yelling, but... I can tell my mum was really upset and, uh, I don't know. I can also feel she's terrified and she doesn't know what to do. We only had a conversation once at that time and for about three or four hours, she just say, you know, we can still, I don't know, "change" you, and you can go and see a doctor, psychologist here, and I'm pretty sure he can change you. And from that point we just never talked about the issue again.*
>
> *(What made you feel like you needed to tell your mum?)*
>
> *(long pause) My boyfriend, at that time, I think everything was great, and he want me to move in to live with him, and we only been together for a short period of time. And I don't know why, but I just really had urge to tell them – it's been so long, like, I wanted to tell my parents for – I had these thoughts for almost two years! It's coming to the point that I couldn't hold back any more and I just had to tell them. So I just called my mum on Skype and came out... and now I regret it... I wasn't prepared.*
>
> *(What would have made it better?)*
>
> *I think if we can sit down and talk about it, that would have been better. I wasn't planned to do it on Skype, it was actually a very reckless decision: "I'm just gonna do it now, and how, I'm going to call them." That decision didn't really went through my brain.*

By contrast, Ivan planned to never tell his parents and extended family about his same sex attraction. In a follow-up conversation online, he stated:

> *Its really sad coz i dont tell her anything in my life anymore, like the way i was brought up*
>
> *And now it exploded back at her coz now she wants to know (the cat is out of the bag unofficially thanks to my best friend) and i dont wanna tell her*
>
> *And life still goes on*
>
> *(smiley face)*

conclusion

The case studies illustrate the usefulness of the three elements in the typology of social connectedness and adaptational style, but also suggest some ways it can be expanded. For instance, a proactive and outgoing personality can enable risk-taking as well as health-seeking, and social isolation can sometimes push people to seek information and support from service providers and community organisations.

Alan and Rajan both connected to gay community, Alan informally through his extensive friendship network, Rajan more formally through services and funded programs. They illustrate in more complex form the two poles of the typology – the positive/connected (yet adventurous and risk-taking) and the distressed and risk-taking (yet conscientious, service-using).

Although both Alan and Rajan have capacity to benefit from interventions of different kinds, Ivan represents the most intense need, since he was effectively invisible to institutional supports, passive in his adaptational style and in denial about risk, and did not know what he did not know about health.

The remaining chapters of this report examine existing practices in response to international students' sexual and reproductive health needs, and make recommendations for a population health strategy to better meet them.

3 existing responses and the operating environment

What are potential barriers to international students accessing education/services?
Are there models of good practice in reaching this group and meeting their needs?

overview

One of our initial research questions asked about 'potential barriers' to students accessing services. The question assumes that international students recognise the need but fail in their attempts to demand information or services (see Alzougool, Chang & Gray, 2008). In fact, from our findings it seems we skipped over an earlier question: whether they recognise they need information/services. The lack or limitations of sex and relationships education prior to arrival, and reliance on close friends from similar backgrounds, means that international students may not know what they don't know.

barriers to education and service access

the 'seven S' of sensitivity

As discussed in the MHSS Resource Manual on BBV/STI in CALD Communities (3rd ed), when clients or patients from non-Anglo cultural backgrounds are dealing with sensitive topics, they may present some or all of the following:

- stigma
- shame (paralysis of expression/action)
- silencing (a form of paralysis)
- apparent secrecy or shiftiness
- stress and distress
- sleeping problems
- somatisation

Shame and silence around one important life issue can become a generalised, all-purpose response that hinders help-seeking and disclosure in other areas of a person's life.

Silencing and shame are closely related to the high *diffusion potential* of certain kinds of personal disclosure. People learn from experiences of gossip that personal expression can have far-reaching and long-term social consequences, due to the secondary connotations of what they disclose.

Shame can be defined as a paranoia about the possibility of this uncontrolled disclosure.

It produces a generalised silence because any topic could accidentally reveal the underlying premise – and through the suspicion of every utterance produced by this fear, everything that is said comes to stand for, and be linked with, the hidden secret. It becomes a truth that is impossible not to express, so that silence becomes the only safe option.

This also produces a mistrust of other people, who might interpret what is said and arrive at what is hidden, so that the empathy of others becomes a danger to be avoided. Where our focus on confidentiality tries to address a simple, rational fear of onward disclosure, shame is different – it is a loss of trust in your ability to control what you mean when you speak.

Research into international students has found the more serious a problem is, the less likely they are to communicate about it or seek help (Bradley, 2000).

The counsellor we interviewed said there was a need for better small group programs for international students, emphasising personal discussion of 'sexuality' and advertised on a regular basis. University queer groups exist, but are not seen and experienced by many international students as safe and welcoming spaces. Such groups may improve help-seeking across the board in students who have become 'stuck' on managing the pressure to 'come out'. This finding lends weight to the recommendation in the Double Trouble report for MHSS to develop a resource for CALD MSM addressing these issues in plain language.

The situation may be equally acute for heterosexual students dealing with the experience of unwanted sex, unhealthy relationships, or unplanned pregnancy, all of which can be profoundly lonely and isolating.

unfamiliarity with 'precautionary culture'

Compared to an international student, a local student in the West has much greater familiarity with life in what some have called "risk society" (Beck & Ritter, 1992) and others "precautionary culture" (Furedi, 2009). This does not mean a risk-taking culture. From primary school onward, students in Australia learn that 'prevention is better than cure' and that adulthood means prudent self-governance to avoid risk. This familiarity is an implicit premise in the construction social marketing campaigns, eg. "If you drink and drive, you're a bloody idiot", or "Think about what you're really gambling with".

A key dimension of the belief is that risk and responsibility are both universal, and this can be seen in the popular mantras "HIV affects everybody" and "Use a condom every time". In many of international students' countries of origin, however, risk is attributed to membership of marginalised social groups and seen as a logical consequence of failing to toe the line and follow the straight and narrow path in life. Protection, on this viewpoint, comes not from particular individual practices (such as using a condom) but simply from belonging to the mainstream and avoiding these social groupings.

In an Australian context, this looks like stigma, and appears to be based on irrational prejudice; in fact, it is a wholly different rationality of self-governance, based on group membership rather than individual practices. Epidemiological and public health 'targeting' of 'risk groups' probably reinforces this system of beliefs. Indeed, from cultures with the highest exposure to targeted epidemic responses, most notably Thailand, there has been pushback against moves to promote condoms for the mainstream community, with men saying they cannot use with wives/girlfriends something that is meant to be used with sex workers.

The consequence of this unfamiliarity is that educational messages and approaches need to 'go back to basics' and spell out explicitly the value of prevention and early intervention, and the danger of waiting for symptoms to appear or cutting oneself a 'risk discount' based on non-membership of risk groups.

information dumping during orientation programmes

Although the ESOS regime specifies minimum information that must be included in letters of offer, it does not specify minimum standards for orientation curriculum, and each institution does it differently. In the case of private colleges, there may be little or no orientation at all.

Both our student respondents and key informants described orientation sessions as an 'information dump', and students reported feeling overwhelmed and having poor recall of the information covered. At most institutions, attendance at these sessions is not mandatory.

Key informants said it was very difficult getting new content into already-crowded orientation programmes, in some cases leading to health promotion activities occurring during 'theme weeks' early in each semester, although with drastically fewer student participants; those who take part tend to be more health-conscious.

Students said from their perspective the main benefit of orientation programmes was meeting classmates and making friends. Key informants reported that non-participation in these activities is a known predictor of later problems in academic progress and personal wellbeing.

Students who began their educational pathways in Australia as 'homestay students' – undertaking secondary education while lodging with an Australian host family – were the most likely to skip orientation, perhaps feeling they already know how the system here works.

Students from South East Asian cultures are also likely to skip orientation activities if they coincide with Lunar New Year – an important family celebration equivalent to Christmas.

further barriers

Apart from the three main barriers, several further barriers were mentioned as having lesser but still noticeable impact.

regional students

A significant number of IS are enrolled at education providers in regional Victoria. The bulk of the response to their unmet health and social support needs has taken the form of creating new services in metropolitan Melbourne, and this cannot benefit regional students. Although most of these new services maintain a website and 1800 number, these responses don't match the way international students in our project described how they solve problems via friends, family, and finally face-to-face service access. Additionally, students at these campuses face all the barriers faced by residents in small towns in regional Victoria.

word of mouth

As we identified in this project and the Double Trouble report, the primary source of advice and support for international students and CALD MSM is their friends. While this is often an asset for their health, it leaves socially unconnected students vulnerable, because they lack 'bridges into care'. These students need to be reached in other ways, such as through social marketing or referrals from those services they do access, which may not be clinical in nature and need capacity development to help identify students at risk and refer them appropriately. For those students who are well-connected, however, the situation is reversed: to reach them, services must advertise in ways compatible and supportive of informal, word-of-mouth referral. Promoting a social norm of learning information and being ready to help a friend may be one way of resourcing people in these networks.

fear of DIAC

In the past, the same student administration staff covered immigration regulations and student wellbeing issues in Orientation sessions. This may have deterred students from bringing their problems to student services when the problem may have touched on immigration regulations – such as any problem that had kept them from attending classes, something institutions are required to monitor and report to Department of Immigration and Citizenship (DIAC).

There has been an improvement since DIAC staff began attending Orientation to cover these requirements themselves, creating more role separation between immigration enforcement and student support. However, a key informant at a DH-funded primary health centre in the CBD reported that homeless former students from South Asian backgrounds were actively avoiding a City of Melbourne-funded service, because they perceived it was 'monitored' by DIAC staff.

uncertainty about OSHC coverage

Some student respondents were unsure about what their OSHC insurance covered, or how to access reimbursement for costs, and not all students were aware there are clinics which bill OSHC providers directly (the equivalent of bulk-billing in Medicare). There was relatively low awareness of OSHC entitlements even among service providers, especially in the BBV/STI sector. Finally, there is a perverse incentive against oral contraception, which at $34 co-payment per script may cost the student up to $408 per year, while a medical abortion may be wholly covered and have no upfront cost.

uncertainty about the GP's role

Burchard, Stocks & Laurence (2009) report that international students do not always view sexual and reproductive health as part of the role of general practitioners.

In their study, one said "(I would see the doctor for) coughs and colds. I wouldn't ask them about this (sexual health). Is it part of their job? I wouldn't think so." This matches what Alan, one of our same sex attracted interviees, had to say about his experience asking for an HIV test at a university clinic:

> *I think, at the first year that I came to Melbourne, I went to the (university) clinic, at the school. It was just really odd – I think the doctor was surprised as well because normally they don't really get people who want HIV testing, I guess, normally they just get people with cold or flu. I didn't really know that there was a sex clinic, at that time, and after that I heard from my friend so from that point I just always go there.*

On the other hand, our heterosexual Chinese interviewee May sought advice from her GP about her contraceptive options, and our key informants in clinical practice were alarmed by the very basic nature of the information many international student clients were seeking.

To a doctor or nurse accustomed to patients who grew up in Australia, these kinds of questions would indicate a catastrophic failure of the educational system and, indeed, popular culture, the two main routes through which adolescent and adult Australians learn about sex and their bodies (for better or worse).

However, as May pointed out and Zheng et al (2001) confirm, one-on-one information provision by doctors is commonplace in major countries of origin for international students. It indicates an adult taking of responsibility by the student, and indeed, students who front up for this advice represent the best case scenario; the students who don't are more vulnerable (but invisible).

Instead, the problem is that information provision by GPs to individual members of such a large population is massively inefficient and resource-intensive, both in terms of time and cost (whether to OSHC providers or the state).

❊ existing responses

inclusion of sexual and reproductive health education in student orientation

Two major universities include presentations on sexual and reproductive health by community workers from MHSS as part of the mandatory orientation session all international students are required to attend. However, the audience is often very large – upwards of 600 students – and this makes it difficult to facilitate audience interaction and gauge their comprehension.

Other universities organise seminars during term time, heavily advertised through e-mail networks and brochures at services. At one such event, a health promotion team invited presentations by a doctor, nurse, counsellor, and community worker; over 100 RSVPs were received, but less than 20 students showed up.

Doctors and nurses at university clinics have reported self-producing podcasts on health topics and making them available from clinic websites. None has attempted to evaluate their uptake by students, and some seemed to conflate potential access with actual access and usage by students.

One regional campus uses its learning management system (LMS) to deliver orientation education via a 'virtual subject' that it is compulsory for students to complete in their first semester of study at that campus. It put considerable effort into developing orientation content into genuinely interactive education, rather than simply 'information dumping'.

Since 2002, providers of education to overseas students in New Zealand are bound to follow a Ministerial *Code of Practice on Pastoral Care for International Students*, specifying minimum standards of support and information provision. As defined in the *Supporting Guidelines (Tertiary)* pastoral care includes:

- Recognising that international students are in a new cultural environment, and providing support that enables students to make the necessary adjustments
- Acknowledging that International students are in New Zealand as a result of enrolment with Code signatories, and that in return those signatories must take responsibility for identifying and addressing the needs of the students, including their safety and wellbeing
- Assisting international students with participation in New Zealand culture by helping them to develop relationships and networks
- Supporting international students to achieve their goals
- Encouraging best practice for student care within the export education industry

These guidelines go a lot further than the minimum standards set out in the ESOS regime, and the result has been a flourishing of innovation in pastoral care, orientation, and intercultural engagement in New Zealand's teritary education sector.

❊ models of good practice

integrating life skills into curriculum

In this section, 'life skills' include problem-solving, information-seeking, help sharing, and forming social connections and communicating interculturally. All of these skills are essential preparation for adult life, and overlap with the abilities needed in order to maintain sexual and reproductive health and wellbeing.

The Catching On project began with funding from the Victorian Government Department of Health and later moved to Department of Education. It takes a unique 'whole-school approach' to encourage and enable schools to integrate sexuality education into their teaching curriculum, rather than leaving it to school nurses to deliver in one-off sessions (or neglecting it altogether). Independent evaluation has found the approach to be highly effective (Hillier & Bradonjic, 2006; DEEC, 2008).

We interviewed the project worker, Stephen O'Connor, to discover the key elements of the approach. These will not be discussed in much detail here, as the project is very well documented online:

> *http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/teachingprog.htm*

The key for our purposes is the combination of 'top down' and 'bottom up' advocacy and capacity-building strategies.

The Catching On Everywhere resources advise schools that sexuality education is mandatory under the Health and Physical Education domain of the Victorian Essential Learning Standards (VELS).

This is the top-down approach, emphasising that state schools are accountable for ensuring that curriculum meets the essential standards and for reporting on students' learning achievements against them.

In an important sense this approach is made possible by the minimum standards specified in educational policy. However, these are not imposed from above by way of policy directives: the Catching On project uses 'bottom up' tactics of diplomacy, advocacy and capacity development to encourage and enable schools, teachers, and parents to craft their own whole-of-school approach to sexuality education.

Sexuality education is spread throughout VELS from level four (year five and six) onward. Although it is contained in the Health & Physical Education domain, its themes overlap with other domains, so that sexuality education could (for instance) be included in an English language class analysing popular cultural texts.

We suggest this approach as a model of good practice for integrating life skills teaching into the everyday business of tertiary education. Learnings from the Catching On project have been carefully considered and in the Action Plan (ch 5) we suggest how they might be applied in a partnership response to health needs.

One key difference is that in tertiary education there is currently no policy identifying minimum standards for orientation or first-year subject curriculum. At the time of writing there was a consultation process underway, being led by the Australian Human RIghts Commission's Race Discrimination Commissioner, to develop minimum standards on student security. This is an encouraging development, but we have not able to find out whether the standards include any 'hooks' for advocacy around the inclusion of personal health and wellbeing issues.

The next section looks at a model of good practice from an expert in the field of international students' health and wellbeing, looking at how he has incorporated intercultural communication skills education in first-year science curriculum.

intercultural communication skills in subject teaching and curriculum development

Dr Shanton Chang is a member of our reference group and a much in-demand trainer in internationalisation of pedagogy. In Chang (2008) he described the principles for developing subject curriculum to provide skills and opportunities

for intercultural dialogue between local and international students.

This is not done 'for' international students; Chang (2008) and Treleaven et al (2007) argue that intercultural communication skills are needed by *all* students to prepare them for the multicultural and multi-national diversity of modern career paths and work environments, and should be 'embedded' in everyday subject teaching rather than 'bolted on' separately.

The lack of opportunities for intercultural friendship formation was clearly identified by students in our focus groups. As we discuss in Ch. 1, homogeneous friendship networks offer strengths and advantages but also have the potential to limit the exposure of international students to novel information and encounters with local norms around help-seeking and service usage.

We suggest Chang's (2008) approach represents a model of good practice because of its careful attention to processes of group formation, as well as the cultural construction of tasks and problems set for assessment.

reducing information overload during orientation

One approach in particular stands out as best practice for reducing the information overload experienced by international students. Beard (2008) offers the "3C" model for reducing the demands placed on student comprehension by the linguistic complexity of presentations:

1. academic word lists are used to identify and simplify terminology students are unlikely to recognise and comprehend;
2. foundation studies teachers attend orientation sessions and at strategic points ask presenters to clarify difficult language;
3. cross-sector collaboration between orientation, support, teaching and research staff develops a cycle of improvement.

In addition to reducing the complexity of language and improving the interactivity of orientation sessions on health topics, this approach offers considerable promise for modelling (demonstrating) information-seeking skills and precautionary health cultural norms.

Where possible, MHSS sessions on sex and relationships are done as co-presentations by male and female educators.

❊ creating supportive environment and services outside the university context

Many international students, particularly those from Indian and other South Asian backgrounds, attend private colleges rather than universities, where orientation and student services may be limited or non-existent. These students depend on government and non-government organisations to create a supportive environment and funded services able to meet their needs.

In the past few years there has been a flurry of activity to identify and meet the needs of international students. The fragmented nature of higher education regulation, which is shared between the Victorian and Australian governments, has posed a particular challenge for the coordination of activities.

A whole-of-government approach incorporating health, social and community services alongside education, trade and immigration is long overdue.

What follows is a brief and partial summary of the different policy-making, regulatory and service provision activities targeting international students and educational providers at different levels of government.

local government

The City of Melbourne (CoM) has been active in promoting the image of Melbourne as a safe and welcoming multicultural city through the Lord Mayor's Student Welcome. It has partnered with the Salvation Army to operate "The Couch" drop-in centre in the city. It is funded by Department of Business and Innovation to operate an international student arrivals desk at Melbourne Airport, coordinating volunteers who provide advice to an estimated 5,000 students and hand out approximately 13,000 information kits during the peak arrival months of February and July each year. CoM also convenes a committee of international students to help plan the Lord Mayor's Student Welcome.

emergency services

The Metropolitan Fire Brigade (MFB) and Victoria Police have undertaken project work and education with newly-arrived international students to improve household fire safety and personal security. Victoria Police has worked hard to reassure current and potential students in overseas markets that Victoria is a safe place to study.

community organisations

Department of Health has funded the Multicultural Health and Support Service (MHSS) to undertake this project to evaluate the sexual and reproductive health needs of international students. MHSS has given presentations to international students during orientation and adult English classes for many years.

Multicultural Centre for Women's Health received funding for a needs analysis and project work around female international students' sexual and reproductive health needs from the City of Melbourne.

Victorian Immigrant and Refugee Women's Coalition received funding from a variety of sources, including DIAC, for a needs analysis of female international students' sexual and reproductive and other health needs, and has launched Project ARIES (Advice, Referral, Information and Educational Support) to meet the needs this report identified.

state government

The Victorian Government Department of Business and Innovation (DBI) led consultations toward and development of "Thinking Global", Victoria's action plan for international education. It has funded CoM to operate an international student arrivals desk at Melbourne Airport, and also funds (at a quoted cost of $1m over four years) and operates the Study Melbourne website.

The Victorian Multicultural Commission funds and auspices the International Student Care Service, which operates a telephone helpline and website, and provides occasional small group sessions in partnership with other services, including the Multicultural Centre for Women's Health.

education providers

There is considerable diversity of size and type among educational providers and institutions, with a small number of enormous providers – universities and TAFE colleges – and a very large number of small providers, mostly registered training organisations (RTO), described in the media as "private colleges".

Each presents different challenges:

- The large organisations have internal structures that separate teaching from administration and student support functions and a hierarchy of management that can make it a daunting challenge to raise an issue for response.
- Smaller providers may have a single person, sometimes doubling in a teaching or administration role, nominated (but not always qualified) to provide support.

mixed state and federal

Separate State and Federal agencies have similar responsibilities for the regulation of quality of teaching and administration in different areas of the overall education sector. There is a proposal to centralise and federalise these functions in two agencies, the Tertiary Education Quality & Standards Agency (TEQSA) and a National VET Regulator, but this proposal depends upon a referral of powers from the state governments.

federal government

The legislative framework governing the admission of international students to educational courses in Australia is the Education Services for Overseas Students (ESOS) regime established by an Act of the same name and administered by the Australian Government Department of Education, Employment & Workplace Relations (DEEWR).

Under the Act, a National Code of Practice (2007) sets out principles and guidelines underpinning the ESOS regime, a description of the roles and responsibilities of state and territory governments, and requirements and standards for education providers registered to enrol overseas students (AEI, undated).

The regulatory regime that applies most directly to international students individually is contained in the student visa entry requirements administered by the Department of Immigration and Citizenship (DIAC).

The policy framework applying Federally and at State government level is the Council of Australian Governments (COAG) International Students Strategy for Australia (ISSA) 2010, responding to a Review of the ESOS Act ("the Baird review") in 2009.

internationally

There are activities undertaken internationally, both via the Internet and onsite in major countries of origin for international students, by governments, NGOs, education providers and (sometimes problematically) their agents.

reliance on websites

Both the Victorian *Thinking Global: Victoria's Action Plan for International Education* (DBI, 2009) and the Commonwealth *International Student Strategy for Australia* (COAG, 2010)

rely heavily on websites to accomplish their communication objectives.

> *The Study in Australia portal will provide a single authoritative source of thorough, up-to-date and accurate information for international students including information about personal safety, support services and employment rights and responsibilities. All information will be translated into several languages. The portal will direct students to more detailed information available on other Commonwealth Government, State and Territory public sector agency websites and portals.* (COAG, 2010:25)

This claims the site will provide a *single* 'authoritative source' yet, within the space of a paragraph, states that it will direct students to *other* sites.

Simply creating a website doesn't inform anybody unless they access it. This reveals a deeper problem – it is not possible to create a 'single authoritative source' for anything on the Internet, because the same search terms that will locate the authoritative site will also reveal dozens of other sites using the same language and often the imagery of an official department or agency as well.

This problem cannot be avoided, because the more well-known the 'authoritative' site becomes, the more incentive there is for unscrupulous operators to copy its key words.

For example, take the results of a Google search for "Study in Australia", conducted at the time of writing. In the first two pages of results, the official StudyInAustralia.gov.au site appears four times, including the first three results.

However, the following sites also appear, many of them intentionally designed to blur the line between corporate enterprise and government agency:

- studyinaustralia.com
- studiesinaustralia.com
- studyinaustralia.com.au
- idp.com
- studyingaustralia.com
- study-in-australia.org
- study.australia.edu
- immi.gov.au
- studyguideaustralia.com
- studyau.com
- we-study-in-australia.com
- study-in-australia.asn.au
- study.vic.gov.au
- australia.internationalstudent.com

All of these sites – including the Victorian Government site – use the search term "Study in Australia" prominently, typically in their title.

As the ISS Report (Marginson et al, 2010) documents, many international students have complained about unscrupulous migration and education agents making false claims about studying in Australia, and these sites make it all too clear how students might be led to rely on wrong information.

A second consideration makes it unlikely that official sites can function as a concentration point for reaching international students with baseline SRH education. This is the concern that talking about sex and relationships on sites visible overseas will cause alarm among the parents of prospective international students, damaging Australia's education export market.

Citing this concern, key informants advised us to abandon any thought of delivering health education at pre-departure briefings conducted in students' countries of origin. It is apparent from their content that official sites are platforms for information but also marketing and reassurance. This makes it unlikely they will accept content that seeks to raise students' awareness of risks and problems they may encounter here.

Finally, the Internet came a distant third in our participants' list of preferred sources of information and support, after close friends and parents. They explained that the Internet worked best when they knew what they were looking for – such as "a clinic near me". When it came to answering questions they had about topics they didn't understand, the Internet was much less helpful. Information and advice varies between sites, was not perceived as authoritative, and was not personalised or customised to the situations they faced.

conclusion

Our participants, key informants and published research offer unanimous support for the finding that international students prefer to find information and support through close friends and family members, with information-seeking online and service usage following only when these have failed. It is therefore striking to note the gap between this preference and the institutional and government response to date, which has focused on creating websites and new services. Strengthened services are essential for meeting the needs of distressed and risk-taking students, but will have little impact in preventing students from ending up in that position. It is therefore essential to rebalance the mix of interventions targeting this group.

4 estimating the impact of unmet health needs

How common are experiences of HIV infection and unplanned pregnancy among international students in Victoria?

overview

Our methodology does not allow us to quantify the incidence and prevalence of harms arising from unmet needs, such as BBV/STI infection and unplanned pregnancy. We knew this ahead of time, but hoped it would be possible to estimate these impacts using data from existing data sources, such as enhanced surveillance, notifications, service usage and quality assurance records, and overseas student health cover insurance claims.

However, as we discovered in the Double Trouble report, DH-funded services such as enhanced and passive surveillance and sexual health clinics do not record patient visa status or migration history, and this makes it impossible to measure how many occasions of service use and BBV/STI notifications can be attributed to international students.

A similar situation exists with regard to terminations of pregnancy. Insurers and providers who keep records on international students declined to make data available, even in summary form, due to concerns about their political and commercial sensitivity.

From our point of view, it was important to represent the impact of unmet needs in this report, because severity of impact is a key determinant of priority in the policy-making process. The project worker spent as much time on this research question as all the others combined, with only limited results, and ultimately frustrated by the process.

We asked one centre if they could ask about visa status on a six month pilot basis in their computerised triage questionnaire. This would help establish whether there *were* any significant differences between international students and the general population on the health needs and risks they present. In response it was stated there was no evidence to justify asking the question.

The centre later changed its triage protocol to manage enormous demand for its services – necessarily without reliably-collected data on demand and service usage by international students.

Based on the available evidence – subject to several caveats about its limitations – this chapter offers a rough estimate of the impact of unmet need in two areas: (1) unplanned pregnancy among heterosexual students and (2) HIV infection among same sex attracted international students.

unplanned pregnancy

At a conference in Canberra about two years before the time of writing this report, an OSHC provider gave a presentation showing cause for alarm about unplanned pregnancies among international students. Terminations were most likely in students' first 12 months in Australia, and a significant number of claims were for surgical termination, indicating later presentation at a point in gestation when abortifacient pharmaceuticals can no longer be used to induce abortion.

Word of these findings spread rapidly through ISANA, the International Education Association in Australia and New Zealand. However, it was not possible to obtain summary data from the OSHC provider in question, and it seemed for a long time that our analysis and report would have to rely entire on anecdotal impressions from clinicians and ISANA members.

Some of the myths and assumptions we highlight in the Double Trouble report surfaced in these anecdotal accounts. For instance, key informants speculated that international students were becoming pregnant in first year because they thought giving birth in Australia would entitle them to permanent residence, and sought termination when they learned this was not the case.

This is a version of the 'queue jumper' narrative about onshore applicants for humanitarian entry into Australia, and the emergence of this theme prompted our further enquiry into education and attitudes about contraception in students' countries of origin.

We conclude that unplanned pregnancies in the first 12 months are far more likely to result from lack of knowledge about contraception upon arrival, and that terminations taper off in subsequent years as students learn information and skills for consistent contraceptive usage.

Our concern is that international students may be presenting later than Australian-born patients of similar age, exposing them to higher risk of complications – but there have been no studies evaluating this question. Uncertainty about cost and affordability of termination may delay decision-making, resulting in later termination (PHAA, 2005). Delay might undoubtedly result from lack of service awareness and lower knowledge of sex and the body, two themes in our focus group and key informant interview findings.

As this report was being written, we became aware of a study from New Zealand (Goodyear-Smith & Arroll, 2003) which used a repeated cross-sectional study design to measure trends in pre- and post-termination contraceptive preferences, from samples of attendees at an inner-urban abortion clinic taken in 1995, 1999, and 2002.

The study reports a dramatic increase in terminations performed on single Chinese patients with no previous pregnancies, increasing from 12% to 55% of presentations from 1995–2002.

This trend reflects the explosion of the international education market in New Zealand during the same time period; the study authors say "the overwhelming majority of these women were ethnic Chinese, mostly young, non-resident women in New Zealand as students, or recent immigrants" (p3). As the demographic profile of the clientele shifted, so did the contraceptive preferences observed in each sample – in ways that strongly reinforce our analysis and findings in Chapter One.

Between 1995 and 2002, the proportion of attendees reporting any prior contraceptive use fell from 54.5% to 30.5%. Condom use declined from 35% to 22%, while oral contraceptive use initially rose from 15.5% in 1995 to 23% in 1999, before declining to 8% in 2002. The study also measured women's choice of contraceptive options post-termination, with preference for condoms rising from 10.5% in 1995 to 38% in 2002, and oral contraception declining from 48.5% to 31% in the same time period.

Even when used consistently, condoms are much less effective in preventing pregnancy (at 88.9%) than the pill (97.8%) or IUD (97.6%) (Goodyear-Smith & Arroll 2003:7). This may offer partial explanation of repeat presentations for termination. However, the authors suggest the problem is non-use, rather than failure of condoms, and note the importance of attendees' attitudes and expectations:

Asian women attending the clinic frequently decline an offer of free samples, express the opinion that it is the man's role to provide the prophylactic, and hold a widespread, misinformed belief that the use of condoms is not necessary for the first week following menstruation. (2003:7).

They report similar attitudes to oral contraceptives as we report in Ch 1:

> *(Chinese women attending for termination) demonstrate a profound reluctance to try any form of contraception other than the condom, and will seldom consider using oral contraceptives, which they believe will be harmful to them. (2003:7)*

Burchard, Stocks & Laurence (2009) reported that international students make up 30% of terminations performed at the Women's & Children's Hospital in Adelaide. Key informants in our study reported – anecdotally, since they don't ask about visa status in admission forms – that international students make up a considerable proportion of their clientele. However, high rates of use at inner-city clinics and student services may simply reflect their convenience and accessibility to international students, rather than high incidence of unplanned pregnancy and BBV/STI in the overall population.

Likewise, the New Zealand study cannot be used to draw conclusions about trends in demand for termination in the overall population of female international students – but it certainly shows increased demand from this group upon that clinic's services. This is strong evidence of the need to ask for visa status in CASI and quality of service questionnaires. Changing demographics and trends in demand can impose considerable strain on services, not just in terms of client numbers and resources, but in terms of the understanding and skills needed to meet any new and different needs they present.

As the New Zealand study authors report, previously reliable clinical strategies like prescribing oral contraception did not work for clients who fit the changed demographic profile. Whereas the Pill can be controlled by women, condoms require negotiation with sexual partners, requiring more intensive counselling that focused on relationships and gender norms. The lower reliability of condoms creates a need for ongoing vigilance against pregnancy, so patients need higher bodily awareness and knowledge. Finally, the shift required the clinic to develop cultural competence in clinical practice and processes.

The next section of this chapter looks at gaps in our knowledge around HIV infection.

The New Zealand study suggests a couple of things we could expect to see if increased numbers of international students were driving shifts in BBV/STI acquisition outcomes:

- more patients from South-East Asian ethnicities than before the increase
- more younger patients than before the increase

HIV infection

As discussed in Ch 5 of the Double Trouble report, HIV infections among CALD MSM born in South-East Asia increased from 6 in 2006 to 16 in 2008, but the HIV notification form only asks for country of birth, not current visa status or migration history, making it impossible to say whether these men are currently or were at some point international students. Combined with the significant increase in international student numbers since 2001, this is strong evidence of a need to begin asking about past and present visa status in all relevant forms. We see this as a priority for the Department of Health to take up, as our own intersectoral relationships and partnerships, while strong, were not sufficient to put this on the agenda.

Only eight cases of STIs were recorded, mostly by women. It is possible that not all incidents of pregnancy or STIs were acknowledged. The number of respondents in Tables 54 and 55 shows that not all students replied to these questions; 32 students did not answer the item concerning pregnancy, although only six omitted the item concerning STIs. Half of the cases of STIs and 13 of the 18 pregnancies are reported by students who 'never' or 'sometimes' use condoms. Of the 13 cases of abortion, 9 are reported by students who 'never' or 'sometimes' use condoms.

At the Double Trouble consultative forum in 2009, Carol el-Hayek from the Burnet Institute presented on HIV infection rates among CALD MSM. The graph (Fig 4) shows an increase in new HIV diagnoses among MSM born in South East Asia, from six in 2006 to 16 in 2008, and we are advised the increased rate continued in 2009 (Carol el-Hayek, personal communication, 2010).

As discussed in the Double Trouble report, it is not possible to say whether international students have contributed to this increase, because the HIV notification form does not ask about visa status. Instead, it asks an ambiguous question about the patient's intention to reside permanently in Australia over the next 12 months.

If an international student were diagnosed in the third year of a five year degree, or intended to apply for permanent residence, they might answer 'yes' to that question. This makes it impossible to establish how many international students are becoming HIV-positive during their time in Australia.

However, in the same time period, the median age of new HIV diagnoses also declined significantly,

from 38.8 years in 2007 to 35.3 years in 2008 (p=0.023), remaining at 35.9 years in 2009 (El-Hayek et al, 2010). In other words, 50% of new HIV infections in 2008 were under the age of 35.3 years.

Along with the increase in HIV infections seen in MSM of South-East Asian ethnicity, this satisfies both of the outcome conditions we'd expect to see if international students were being infected with HIV.

Tom Carter, a Partner Notification Officer employed by Department of Health who works from an office at the Melbourne Sexual Health Centre, was able to give an interview about his experience working with international students who are diagnosed HIV-positive during the immigration health check as part of their application for permanent residence in Australia.

Immigration health checks were originally performed by doctors/nurses employed by the Department of Immigration, but some time ago this function was privatised, and is now undertaken by Medibank Health Solutions at their office in Swanston St.

Diagnosing positive results placed doctors under stress and some years ago an arrangement was reached where they would call the Partner Notification Officers (PNO), and the PNO would then attend and assist in the diagnosis consultation, including doing the post-diagnosis interview. Before the PNO became involved, students who were diagnosed were shown the door and then completely lost to follow-up.

For immigration purposes, HIV-positive applicants are required to attend an HIV physician and obtain further tests for viral load and CD4 counts. The vast majority will attend the Melbourne Sexual Health Centre for these, and because the PNO have an office there, they are able to facilitate quick referral to the Green Room, often on the same day as diagnosis.

Some international students apply for permanent residence after graduation; others (often Asian men) are in relationships with Australian men and apply for interdependency visas. Applications from HIV-positive international students are often rejected but Tom doesn't know of a single appeal that has been unsuccessful. However, appealing a rejection requires a lawyer, time and money, and some applicants have been known to give up and go home, due to limited confidence and resources.

Tom does not see many diagnoses among international students – maybe 5-6 per year – but he notes that many will be diagnosed by high-caseload GPs and the number diagnosed during immigration are 'the tip of the iceberg'.

If an international student is diagnosed later (than a local resident would be), they are more likely to have higher VL and lower CD4, and more likely to need to start treatment immediately. Obtaining antiretrovirals when you don't have Medicare access is difficult; it often requires importing medication from overseas and places strain on clinicians at MSHC.

HIV-positive international students from Asian cultural backgrounds present with particularly intense support needs, especially when they come from countries where homosexuality is heavily stigmatised. It is harder for them to raise and discuss same sex attraction, and once they do reach that point, they may resist onward referral to services.

With one student from South East Asia, Tom recalls he needed months and months of support, not just about HIV-related issues, but about gay life, sexuality and family issues. This student's application was eventually rejected and he was sent back to his home country, where he lived with an intensely conservative family.

total estimate

In 2008 there were 16 new infections among MSM born in South-East Asia.

We know only 34% of international students will apply for permanent residence following graduation (AEI, 2010).

The Asian Gay Community Periodic Surveys (AGCPS) in Sydney found 25.8% of Asian men in 1999 and 22.8% in 2002 had never tested for HIV (Mao et al, 2003:20).

It seems logical that these students who never test may be more likely to be diagnosed when forced by immigration requirements. Students who test more frequently are more likely to be diagnosed at sexual health and gay-friendly clinics.

As a result, the estimate of 5-6 students (all ethnicities) diagnosed for the first time during immigration is likely to represent between 25.8–34% of total HIV infections attributable to international student MSM, suggesting around 18-24 HIV infections per year in this group.

This is a very fuzzy estimate, and the proportion we know about may be even smaller than estimated, since we have no idea how many students are infected with HIV in Australia and return home without being tested and diagnosed.

conclusion

More research is needed to quantify the number of female international students experiencing unplanned pregnancy and the number of same sex attracted male international students becoming HIV-infected. However, there is already evidence that unmet sexual and reproductive health needs are contributing to negative health outcomes for individual students and substantial demand for clinical services.

5 developing an effective and coordinated response

overview

This chapter draws together the report's findings in summary form and connects them up to suggest directions for an effective and coordinated population health response to the sexual and reproductive health needs of international students in Victoria.

health needs in summary

One of the dangers in presenting a long list of risks/harms faced by international students is the way it makes them sound like a group beset by problems and in desperate need of help. This section works backwards from the risks/harms identified in Ch 1 and 2 to make positive statements of the knowledge, skills, attributes and opportunities that will enable students to achieve sexual and reproductive health and protect them from harm.

Most students meet these needs for themselves with minimal intervention. The challenge for educators and service providers is recognising and working with their existing strengths and assets, and this is where positive statements are helpful.

Later in this chapter, we develop the idea of 'baseline' messages that meet the sexual and reproductive health educational needs of most students. The objective is not perfect knowledge but to help students recognise and demand their health needs (Alzougool, Chang & Gray, 2008) and to model skills and norms that will help in negotiating Australia's different culture of health promotion and care.

A significant minority of students are vulnerable in the technical sense of being at greater 'risk of risks' (Frohlich & Potvin, 2006). For these students we have attempted to identify the drivers of their vulnerability and the specific interventions that would benefit them.

overall needs

All international students need knowledge, skills/attributes and opportunities enabling them to:

1. achieve sexual and reproductive health and wellbeing
2. negotiate the kind of sex and relationships they desire
3. form close friendships and cosmopolitan social networks
4. solve problems for themselves and 'share help' with their friends
5. access affordable, convenient, confidential, and culturally responsive care/support

These are positive statements of students' overall health needs relating to sexual and reproductive health. We can further specify the knowledge, skills/attributes and opportunities they need, based on the kinds of health risks and harms they may encounter.

heterosexual students

Heterosexual students need the following knowledge, skills/attributes and opportunities:

- basic knowledge of the body, sexual intercourse and reproduction
- awareness of services available, how to access them, and what to expect
- combination of contraceptive strategies tailored to individual students' preferences

  — increased confidence in hormonal contraceptive safety in Australia

  — coaching in correct and consistent condom use if necessary
- emergency contraception and non-surgical options for pregnancy termination
- social activities and opportunities to meet and make friends
- understanding of OSHC entitlements (equivalent to Medicare)
- exposure to 'health promoting culture' norms including the value of prevention and early intervention, and regular STI testing despite the absence of symptoms
- information- and help-seeking skills and behaviours
- starting points for information and further enquiry on health and support needs

Most students only need intervention to help them recognise their health needs, and will seek out information, support from friends and services to meet those needs (Rosenthal, Russell & Thomson, 2006). (For further discussion of the relationship between recognised and demanded health needs, see Alzougool, Chang & Gray, 2008).

It is sufficient if baseline coverage of sexual and reproductive health needs provides pointers to good resources on the topic, and models skills and norms for effectively seeking out and evaluation information and services. This is consistent with adult education principles and leaves students free to pursue life according to their own values.

When these international students present for services, however, their needs may be more intense: appointments may take longer, require careful explanation and even coaching, sometimes over multiple appointments. This calls for cross-cultural competence in providers and a closer understanding of cultural background international students bring.

vulnerable students

Key drivers of vulnerability in heterosexual students are:

- delaying when things go wrong, leading to more complex problems and crises
- loneliness increasing dependence on primary relationships and vulnerability to unwanted sex and unhealthy/ abusive relationships
- lack of social connection decreasing access to information and support
- stress reduces capacity for problem solving and social connection

It is a paradox that vulnerable same sex attracted students often have better access to community (both formal and informal) than heterosexual students. For heterosexual students, these needs may be met by religious communities, but these exert their own influences on social learning and support around sex and relationships.

The needs of vulnerable heterosexual students include:

- 'coaching' in life skills needed to meet friends and solve problems
- structured opportunities for social contact and networking
- explication of tacit/implicit values in Australian culture
- early identification by teaching and support staff
- supported referral (or 'handholding') to access relevant services/opportunities

These needs are more intense but much less common than the 'baseline' needs that apply to students in the 'positive/connected' group, and flow from the overall needs 2-4 not being met. There are many reasons why this might occur, and 'vulnerability' does not refer to personal deficit or pathology – it refers to an 'increased risk of risks' resulting from a combination of personal and social circumstances.

same sex attracted students

Same sex attracted students need the following knowledge, skills/attributes, and opportunities:

- Understanding HIV transmission pathways and how risk does and does not work
- Effective, personalised combination of HIV prevention strategies (including condoms, risk reduction, status knowledge, STI testing and treatment, and post-exposure prophylaxis) and the behavioural skills, confidence and motivation to use them
- Negotiated safety protocol for unprotected sex in relationships
- Ability to identify and negotiate personal desires and limits in sexual encounters and relationships, and to avoid HIV infection, unwanted sex
- Awareness of SSA-friendly services for sexual health, social connection and counselling
- Ability to manage who knows what about their sexual attraction and relationships
- Opportunities to learn about and discuss cultural differences around friendship, relationships and community between Victoria and their countries of origin
- Health promotion and service delivery that responds to culturally-specific attitudes and understandings they bring to sex and relationships (and related risks/harms)
- Opportunities to experience and engage in community that aren't diminished by racism or dependent on 'coming out' as a condition of entry

vulnerable students

The particular needs of vulnerable SSA students vary according to what makes them vulnerable:

- students who have great difficulty meeting friends and potential partners may actually be relatively protected from HIV if they are not having sex at all – but this falls a long way short from sexual and emotional wellbeing and calls for remediation;
- if loneliness becomes unbearable, or a student is very unskilled in meeting people and negotiating sex/relationships, attempts to find connection may be chaotic and increase the risk of unwanted sex, emotional harm and HIV infection;
- these students may need one-on-one coaching and counselling-type interventions, as well as more structured social and learning opportunities, such as workshops.

On the other hand:

- a 'positive/connected' approach to life may facilitate greater risk-taking in sexually adventurous cultures, and this creates a need for more advanced prevention skills and knowledge – such as messages about harm reduction for drugs and unsafe sex;
- sexually adventurous students learn best from peers and elders in their social networks, emphasising the need for peer influence-based approaches.

The peer education program at the Victorian AIDS Council/Gay Men's Health Centre has over time developed an approach called PRAFT, short for Personal Risk Assessment Framework Training, which uses group activities to help students identify their own appetite and comfort levels around sexual risk, and to choose appropriate risk reduction strategies. Both counselling and peer education allow students to find their own level with regard to risk, while peer education by trained facilitators can help provide more customised advice for each group.

characteristics of the population

The following sections look at the conditions on our ability to respond effectively to the health needs identified in the two preceding sections.

Since 2000 there has been considerable growth in the international student population in Australia, driven primarily by university study and vocational training (AEI, 2011). See graph:

In December 2010, the year-to-date cumulative total of international student enrolments in Victoria was 183,580 (AEI Dec 2010, Table 7a).

The enrolments figure overestimates the number of students, since a student may enrol in multiple courses (called a 'pathway' in enrolments lingo). It is necessary to use enrolments data as a rough guide to student numbers in Victoria, because the de-duplicated student numbers available from AEI are not broken down by state/territory.

The top five countries of origin for enrolments in Victoria were China (50,908) and India (46,209), followed by Viet Nam (11,259), Malaysia (8,592) and Indonesia (5,918) (ibid).

Note: The mix in New South Wales was significantly different, with China (66,879) higher and India (21,743) much lower, followed by South Korea (16,251), Thailand (15,270) and Nepal (14,196).

Reports on student numbers, which avoid double-counting by matching key data variables from enrolments data, show a majority of Chinese students enrolled in the Higher Education sector (42.2%) whereas a majority of Indian students enrolled in Vocational Education & Training (61.4%) (AEI, 2010).

This report uses the term population to refer to international students in Victoria, because we can't assume they are a community, despite being a visible cohort (Double Trouble, 2010). In the literature, international students have been described as 'sojourners' (ISS Report, 2010), because they are temporary residents who spend a period of time ('a sojourn') in Victoria.

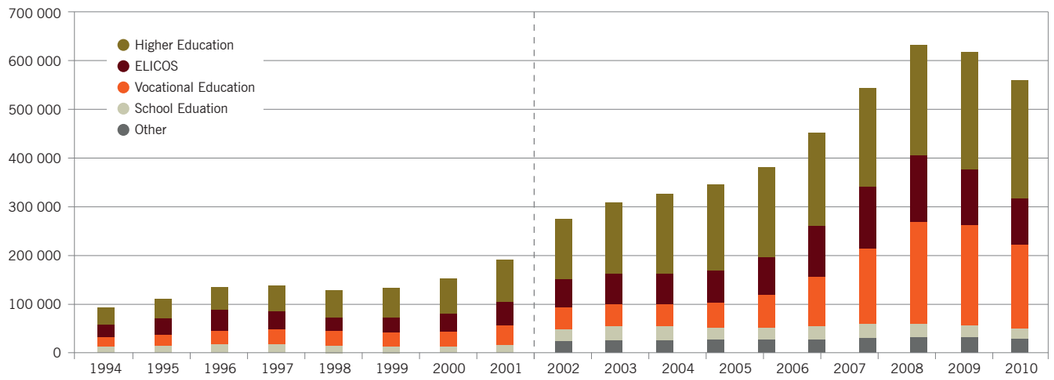
About 35.5% of international students will study multiple course 'pathways' in Australia (AEI, 2008), and before the General Skilled Migration rules were changed, about 35% obtained permanent residence in Australia at the completion of their studies.

In both cases, about 65% will return home at the end of single or multi-course study pathways, and will be replaced by new students. As the education export industry has continued to grow, there are also more new international students every year.

As temporary residents, international students are somewhat different from an itinerant or mobile population (Kearns, 1977) whose members continually move from place to place. However, the high rate of replacement (i.e. turnover) among international students means they share important characteristics with itinerant populations – in particular, the challenges they pose for health promotion.

With a permanently resident, geographically concentrated, 'settled' population, it is possible

International Student Enrolments in Australia 1994–2011



Note. There is a break in series between 2001 and 2002
Source. https://aei.gov.au/research/International-Student-Data/Documents/INTERNATIONAL%20STUDENT%20DATA/2011/2011%20Time%20Series%20Graph.pdf

to undertake community development activities, establish long-term partnerships, and contribute to residual knowledge and informal helping among the membership. It may also be possible to assume that a strong campaign message will have an influence over multiple years. As community develops, existing members may take responsibility for initiating new members into group culture, knowledge and relations of support.

By contrast, sexual health promotion targeting itinerant and sojourner populations must be continual and ongoing, literally repeating itself, just to bring new arrivals 'up to speed' on the basics of sexual and reproductive health.

how students find information and meet life challenges

Students in our project and the literature reviewed consistently report that – when facing problems in their lives – close friends are their number one source of advice and support. This was followed by parents, then information-seeking online, and finally, the absolute last resort was accessing services.

However, in this project and the Double Trouble consultation, clinicians and counsellors often mentioned that international students request one-on-one appointments to receive basic information and learn personal skills that, in Australia, are typically learned through more public channels such as school-based sex education or small group peer education.

For doctors in particular, this seems to imply an alarming failure of health promotion leading up to the appointment. For international students, by contrast, making the appointment means initiating health promotion and taking adult responsibility for health.

Health promotion by doctors was highly valued by most students. The role of doctors is understood to include private, one-on-one information provision in many students' prior countries of residence. It offers privacy, authority and personal relevance of information.

In Australia, however, information provision to individual students by doctors is the least efficient health promotion method imaginable. Clinical services popular with international students are coming under enormous strain, with the largest sexual health centre now declining service to clients who do not report risk practices in triage.

In short, when students are facing problems, accessing services often comes last, but when seeking basic information on personal topics, doctors' visits often come first.

In the name of early intervention and cost-effectiveness, it is essential to flip these around.

A key task for a population health response to international student health needs is therefore promoting the values of health promotion and early intervention, as central dimensions of health literacy in an Australian context.

how to reach students: content matters

Students endorsed three contact methods to reach them with messages about BBV and sexual health. They recommended the student portal, entertaining video messages published on Youtube and distributed 'virally' by peers on Facebook, and posters on the back of toilet door. Almost all the participants had at some point copied down a number or web address from one of those posters.

Students doubted they would ever voluntarily attend a session about sexual health, even if it was framed more in terms of relationships.

> *I think the thing about sexual health, it's usually something that people try to ignore, until you are faced with the scenario where you need the information, and then you will actively look for it. So it's actually hard to recruit people who are not in a problem, do not have a problem, but are interested – there are very few people like that out there... So really the thing is not to reach out but to be findable, or available. (female, 21yo, Malaysia)*

> *Having sexual health as the title of your seminar might make people want to avoid it, because people might assume you have the sexual health problem! (laughter) I think it would be better to make it sound like an information session rather than a support group for people with sexual problems... (female, 21yo, Singapore)*

> *Do you think this kind of topic is more suitable for like, one to one basis? I don't feel any uncomfortable if I talk to my GP, but I may not really want to go to a public place that is teaching something about it. (female, 19yo, Viet Nam)*

> *(What if we called it 'making friends and relationships'?)*

> *I just feel like, when people see title, they build up expectation about what they're going to get there – but if they show up and it's too*

different, (they might) not want to stay there. (female, 24yo, China)

(So it should be very upfront about what it's about?)

I would say it's better to give a descriptive title of what you are offering, rather than be a bit ambiguous. And the thing about calling it friendships and relationships is also there's a stigma associated to it – you go for a friendship seminar, people will be like 'oh, you don't know how to make friends?' So I'd say the best way is to just be descriptive, and then you might not get numbers, but then the people who come will be the people that matters; the people who need advice or who are looking for help, but in terms of popularity-wise you probably wouldn't get that big a response. (female, 21yo, Malaysia)

They do pay attention to resources that explicitly target international students.

I think you should mention 'international students' in the heading – that's the first thing they'll be looking for, because if I'm an international student I'll be concerned about it. (female, 19yo, Brunei)

Health promotion messages need to be quite 'slick' and entertaining to reach this group, but they cannot disguise their purpose too much either.

(What about Youtube?)

— If it has a catchy title then I'd be more tempted to press play.

— It has to be entertaining, otherwise you just close it.

— I guess like, with an international student (audience), it depends a lot on word of mouth – from friend to friend to friends.

❊ characteristics of the environment

The international education sector in Australia presents a challenging environment for planning a population health response to the needs identified in this report.

As outlined in Ch. 3, there must be coordination across multiple levels, with policy-making, regulation and service provision activities targeting international students and education providers currently taking place at every level of government.

Nearly all of these activities hook into export market discourse for their rationale, i.e. they have been funded in order to protect Australia's reputation in export markets. 'Discourse' refers to the conceptual vocabulary of a discipline or movement, which makes some ideas and objectives seem natural and easy to express, and others seem exceptional or difficult.

Personal health and wellbeing was not mentioned at all in the Victorian International Education Plan produced by DIIRD, nor the Baird Review and subsequent ESOS Act reforms, nor the COAG International Students Strategy for Australia (2010).

They have not been raised as issues at either the Victorian Overseas Student Experience Taskforce or in the consultation process organised by DEEWR for the Baird Review, nor at the non-government consultation forum organised by the Centre for Multicultural Youth.

The implicit and at-times explicit focus of these policies has been protecting Australia's educational export market. This is a legitimate objective for the departments responsible, but it is also a discourse whose terms weigh against admitting students are in any way at risk in Australia.

The purpose of the International Students Strategy for Australia is:

to support a high-quality experience for international students, in order to ensure a sustainable future for quality international education in Australia. (2010:2)

In Victoria and federally, the departments responsible for international students are the Department of Innovation, Industry and Regional Development (DIIRD) and the Department of Education, Employment and Workplace Relations (DEEWR) respectively. The frameworks and paradigms they use are predominantly market-oriented and macroeconomic in nature, and these do not make it easy to raise issues of individual wellbeing and population health.

As the ISS Report and ISSA make clear, issues of health only raise concern to the extent they might impact on export markets. A health problem does not become a market problem until it appears in the media, and this explains why the agenda for change is driven by media problematisation.

The ISS Report (Marginson et al, 2010) analysed the media, regulatory and institutional responses to a number of scandals or crises in the international education sector, and from their analysis it is possible to sketch an outline of how change often occurs:

1. an issue has an impact on students, provoking advocacy or media activity
2. institutions deny there is an issue in public, fearing that moving first on an issue will imply or admit there is a problem and potentially damage export markets
3. (overseas governments have expressed concern: this step is optional)
4. the media has championed an issue, raising a scandal about it
5. in the name of protecting markets, state or federal governments announce new services, policy review, or strategic responses

The Baird Review and International Student Strategy (both Commonwealth) have addressed issues placed on the agenda by media-driven problematisation. Marginson et al praise the journalists who contributed to this process for helping draw attention to IS needs.

However, this mode of agenda-setting does not suit complex or sensitive problems, where media treatment may sensationalise or unhelpfully personalise the issue. Such an approach would not be helpful for raising awareness of international students' sexual and reproductive health, since it would have unintended consequences, such as reinforcing anti-immigrant prejudice.

At another forum – workshops and conferences organised by ISANA – issues of personal health and wellbeing have been extensively discussed, but this ongoing conversation has not translated into change within the organisations whose staff attend those meetings. This may be due to the difficulty of working within a large and hierarchical institution, but it may also reflect the difficulty of articulating the need for change in the different languages used by staff located in different 'siloes' within the organisation (see for example Forbes-Mewett, 2010).

There has been a comparative under-use of population health and health promotion discourse in identifying and planning responses to personal health and wellbeing needs among international students, resulting in over-reliance on creating and referring to services for students in crisis, and underuse of health promotion strategies for preventive messaging.

The Department of Health (DH) in Victoria and Department of Health and Ageing (DOHA) are responsible for a different set of concerns, using methods and frameworks in which the health and wellbeing of international students are directly valued in their own right. It is important therefore to plan a whole-of-government approach including a population health response led and funded by Department of Health.

conditions on our response

Considering the characteristics of the population above, it very quickly becomes obvious that scale and reach are key issues in planning an effective and coordinated population health response to meet their health promotion needs.

We can apply Rosenthal, Russell and Thompson's (2006) finding that a 7% proportion of international students at the University of Melbourne were 'distressed and risk-taking' to the whole international student population. This would produce an estimate of 12,077 students likely to be 'distressed and risk-taking'. We would suggest that University of Melbourne students have better access to services and financial resources than students at private colleges, so this figure probably under-estimates risk-taking in the broader population.

Even if we only concentrated on the highest-risk students, a response comprising of face-to-face and small group interventions could reach only a tiny fraction of students in need, and would have no impact at all in preventing students ending up in that state.

lack of capacity

Depending on our staffing arrangements, MHSS typically has 2-4 educators who are capable of providing sessions to international students. Even if all our staff could do so, we still would not have capacity to reach every international student in Victoria.

To date, many services for international students have been funded on a pilot basis, often as a reaction to media coverage, often using small amounts of project funding from a range of sources, staffed by part-time or casual workers or volunteers (who are often students themselves), using drop-in, face-to-face and small group intervention methods.

In addition, there is an emerging trend to 'mainstream' international student support services, instead of hiring separate and dedicated staff and organisational units to meet their needs.

The only possible approach to reaching a population of this size is for education providers to deliver baseline education to their students.

"Baseline education" means the basic messages that all students need to know. It does not need to be comprehensive or so detailed that an expert presenter would be essential.

The role of MHSS and its partner organisations would be to develop baseline messages in consultation with education providers, support workers and researchers, and to provide training to education providers on how to deliver this curriculum.

low diffusion

Diffusion refers to the spread of new information/skills within a population or community. When a video or e-mail 'goes viral' on the Internet, that is an example of diffusion in action.

Diffusion is an implicit assumption in any strategy that aims to affect a problem in a population by reaching a small fraction of that population with a health promotion intervention. The assumption is that participants will pass on the skills and information they receive to their friends, family and other social contacts. Diffusion is commonly assumed to be the causal 'bridge' between the limited reach of funded health promotion interventions and having an impact on a problem distributed throughout the broader population. But it is a hidden assumption that is rarely surfaced for interrogation during health promotion planning.

This is a problem because there are certain questions that need to be asked before we can safely assume that diffusion will actually occur.

The first question relates to how members of a population typically view the nature of the subject matter. If a topic is seen as sensitive or private, there may be constraints on how it can be communicated and whether and how it will diffuse. For example, in most communities, information that a particular member is having sex outside their primary relationship is highly private and sensitive, yet will diffuse like wildfire (as gossip). Passing on information about HIV/STI may be taken to imply the communicator has a reason for knowing it – that they are sexually active themselves. The high diffusion potential of those secondary connotations therefore inhibits the diffusion of the HIV/STI information. This is why it is too simple to say that a particular topic is inherently 'taboo', or that cultures have 'silences' around it.

The second question relates to the intensity of an intervention. A peer education program might run for six weeks, one night per week, for three hours. The facilitation of the group and its activities might be designed to build confidence in participants and overcome their reluctance to talk in small groups about sex, relationships, and HIV/AIDS. A highly interactive, discussion-based curriculum might help participants elaborate a strongly-held, personalised understanding of HIV and STI. (Elaboration is the process through which complex information is transformed into personal knowledge: see Petty & Cacioppo.) Participants who complete such a group are highly likely to become knowledgeable ambassadors, both for the program, the organisation, and safe sex in general, amongst their friends and social contacts.

The peer education program achieves a balance between the sensitivity of the subject matter, the intensity of the intervention, and giving people skills and confidence to communicate about the topic and overcome shame and the use of silence. A particular individual may depart from the way members of the population typically view the nature of the subject matter, if the intensity of the intervention is sufficient and optimised for this to happen.

With international students, our focus groups clearly showed that sexual health information will not diffuse. It is seen as personal and private information, which is good to know, but not appropriate for discussion between friends or classmates. However, it might be disclosed between very close friends during a crisis, when there is immediate personal need for the information, and the urgency of the situation, intensity of distress and/or closeness of the relationship authorises the suspension of ordinary social conventions.

Most participants reported having 1-4 really close friends who they relied on for help in tricky situations, suggesting a communication approach based on diffusion would need to reach at least one-quarter of the entire population in order to 'seed' the information so that it was available within most close friendship networks at the point when the situation authorised its disclosure. However, an approach relying heavily on social diffusion would increase the vulnerability of individuals who lack social connections, since their networks are smaller and weaker and less likely to be reached. As we put it in the Double Trouble report, individuals who lack social connectedness are vulnerable because they lack bridges into care and sources of information and support around them.

communication channels

As discussed above, a population health response to the SRH needs of international students cannot be premised on assuming they are a community. There are very few media channels or membership organisations that reach a concentrated audience of international students.

In combination with the relative complexity of the baseline SRH messages, and the lack of health literacy (including how to make sense of social marketing for health), this constrains the reach and appropriateness of social marketing as a communication method.

Because of the size and distribution of the population, the reach of traditional channels and methods for communication is limited. It is therefore essential to identify points of concentration where a high proportion of the population can be reached at the same time.

These are channels with broad reach, able to reach a majority or large proportion of students:

reaching all students

1. **Overseas Student Health Cover** (OSHC). The majority of international students are required to take out OSHC contracts, providing them with health insurance equivalent to Medicare for the length of their course. OSHC providers maintain websites and e-mail lists for their members, and some providers have used these channels to deliver health promotion messages in the past, planned in collaboration and consultation with specific educational institutions. Students remain in contact with OSHC providers for the length of their study, not just to make claims for reimbursement but to ask questions about healthcare and locate clinics which bill OSHC directly (the equivalent of bulk-billing Medicare). While it may seem unusual to treat insurance providers as a health promotion channel, in the United States it is very common, since health promotion and early intervention may reduce their expenditure on delayed and therefore more complex treatments.

2. **Department of Immigration and Citizenship** (DIAC). All international students come in contact with DIAC when they apply for a student visa. However, key informants reported considerable distrust of DIAC among students, due to its enforcement role where students' attendance and progress suffer, and students report feeling overwhelmed by the complexity of visa information and processes. This makes it unlikely it could undertake health promotion activities effectively.

reaching many students

1. **Student Orientation.** Many, but not all students attend Orientation. There is currently no mandated curriculum for student orientation, whether international or local students. Attendance at Orientation is not generally compulsory. Students at shorter courses or studying with private providers may receive little to no orientation.

2. **Institutional E-mail.** Most institutions now provide their students and staff with e-mail accounts and these are heavily used for communication on all sorts of different topics – to such an extent it is very difficult to 'cut through' with messaging.

3. **Learning Management Systems.** Often described as "portals", these systems offer access to course materials, e-learning and administration functions. They are more common in larger institutions, such as the universities and TAFE colleges.

4. **Word of Mouth.** Word of mouth is a major communication medium among students. It can be used to reach many students with baseline messages about sexual and reproductive health, but it is unlikely to reach students who are vulnerable because of their lack of social connectedness, and it works better for values/ norms (which are 'fuzzy') rather than specific information (where precise reproduction matters).

❊ optimising the mix of activities

At present, the Victorian response to international students delivers high quality interventions to very small numbers of people, once they have reached a time of distress and crisis.

There is much less awareness of the value of timely, lower-impact preventive interventions reaching a larger proportion of the population. (See table above).

The aim is to plan for high intensity/low reach activity with individuals at most risk, and high reach/low intensity activity to improve preventive capacity in the whole population. (See figure below.)

• Cost, efficacy and scope of an array of direct contact interventions

The goal should be to target intensity of intervention according to severity of need:

Level	Methods	Content
Whole population: international students	• Mass communication • Orientation programming • Subject curriculum	• Health literacy and intercultural communication skills • Baseline messages about sexual and reproductive health
Vulnerable sub-population: socially unconnected students	• Online, social network-based resource content • Small group counselling or peer education programs	• Making the most of your time in Melbourne • Friendships and relationships (using adult education principles)
At-risk individuals: distressed & risk-taking	• Small groups by referral • Individual client support • Clinical service provision	• Coaching and counselling on relationship skills and protective behaviours • Clinical intervention as needed

action plan

The goal of this section is to identify ways forward in crafting an effective and coordinated population health response to the sexual and reproductive health needs of international students.

aim

- Achieve an appropriate mix of health promotion and education interventions that recognises and responds to the diversity and needs of the population.

objectives

- Increase the use of strategies that encourage prevention and early intervention
- Support students in solving problems for themselves and helping their friends
- Target more intensive strategies to students who are vulnerable or risk-taking
- Achieve a sustainable, partnership and evidence based whole-of-government response

overall strategy

As discussed in Ch 3, recent efforts to strengthen services for individual students are essential for responding to students who are experiencing crisis and distress, and should be further strengthened. This action plan focuses on strengthening population-level prevention and early intervention.

matching approaches to sectors

- An approach based on partnership and coalition-building will be most effective for securing the involvement of large institutions in a consortium to pilot the strategies outlined in this plan;
- Small 'private colleges' typically offer the bare minimum required to maintain their registration, and to reach students in this setting we need to advocate for policy and regulatory reform.

targeting interventions

- Given the size of the population and very limited exposure to sex education pre-arrival, we recommend **all students** receive basic health education as part of orientation.
- This 'baseline' education should be constructed according to adult education principles and enable students to seek information, solve problems and access services. Most students only need messages to help them recognise and demand their health information needs, not comprehensive sex and reproductive health education.
- Messages should be developed in consultation and partnership with education providers and general enough for their staff to deliver comfortably themselves. The role of MHSS and related agencies would be to develop creative and dynamic audiovisual materials for these sessions and flexible delivery online, and to provide training for student orientation and support staff.
- **Vulnerable students** need opportunities for social connection and participation in community to reduce loneliness and social isolation. Early identification and supportive referral for peer education in groups and one-on-one coaching and counselling will help them solve problems, reduce stress and distress, and develop personally-relevant skills and understandings.
- Advocacy and capacity development targeting education providers will be essential, not just to raise awareness of unmet sexual and reproductive health needs, but also to build support for using population health insights and health promotion strategies in the educational setting.

priorities for action

There are no 'quick fixes' for responding to the needs we have identified in this report; creating a sustainable and effective response requires a coordinated long-term approach. There are some steps we can take now, while others depend on building new relationships and capacity first.

short term

- Convene a working partnership of education providers and related agencies (including OSHC insurers) to develop, pilot and evaluate 'baseline' education messages for all students
- Use creative and innovative resource development strategies in formats suitable for online delivery to develop dynamic and appealing content with high 'cut through' for students
- Promote existing sources of information including Better Health Channel and youth-friendly sexual and reproductive health websites like Your Sex Health.org

medium term

- Build partnerships and points of interconnection between the health and education sectors
- Develop channels for mass communication with international students
- Develop and promote capacity development opportunities for higher education providers

long term

- Promote evidence showing 'what works' in meeting students' health educational needs
- Advocate for inclusion of health education in orientation as part of ESOS requirements

conclusion

Meeting the sexual and reproductive health needs of international students presents a number of challenges. The population is large and has very high turnover, internal diversity and wide distribution. The operating environment is structurally diverse and uses discourse that is very different from the language and concepts used to articulate and respond to issues and concerns of health and wellbeing.

There has been little research to date looking at international students' sexual and reproductive health needs, and careful planning is needed in selecting and targeting interventions to meet these needs. Effort will be wasted unless we acknowledge the assets and resilience of international students, and the diversity of personal styles in learning and adaptation that can reduce or increase risk.

This report suggests directions for interventions that work to strengthen existing assets and target our energies where they can help those students who need it. It avoids stereotyping international students as a group marked by problems and deficits, but does not shy away from identifying drivers of vulnerability where they occur. It identifies a serious mismatch between the way in which students prefer to find information and help, and how we have gone about providing it to date. The challenge now is to craft an effective and coordinated population health response to the needs we have identified.

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