HAPPINESS IS

VITAL

No 2 Vol 18 Winter 2016

AIDS WEST

World AIDS Day 2016

Editorial

IT SEEMS HARD TO BELIEVE that just about a year ago, the then Minister for Health, Leo Varadkar published Ireland's first National Sexual Health Strategy providing a framework for sexual health & wellbeing in Ireland for 2015-2020. As I highlighted at the time HIV prevention and working together in partnership to achieve this is a key aspect of this strategy and that 'we all have a part to play in achieving these recommendations'.

I took the opportunity to reflect and asked myself the question - what have we, in AIDS West done in the past year to ensure that we have played our part in helping to achieve the recommendations in the sexual health strategy and action plan. It's been an exciting and busy year and a few real concrete areas come to mind . . . I feel that we have taken a massive step forward in our prevention work as we are to launch a Free Rapid HIV Testing Service in Galway. We will offer this service on a monthly basis on the last Tuesday of each month starting 31 January 2017 from 5:00pm-8:00pm at the Teach Solais Resource Centre on Merchants Road in Galway. The Rapid HIV Test involves a simple fingertip prick, a specimen is then applied to the test kit and the result of the test is available within a minute. AIDS West has an agreed referral protocol and pathway to the University Hospital Galway which will ensure that any person who receives a reactive test result from the Rapid HIV Test can be tested again for a confirmatory test result. We have looked to respond to the growing phenomenon of Chemsex, 'a little-discussed public health issue in the gay community', as we screened the documentary as a part of Galway City Social Inclusion Week. We are now looking to develop a training and awareness raising programme to be offered to GPs and other health professionals in the west of Ireland. Our sexual health education team continue to develop specific programmes in response to the needs of the young people we are working with – we are to launch workshops which focus on Consent, Porn, Social Media & Transgender, Body & Self Image. In the last year we have also developed the WISER Website (West Ireland Sex Education Resource) – this exciting website dovetails neatly and supports the sexual health education programmes that we deliver to schools, colleges and community / at risk groups. We are looking to develop our work and role in the communities of Galway and the West of Ireland with specific target groups for example the Teach Solais LGBT Resource Centre. In the summer of 2016, the AIDS West education team undertook the Irish Family Planning Association Speakeasy Plus Training which equips the team to comprehensively work with and support people with learning & intellectual disabilities with regard to sexual health and education. I hope that you can see that we are responding in a very real and proactive manner to Minister Leo Varadkar's challenge, and are demonstrating that we are playing our part in helping to achieve the recommendations of the sexual health strategy.

It is of great concern to AIDS West that new diagnoses of HIV in Ireland have increased by 35% since 2011. A total of 485 people were newly diagnosed as living with HIV in 2015, compared with 372 in 2014 while the largest group of people contracting HIV in Ireland continues to be men who have sex with men (MSM). And to date in 2016, there have been a further 463 new diagnoses of HIV in Ireland this year alone – I believe that the launch of our free Rapid HIV Testing service is indeed very welcome. Additionally, promoting condom use and regular testing remain key to limiting the spread of HIV and STIs among those who are sexually active. Being diagnosed with HIV today means something very different than it did 20 or 30 years ago, however, the stigma associated with HIV can act as a barrier to people accessing testing services.

World AIDS Day, celebrated on Thursday 1st December 2016, is a day people all over the world come together to raise awareness about HIV/AIDS, encourage progress in prevention, treatment and care, and break down the stigma and discrimination still surrounding the condition. Once again AIDS West hosted the annual World AIDS Day Memorial Concert in the wonderful surroundings of St Nicholas' Collegiate Church, Galway. The event was attended by over 300 people and those gathered were treated to a selection of wonderful hymns and carols performed by Cois Cladaigh under the musical direction of Brendan O'Connor as well as the beautifully blended and magnificent voices of Bel Canto. We also heard a very moving account from a friend from the USA, the recently retired Reverend David Butler who recalled his experiences of supporting a families and friends in the USA in the early days of HIV/AIDS. To all who attended on the evening and helped in making this such a wonderful event, in particular Patrick Towers for his wonderful compering of the concert and the excellent staff team at AIDS West, a very special 'thank you'.

A sincere thanks to GSK and GILEAD as the sponsors of this edition of the newsletter – your ongoing support is very much appreciated.

Rath oraibh le haghaidh na Nollag agus bliain nua sásta.

Joe McDonagh
General Manager, AIDS West

Contents

Challenging Times

Fear and Loathing in the USA *(with apologies to Hunter S. Thomson)*

I WAS BORN EIGHT YEARS after the end of the Second World War. To give you an idea of the time, rural electrification was still not completed on our tiny island. They were frugal times but over the coming years we began to develop and take our place in the world.

Now for the first time in my 63 years on the planet I fear for all our futures. Yes, nuclear weapons in places like North Korea, Israel and Pakistan have caused worry over the years but the superpowers, especially the US, could always be relied on to keep things relatively calm. The world is a very unstable place but the world order seemed to keep it stable. But now an enormous change has taken place and for the first time in my life I feel anxious about the future.

On Wednesday morning 8th November I went to bed at 3.30am having watched, with increasing horror, the American electorate vote for a racist, sexist and dangerous man to lead the greatest economy in the world for the next 4 or 8 years. Watching him and his cohorts create havoc on the election trail, to the extent that one just wanted it to be over, was a most unsettling time. But even after the shock of Brexit we believed, as did the polls, that he was going to crash and burn and we could all get on with our lives after Election Day. And now I can't assimilate the results. How could 53% of white women vote for this sexist pig? How could many Democrats change sides and put such an ignorant man in office? What will happen now to immigrants, Muslims and the undocumented Irish, to name but a few? And a big question relates to how LBGT and sexual health issues will be dealt with by the incoming administration. Stephen W Thrasher in the Guardian (9th November) said, in an article headed: **This is a terrifying moment for America. Hold your loved ones close.**

Hold tight to the ones who are queer in your life – to the people living with HIV, who enjoy their sex lives being legal, who value the right to love or wed free from stigma and shame.

We who are queer or LGBT are going to face a rolling back of our rights. We're going to be stuck with abstinence-only education, which vice-president-elect Pence favors in Indiana. We are going to have no plan for HIV/AIDS, and a complete governmental indifference to such matters as gender identity or LGBT teen homelessness. Hold tight to us, please, because our government is going to try to shove us back into a closet.

Nearer to home there are even bigger worries. On Dec. 4, it's Italy's turn to wobble, as a crucial constitutional reform referendum could decide the future of the country. The referendum will ask voters to back the approval by parliament of President Renzi's ambitious reforms. Were Italians to vote against the reform, the premier has repeatedly pledged to step down from office which could trigger political chaos at a delicate moment when the economic outlook is still gloomy.

If the "no" vote does emerge victorious, it would translate into "Renzexit" — as Italian populists, nationalists and far-right parties have already dubbed the potential departure of Renzi from Italy's political stage

Following that, France are going to elections in 6 months' time with Marie Le Pen looking like she could succeed in bringing her far right party into government. She has declared that her first act would be taking France out of Europe. If she succeeds its hard not to believe that it will be the last of Europe and the EU dream will be dead.

Finally I am giving the last word to the Guardian editorial on the day after the US election:

The final and overarching fear, though, is for the world. Mr Trump's win means uncertainty about America's future strategy in a world that has long relied on the United States for stability. But Mr Trump's capacity to destabilise is almost limitless. His military, diplomatic, security, environmental and trade policies all have the capacity to change the world for the worse. Americans have done a very dangerous thing this week. Because of what they have done we all face dark, uncertain and fearful times.

Happy Christmas one and all, enjoy it while you can.

Gerry Coy

Discuss with *Dr Shay*

Scrotal Masses

IN A BREAK FROM my usual discussion on aspects of HIV, I decided to discuss what should be an integral part of all male Sexually Transmitted Infection (STI) screening, the testicular check. A routine STI examination in men should include a scrotal and testicular examination and as a physician, I believe it is an ideal time to instruct men on how to examine their testicles. Once every one to two months should suffice. This examination, like a breast examination in women, is aimed at picking up pathology as soon as possible, thereby limiting morbidity and mortality.

Testicles should be checked for masses (lumps), volume (size), tenderness and cryptorchidism (hidden or obscure testes). A testicle less than 3.5cm is considered small and therefore not within the normal range. The medical term for a shrinking testicle is atrophy and may signal chronic disease and subsequent testosterone loss and infertility.

And now the science bit! The testicles are in the scrotum attached to a tube called the spermatic cord. This cord contains the essential blood supply to the testicle, the testicular artery and the veins which bring the blood back to the heart, the venous return. In addition, the cord contains the vas deferens, which brings part of the semen content, in the healthy testicle, containing sperm from the testicle where it is made. Furthermore, the testicle is surrounded by two layers of tissue termed the tunica. The testicle are for most men fixed at the back to the scrotum so do not swing on the spermatic cord in the scrotum. When we discuss potential pathologies of the testicle, a basic knowledge of the anatomy of the testicle is desired.

There are five 'must not miss' pathologies which give rise to a scrotal mass. These are testicular torsion, epididymitis, orchitis, inguinal hernia and testicular cancer. Less serious abnormalities in the scrotum include hydrocoele, varicocoele and spermatocoele.

A testicular torsion occurs due to an anatomical deformity which allows the testicle to twist around the spermatic cord. This happens when the spermatic cord is not fixed in place at the back of the scrotum. The blood supply can then be cut off to the testicle and gangrene can set in. Men with torsion usually feel a severe one-sided scrotal pain. When the urine is checked for infection, it is sterile. This is a surgical emergency and prompt intervention is essential. Epididymitis, inflammation of the part of the vas deferens which is attached to the testicle, is the commonest cause of swollen testes in post-pubertal males. Scrotal pain with fever and or urethral discharge is gradual. The epidiymis is enlarged and the scrotum may be red. In the under thirty fives, the commonest causes of epidiymitis are Chlamydia and Gonorrhoea. In over thirty five, organisms which cause urinary tract infections are implicated such as E. coli. A surgical review is not warranted in uncomplicated cases. Treatment is with bed rest, appropriate antibiotics and scrotal support. Similarly, orchitis, inflammation of the testicle itself manifests with a sudden onset testicular pain and or temperature. The testicle is enlarged and commonly the organisms responsible are as for epidiymitis, Chlamydia and Gonorrhoea in the under thirty five, and E. coli in the over thirty fives. Orchitis can occur in 20-30% of cases of mumps and is a real risk of infertility in men. Tuberculosis and syphilis are rarer causes of orchitis. Once again, bed rest, scrotal support and antimicrobials are advised.

An inguinal hernia occurs when part of the bowel pushes through a weak part of the muscle in the groin above the scrotum, right or left. This can be either direct or indirect. With a direct inguinal hernia, the bowel pushes through the muscle forming a lump which is worse when standing or coughing. In early cases it can be pushed in temporarily but surgical closure of the breached muscle layer is usually warranted. An indirect inguinal hernia occurs when the bowel pushes through a channel (the inguinal canal) from the lower abdomen into the scrotum. The worry here is that the blood supply to the bowel might be compromised and gangrene of the bowel may follow. As with testicular torsion, urgent surgical evaluation is essential. Testicular cancer is usually identified by a physician or patient on finding a painless mass in the body of the testicle. The patient might describe a dull ache or heaviness in the scrotum on the side of the tumour. The average age is 32 years but from late teens to early forties, as mentioned earlier, regular checking of the scrotum and testicles is strongly advised. There are different types of testicular cancer and therapeutic options, removal, chemotherapy or radiotherapy in advanced cases are indicated. A cryptorchidism (hidden or absent testicle) may herald the onset of cancer in an un-descended testicle.

Less serious scrotal masses include hydrocoele, varicocoele and spermatocoele. A hydrocoele occurs when fluid builds up between the two layers of 'tunica' surrounding the testicle. This is usually an anatomical defect but is quite common in clinical practice. It may be uncomfortable and grow big. In this case, surgery to stick the two layers of the tunica together may be indicated. A varicocoele occurs when the plexus or network of veins bring blood from the testicle to the heart, the venous return becomes engorged. Anatomically this usually occurs on the left side. It may be uncomfortable but for many is not problematic and may feel like a 'bag of worms' when felt in the scrotum. It is however implicated in infertility for some men due to the increased temperature of the testicles. A sudden presentation of a varicocoele in an older man should prompt investigation to rule out any blockage of the venous return by tumours in the bowel or around the kidney. Finally a spermatocoele painless cyst separate from the testicle on the top or bottom of the testicle. It is a small blocked tube from the testicle to the epidiymis and is benign and may contain a few sperm. It may need reduction but for most, no intervention is required.

So to summarise, physicians and patients need to be vigilant to pick up the 'must not miss' scrotal masses. Early pick up improves outcome so regular checking is essential in the young man.

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Shay is a Private Practitioner and a Medical Officer with the Drug Treatment Centre in Dublin and has a special interest in positive sexual health.

TALK OF A CURE FOR HIV IS PREMATURE

Beware of headlines which suggest scientists are "on the brink of HIV cure", or "HIV cure close". They grab the attention - which is of course the aim of a headline - but talk of a breakthrough is premature.

The Sunday Times reported that a British man with HIV was receiving a prototype therapy designed to eradicate the virus from his body. Early tests from the clinical trial have apparently shown no signs of the virus in his blood. That may sound astonishing unless you know that conventional antiretroviral therapy (ART) - which the patient was also taking - already reduces HIV to undetectable levels.

Sarah Fidler, Prof of HIV Medicine at Imperial College London, who is leading the trial, told me: "All the participants are taking antiretrovirals and so will have an undetectable viral load, which shows the great success of current treatment."

It does indeed. HIV medication has turned the infection from a death sentence to a chronic, manageable condition, which is remarkable. The limitation of ART is that it cannot eliminate HIV. The virus remains dormant in some immune cells and will start replicating if patients stop taking their medication. That's why antiretrovirals must be taken for life.

The RIVERS trial - which stands for Research in Viral Eradication of HIV Reservoirs - is trying to rid the virus completely from the body. So far, 39 out of a total of 50 patients have been recruited to the trial. All will receive ART but half will also be given a drug which forces the virus to emerge from hiding places in the body. These chosen patients will also receive two vaccines which aim to boost the immune system so that it can attack HIV-infected cells. The strategy is called "kick and kill".

All of the trial volunteers are newly infected HIV patients which means they will have a small viral reservoir and their immune system will not have been repeatedly damaged by the virus. If it is possible to cure HIV, these patients represent the easiest target.

But even if the trial is a complete success, caution will be required in interpreting the results because it may not work in long-standing HIV patients. "In test tubes it has been shown that you can drive the virus out of dormant cells, but we will have to wait and see whether it works in patients. Even if it works we can't talk about a cure for everyone and there would need to be bigger trials." Said Dr Michael Brady, medical director of Terrence Higgins Trust To date, only one person appears to have been cured of HIV infection.

SMOKING CAUSES MORE HARM THAN HIV

Smoking has the potential to shorten the life of a person taking HIV treatment by an average of six years, and is far more harmful to the life expectancy of people living with HIV than well-managed HIV infection itself, an American modelling study suggests.

The new study is based on American people living with HIV who are diagnosed and start HIV treatment at the age of 40. It found that:

- Men who continued to smoke had an estimated life expectancy of 65 years.
- Men who quit smoking at the age of 40 would live to the age of 71 years.
- Men who had never smoked had a life expectancy of 72 years.

Women are expected to live for longer:

- Women who continued to smoke would live to 70 years.
- Women who quit smoking at 40 had an estimated life expectancy of 73 years.
- Women who had never smoked would live to the age of 74 years.

The researchers found that stopping smoking at the age of 40 was associated with greater gains in life expectancy for both men and women than starting HIV treatment with a CD4 count above 500, compared to starting late.

"It is time to recognise that smoking is now the primary killer of people with HIV who are receiving treatment," commented the researchers. They say that HIV services need to integrate smoking cessation into their programmes.

NAM AIDS Map

THE CONDOM DEBATE

In the face of extensive research showing that people living with HIV who are on antiretroviral therapy (ART) with stable undetectable viral load have an extremely low likelihood of transmitting the virus, a majority of participants at IDWeek 2016 in New Orleans thought they should still be advised to use condoms.

Before the debate audience members were asked to vote on whether it is completely unnecessary for HIV-positive men with undetectable viral load to wear a condom, unnecessary if viral load has been continuously negative for a year, or condoms should always be used. At the outset 63.5% voted for always using a condom, 12.8% said it was completely unnecessary and 23.6% thought it was unnecessary with conditions.

Lisa Winston of the University of California at San Francisco argued the 'Pro' side, while Roy Gulick from Weill Medical College of Cornell University took the 'Con' position.

Dr Gulick emphasised that several studies of HIV transmission within serodiscordant couples saw no new linked infections when the HIV-positive partner was on ART with undetectable viral load.

"Condoms certainly do the job, but you have to put them on correctly and they can fail," he said. "Let's face it – no one really wants to use a condom if they don't have to."

Dr Winston offered three arguments for continued condom use:

- Condoms prevent transmission of diseases other than HIV.
- HIV that is undetectable can become detectable.
- HIV transmission is theoretically possible when viral load is undetectable in plasma or semen

After the debate, the IDWeek audience remained cautious. Repeating the same poll after the debate, the proportion who would recommend that HIV-positive men with undetectable viral load should always wear a condom rose to 69.6%.

NAM AIDS Map.

Ask Lorraine

Lorraine is here to answer any of your questions in relation to sexual health. If you need a prompt reply to your query please contact us in confidence on 091-566266.

Dear Lorraine,
I am a new dad and a little bit worried about the size of my son's penis, I know it may seem silly, but it does seem to be particularly small, I said it to my wife and she thinks I'm over-reacting and it will grow as he gets older. I'm wondering should I take him to the doctor?
Carl.

DEAR CARL,

Many men worry about the size of their penis; however, not many realise that there is an actual medical condition where the size of the penis is referred to as a "Micropenis". The condition refers to any penis which, when stretched, is 2.5 standard deviations below the mean size for the age of the patient. What does 2.5 standard deviations below the mean work out as? In adults, the condition refers to any penis smaller than 2.8 inches in length.

In infants, a micropenis is classed as any penis that is less than 0.75 inches in length. This is considered significantly smaller than a "normal" male newborn's penis, which is between 1.1 and 1.6 inches in length when stretched gently.

Having a micropenis can cause several problems, including difficulty urinating and having sexual intercourse. Fertility can also be affected. Some people will have a low sperm count which results in infertility or decreased fertility. The condition can also have a major impact psychologically. Many men with the condition have very low self-esteem and some even suffer from depression.

A micropenis is caused by the male baby's penis failing to elongate after the first trimester of pregnancy. The cause of this is thought to be a hormonal problem. Specifically, it is thought to be due to insufficient levels of testosterone, a male sex hormone.

The inadequate levels of testosterone may come as a result of inadequate production of testosterone during the second and third trimesters of pregnancy; or as a result of the unborn child not responding to the produced testosterone.

Researchers have found that there may be a genetic condition which makes boys more susceptible to the development of a micropenis triggered by factors in the environment.

The condition isn't usually something a man discovers when he's an adult. The penis starts to develop when a foetus is just 8 weeks old. By week 12, the penis has developed and begins to grow. During the second and third trimesters, male sex hormones cause the penis to grow to normal length. Factors that interfere with hormone production and hormone action stunt penis growth.

Diagnosis is usually made by a physical examination. Your child may then be referred to several specialists including a paediatric urologist (a doctor who specializes in disorders and care of the urinary tract and the male genital tract) and a paediatric endocrinologist (a doctor who specializes in hormones).

When discovered in infancy, a micropenis can be treated with testosterone, which can stimulate penis growth in childhood, even after puberty. While the safety and long-term efficacy of this treatment remains to be proved, available data suggest the treatment does not affect normal development during puberty.

I would suggest you go to your doctor with your son, and if he is diagnosed with this condition, then at least you know and can discuss treatment.

All the best,
Lorraine

Siobhán O'Higgins
St. Patrick's Founder's Day Conference

EACH YEAR ST Patrick's Mental Health Services hosts its annual conference to mark the legacy of its Founder, Jonathan Swift, and his vision for excellence and innovation in mental health care. This year's Founder's Day conference on October 28th was entitled Youth Mental Health and Gender Dysphoria: Surviving Transitions.

The day brought speakers from Ireland, UK and Australia together to discuss youth mental health transitions; from adolescence to young adult, and the personal, social and medical transitions which may be chosen by young people to manage gender dysphoria. Professor Patrick McGory, Director of Orygen Youth Health and Orygen Youth Health Research Centre, Victoria, Australia topped the bill.

The main reason I wanted to be there was to learn more about how Irish Transgender young people are being supported, or not, through their journey away from gender dysphoria into a happier and healthier way of being who they know themselves to be. So I was really interested by Drs. Polly Carmichael and Natasha Prescott, Clinical Psychologist of the Gender Identity Development Service, Tavistock Clinic, London, as well as the panel discussion at the end of the very interesting day with Prof Donal O'Shea, Consultant Endocrinologist, St Colmcille's Hospital, Loughlinstown, Vanessa Lacey, Health & Education Manager, TENI (Transgender Equality Network Ireland) and Dr Paddy Power and Dr Aileen Murtagh, Consultant Adolescent and Adult Psychiatrists, St Patrick's Mental Health Services. Dr Carmichael and Dr. Prescott run a gender identity and development service. Greater awareness of trans young people has been associated with a rapid and large increase in referrals to the service. Care for this group of young people is evolving rapidly, often in advance of an evidence base. The number of new clients in their clinic has soared in the past 5 years in the UK; demand in Ireland has also risen and they are now running a satellite clinic in Dublin. From UK figures it is believed there is an underestimate of 1.6 per 100,000 of the population who suffer from gender dysphoria (or gender identity disorder (GID) defined as the distress a person experiences because there's a mismatch between their biological sex and gender identity). More girls are now wishing to transition into being male than ever before, especially in the 12-15 year old age group. We can speculate as to why that is (possibly in the next newsletter!)

Gender dysphoria in young people is no longer seen as an event or a diagnosis but rather as a process that is both individual and changes over time. Although there is no specialised training for health care providers when working with transgender individuals – the two English doctors recommend a staged approach to supporting transgender youth. Although young children hold very binary views on gender as they get older they develop the ability to think about things in different ways. It might help if we had more gender fluid story books and toys and so started to move away from the stereotypical blues and pinks that dominate toy shops.

The average age for transitioning is becoming younger creating situations where young people are transitioning while they are still at school. This means new demands on schools to be more flexible in terms of uniforms, changing rooms and toilet facilities. It must take extraordinary courage to stop 'living in stealth' and try stepping into and living in a new social role. With the right support our young people may eventually not develop internalised oppression, which we know can be detrimental to anyone's mental well-being. Anxieties amongst all young people appear to be increasing as is Autism Spectrum Disorder (ASD) and self-harm. Part of our duty of care must clearly be to explore new ways to support our children to navigate their way into adulthood, be they cis-or transgender. One of the ways to do this would be the establishment of truly comprehensive sexuality and relationships education in schools both here and in the UK which would reduce fear, uncertainty and ignorance.

"Sure, aren't ye **equal** now?!

Vivienne Ivers

"SURE, AREN'T YE EQUAL NOW?!" – a phrase I've heard many times since the passing of the Marriage Equality referendum in May 2015. No. The answer is no. Despite the great strides being made recently in respect to the legal protection and equal rights of LGBT+ (Lesbian, Gay, Bisexual, Transgender, plus) people in Ireland, true equality is still far from being reached. Discrimination, and indeed the expectation of discrimination, is a daily reality for many people in the LGBT+ community. "Will I get the job if I am out? Will my family disown me? Will my friends and colleagues still talk to me?" These questions are unfortunately still very much a reality in Irish society today. Much like other minority groups, such as the travelling community, the effects of discrimination are most evident when looking at the figures in relation to their health outcomes.

To look at the health outcomes for those identifying as LGBT+ gives us some insight into the effects of that inequality. LGBT+ people consistently suffer from greater mental health problems, have much higher rates of suicidality and self-harm, and are more likely to have issues around substance abuse than their heterosexual peers. A recent study shows that only 8% of LGBT+ school children in Ireland feel that their school is a safe environment for them despite the outcome of the Marriage Equality referendum. When that figure is considered alongside figures from the LGBTIreland study which shows that 68% of parents would not be comfortable with having a child who identifies as LGB (lesbian, gay, bisexual), then it is clear that supports for young LGBT+ people in Ireland are potentially lacking, both at an institutional and personal level.

Since the referendum and the perception by many that full equality has been achieved, there have been questions asked as to why there is a need for LGBT+ specific services, and even questions as to the need of the annual Pride festival. Some of these questions have even come from members of the community themselves. The reality is that extra supports and services are greatly needed for those who experience negative health outcomes as a direct result of their sexual identity. LGBT+ specific services are not about equality but about equity. It's about levelling the playing field and giving all people, young and old, regardless of their minority status, a chance to live a healthy life free from discrimination and preventable negative health outcomes. The reality of delivering on such a goal is delivering services specifically directed at, and designed for, the minority group in question. Not only that, but also educational programmes accessible to all should promote further acceptance and equality of LGBT+ people within the wider society. Such programmes would greatly help parents and grandparents who are, on a daily basis across Ireland, being faced with the reality of a member of their family coming out as LGBT+, while not feeling prepared or informed to deal with it. This was evident in the recent episode of 'Reality Bites' on RTE called "The Only Gay in the Village", which showed interviews with parents telling their misbeliefs upon hearing that their loved ones had come out. Parents spoke of their belief in needing to somehow 'fix' their child, or if it was something negative they had done when pregnant that had caused it.

These are common beliefs that are still held by people all around Ireland to this day. The belief that being gay is something wrong, something to be fixed, something that happened as a result of failure on their part as a parent. Although there is full equality of LGBT+ people under Irish law, there is not full understanding in Irish society.

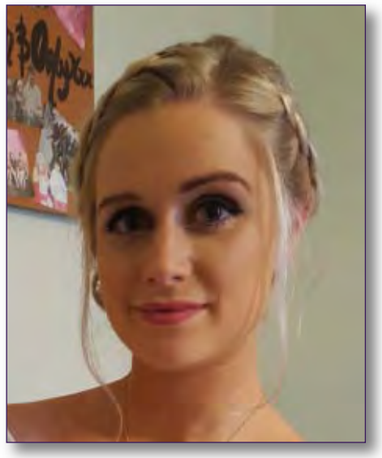
*Let's Talk About **Consent**, Baby*

Fawn Guilfoyle

"LET'S TALK ABOUT SEX BABY. Let's talk about you and me. Let's talk about all the good things and the bad things that may be. Let's talk about sex!" This song was released in 1990. 26 years ago, and in Ireland today we are still struggling to talk openly about the subject. Watching Louise O'Neill's documentary "Asking for It" really made an impact on me. It highlights that 4 in 10 women in Ireland will be the victim of sexual assault. When I approached the subject with some of the women in my life it shocked me how many of us felt we had sexual experiences in our life where consent was unclear, not given, not asked for, or not regarded. If we want to counteract these figures we need to get the discussion going. To try and swallow the shame and taboo and speak out, to think more deeply about our sexual encounters and reflect on our values, our society's values, what they are now and what we want them to be.

The first time I went home with a guy I was in first year in college, I was 17. We had been kissing all night and he asked did I want to go back to a party at his house, but when we got back there was no party. His roommates were there but he asked them to leave us alone so we could sleep on the made up bed on the floor in the sitting room. When things started to get hot and heavy I decided that I didn't want to have sex with him, to which he responded "then why did you come back here?" I do not remember what I responded, but I remember what I felt. Shame. I felt like I had led him on, and although we did not have intercourse, I did things I didn't want to and I hated every second of it. I stayed the night and he paid for my taxi the next morning and he texted me after to make sure I got home OK. He was not a monster, but yet, I used to see him around the city for years afterwards and every time I saw him the same sense of shame would come creeping back and I could not even bear to make eye contact with him. I ended up talking to him in a nightclub a few years after and point blank refused to admit I remembered him when he asked. Why did I feel I owed him something that night? Why did he feel like I owed him something?

I went on my J1 three summers ago when I was 20; it included a lot of going out and a lot of heavy drinking. We lived next to an apartment of Irish lads who we spent the majority of our time with. They were all nice lads. One night I got too drunk and passed out in their apartment, I could not remember much but when I woke up one of their friends, who I didn't know, was trying to put his hands down my pants. I very quickly removed myself from the situation and ran back to our own apartment in tears. I told the girls about it but made them promise not to tell anyone, because I was embarrassed and I was ashamed. We didn't take it too seriously and I put it to the back of my mind not to be thought much about again. But watching things like "Asking For It" and "Audrie and Daisy" makes it all the more real, and makes me ask questions: why was my first reaction shame and not anger? Why am I even afraid now to tell people that it happened? Why did I assume it was my fault because I was too drunk?



These are just a couple of my personal encounters with consent but I feel it is important to get this discussion going. We need to be brave enough to approach the subject.How many of us have experiences similar to this? Do we feel comfortable enough to talk about it? Can we fully support those who are brave enough to talk about it? Louise says "we are raising the next generation with no understanding of what consent really means" I am 23 years old and up until very recently consent was still confusing for me. I have given it many times in my life not because I wanted to, but because I felt I had to. Naked photos taken and shared without consent, waking up to a person with their hands between your legs when you didn't want it, waking up in the middle of a threesome you did not want to be part of, being coerced into sex because you felt guilty, saying no but the other person continues anyway, not being able to remember if you gave consent, being told that you'd had sex with someone when you were passed out. These are stories of people I personally know. None of these stories have been reported and are rarely talked about. Could bringing this subject to light help others come out of the darkness and speak up?

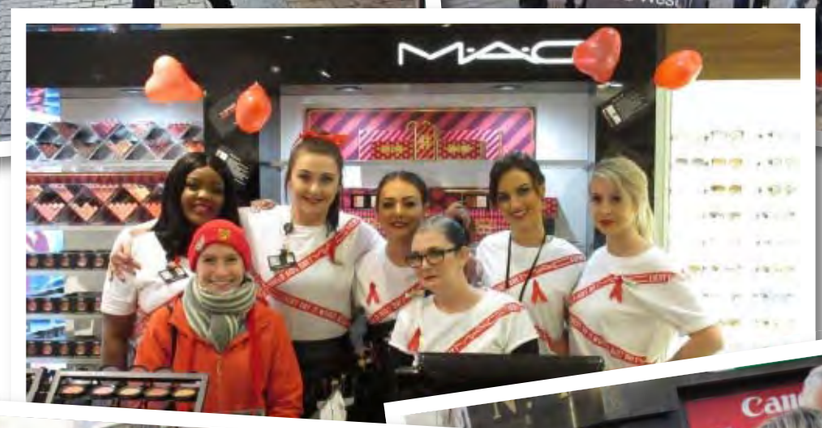
I am a mother now, I have a daughter who will grow up in this society and it scares me that she could so easily have a story like these. But I think it would scare me just as much if I had a son. That there is a possibility that he could behave in this way. Society seems to have groomed us to behave like this; women as conquests and men as conquerors. There are men out there who may have sexually assaulted someone and did not understand that they did it and women who don't understand that they were the victim of it. The figure of women assaulted is so high but what about the other side of it? How many men in ten does that mean have sexually assaulted someone? Why do they think it is OK? Are we enabling this kind of behaviour? Can we stop it?

I do not have all the answers but it's clear to me that if we want to even try to counteract it we need to create more awareness of it. We teach our children the risks of drinking heavily and taking drugs, the risks of putting oneself in a dangerous situation but why are we afraid to teach them not to sexually assault someone? This includes both genders, although even less spoken about men are sexually assaulted too. For it to be happening so often there must be a grey area there. We are so quick to tell our children to be wary but would it not make more sense to go straight to the root of the problem? To give them a clear cut understanding of consent. Unfortunately education will not stop all cases of rape but it could bring us a step towards breaking the stigma.

We are sexual beings. Sex is healthy; sex is normal, it is literally what we are made from but why are we so ashamed of it? Is it all I can hope that my daughter will be one of the lucky ones that is not assaulted or is it in us to hope that we can change things? Sex should be about intimacy, mutual respect and pleasure. It should be celebrated. But to achieve this, we need to consent to it first and to consent to it, we need to talk about it.

To read more of Fawn's blog on Motherhood, Womanhood and Humanhood see https://fawningoverivy.wordpress.com/.

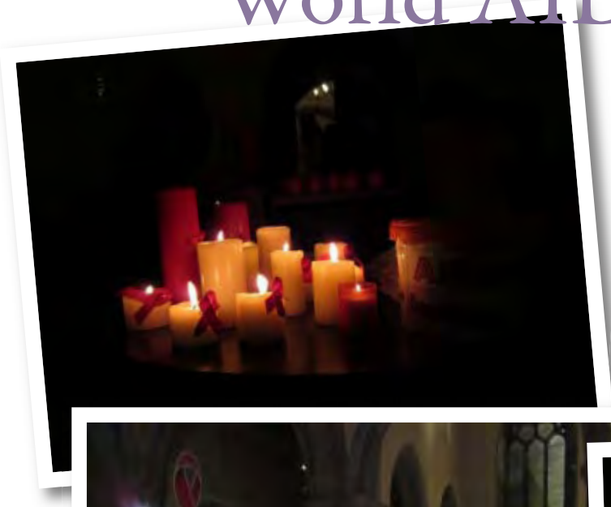
World AIDS Day 2016

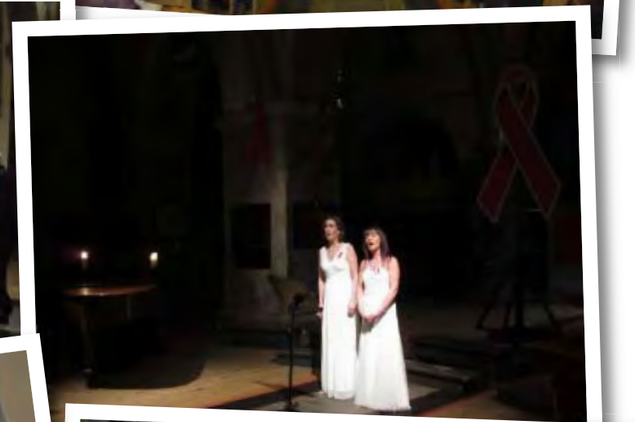






Happiness is Vital — page 10

World AIDS Day 2016





Happiness is Vital — page 11

Sex, dating, and disclosure: what's right for you?

Patrick Murphy

IN 2015 I COMPLETED A PhD in psychology where I researched how gay men living with HIV decide to disclose their HIV status to sex partners. Over the course of my studies more than 500 HIV positive gay men, living here in Ireland and elsewhere, shared their experiences of disclosure with me. While that research produced a lot of new and interesting results, I think there was one result that won't come as a surprise to many readers – disclosing that you're HIV positive to somebody you're sexually or romantically interested in can be *really* challenging.

Disclosure can be so challenging because it leaves people living with HIV vulnerable to some potentially undesirable consequences. If you tell somebody that you're HIV positive, they might not want to have sex with you or date you. They might react to the news of your HIV status with fear or anger, perhaps saying or doing things that they will later regret. They might also tell other people about your HIV status. For reasons like these, most of the men who took part in my research avoided disclosing to casual sex partners. They kept their HIV status private, and then took responsibility for ensuring their partners were not at risk of infection, for example by using condoms, selective sexual positioning, and by maintaining an undetectable viral load.

When a person living with HIV has an undetectable viral load, this means that the virus can no longer be detected in their blood using clinical tests. People can achieve an undetectable viral load when they are on effective antiretroviral medication. An undetectable viral load doesn't mean that a person is cured of HIV – the virus will still be present in small amounts in other parts of the body. Anyone with an undetectable viral load needs to keep taking medication to ensure that the virus doesn't start to multiply in their blood again.

An undetectable viral load has clear health benefits for people living with HIV, as it prevents the virus from damaging the immune system. Additionally, an undetectable viral load has benefits for transmission risk. Evidence for this has been accumulating for a long time, but the most conclusive piece of evidence comes from the HIV PARTNER study (i-base.info/htb/30108). This study included more than a thousand couples who were having sex without using condoms. Some of the couples were straight and some were gay, but in all the couples one partner was HIV negative, and the other partner was HIV positive with an undetectable viral load. These couples were followed over several years, and the researchers documented at least 58,000 instances of penetrative sex without condoms, but zero instances of HIV transmission within the couples. The researchers concluded that when a person living with HIV has an undetectable viral load there is zero risk of viral transmission during sex with an HIV negative partner. People living with HIV who have an undetectable viral load are sexually non-infectious.

In my research most men with an undetectable viral load knew they were not sexually infectious. They knew that they didn't need to disclose to reduce transmission risk because the risk was already zero. Yet again and again I heard from men who wanted to disclose. Disclosure had one big potential benefit – it was necessary for establishing emotionally intimate, romantic relationships. You wouldn't need to disclose if you just wanted a hookup, but you would need to disclose if you wanted a boyfriend.

The men I did research with often asked when was the right time to disclose to a potential boyfriend. They often worried that if they disclosed too early, the person they liked might decide it was not worth the effort of getting to know somebody living with HIV. They also worried that if they waited too long they could be accused of deception or of betraying trust.

So when should a person living with HIV disclose to a potential partner? While there is no 'right' answer to that question, if you're living with HIV you might find it helpful to think about the right answer for you. I know some people who disclose to potential boyfriends on the third date, as by then they know if they want a relationship or not. I know others who don't disclose on dates, but do disclose before having sex, as disclosing afterwards can be too tricky. Having a 'rule of thumb' like this can take some of the stress out of disclosure, and allow you to plan both the 'when' and the 'how' of disclosure.

It is normal to have worries about disclosure. Bad reactions are possible. However, I think bad reactions are less common than they were in the past. More and more people in the gay community understand what an undetectable viral load means, both in terms of good health and sexual non-infectiousness. More and more people are responding to disclosure by being loving, accepting, kind, supportive, or even totally unconcerned! The only way to know for sure how somebody will react is to tell them. If you would like help disclosing your HIV status, contact AIDS West for support.

High Times with NEIL WILSON The s**t doesn't lie!

THE PRESENTATION OF statistics concerning prevalence rates of alcohol and drug use is an everyday part of the life of a drugs education worker. Audience or participant reaction to presented figures takes on a number of forms. These generally range from a blind acceptance to outright incredulity and everything in-between.

Parents sometimes wish to be assured that the level of teenage drug use is actually lower than the generally higher public perception of it. On the other hand some parents wish to be assured that the drug use of their offspring is not that unusual.

Professionals on the other hand may have a somewhat jaundiced view of official figures, believing that they significantly understate the problem. The question of 'vested interest' also arises as professionals may feel the need to justify their organisations existence and capabilities. A general acceptance of an under-reporting in official usage figures would certainly help their case.

Both groups do, however, share a wish to receive accurate information.

Perhaps technology can come to our aid ? Attention has recently been focussed on the increasingly sophisticated science of 'sewage epidemiology' or 'Forensic Epidemiology Using Drugs in Sewage' (FEUDS). Our least precious bodily fluid may just tell the tale of our collective taste for illicit drugs, if these techniques for sampling sewage for evidence of their use prove effective. Scientists have been developing methods for isolating the by-products of drug use that are excreted in urine. More simply we can refer to it as 'wastewater analysis'.

A seminal study had Italian pharmacologists sampling the sewage of 5 million people contained in the river Po. It estimated there were 40,000 individual 'hits' of cocaine a day when traditional surveys put the figure at around 15,000.

Nearly all studies in this area utilise the techniques of liquid chromatographic (LC) separation linked to mass spectrometry (MS) detection. This is usually completed through solid-phase extraction (SPE). As the technology improves variation in sample sizes and the introduction of semi and fully automated systems are more likely to be used.

Once the 'science' part of the process has been completed the next step involves 'back calculation'. Here the quantitative data received from the SPE sampling is processed to enable a figure to be extrapolated for the population of the 'catchment area' as a whole.

Only then can comparisons be made between the data obtained from wastewater analysis and the more 'traditional' forms of questionnaire and survey based methods.

With such rapid progress, the quest for accurate prevalence data would dictate that wastewater analysis has to be taken into account when trying to establish drug use prevalence figures. The most accurate data obtainable via this method would involve the compulsory analysis of the wastewater produced by one toilet, that was only used by one identifiable occupant (who didn't use other toilets !). This would be technically feasible (especially in a highly controlled environment such as a modern prison) but is unlikely to be used due to organisational, financial and ethical concerns. Particular communities or locations could well be subject to public / press attention when certain results are inevitably highlighted. This may be considered to be unacceptable to many. Ethical considerations diminish as the sample size increases.

The value of using 'science' to provide objective data cannot be underestimated in terms of how it is regarded by policymakers, professionals and the public alike. As the technology can be extended to include other substances, such as tobacco and alcohol, the data can be used by public health agencies to rapidly assess the health of a given population via their 'sewage biomarker fingerprint'. One Norwegian ski resort has even examined the possibility of more effectively deploying their police and emergency services to coincide with the predicted spikes of drug use obtained from analysis of the wastewater data.

If the new science of wastewater analysis and the traditional approaches to obtaining drug prevalence figures can learn from each other, it may help us find the 'true' level of drug use within society. As Oscar Wilde said : "The truth is rarely pure and never simple." On the other hand he never had to deliver a drugs education programme.

All pics Nuala Ward

Surrogacy:
A Debate that is long overdue.

BAN ON SURROGACY IN IRELAND URGED BY CAMPAIGNER

Practice not illegal in State but largely unregulated despite calls for legislative clarity

Surrogacy should be banned in Ireland as it exploits women and "commodifies" children, a campaigner has said.

Jennifer Lahl, founder and president of the Center for Bioethics and Culture in California, spoke in Dublin on Tuesday night at an event organised by the Iona Institute, which is also campaigning against surrogacy.

Surrogacy is where a woman carries a pregnancy to term for a couple or individual who cannot themselves.

Surrogacy is not illegal in Ireland but remains largely unregulated. It can be fraught with legal difficulties, particularly if a couple wishes to bring a baby into Ireland that was born to a surrogate abroad, or around establishing legal custody if parentage is disputed after birth.

Calls for legislative clarity have been made by among others, Chief Justice Mrs Justice Susan Denham and groups such as Families Through Surrogacy. The Government has indicated it intends to legislate on assisted human reproduction issues.

Ms Lahl, also a founder of the Stop Surrogacy Now campaign, says the practice is unsafe for women, exploitative and damaging to their mental health. In many cases it deprives the children of a "natural parentage" while turning them into commodities.

She has interviewed women who have been surrogates – some for family members, some for strangers, some for payment and some for none."And all of them had horrible outcomes. Families broke down. I know women who were surrogates for family members who don't even speak to each other anymore. There's tension. There's guilt. There's resentment. There can be horrible custody battles. It's muddy."

Ms Lahl said she does not "buy" the argument that some surrogates lift themselves and their families out of poverty, asking why people who argue this do not campaign for decent basic incomes for all women "I'm all for lifting people out of poverty, but not using their body for gain and then saying, 'I feel so good about myself'."

Many couples and individuals are "desperate" to have children, but she said, surrogacy is "not good medicine" and there should be "limits" on what people are allowed to buy and what risks vulnerable women are allowed to take. Surrogacy is "big business", she says, with estimates that by 2022 it could be worth $27 billion (€24.7 billion), globally, a year.

Earlier this month the Council of Europe rejected a proposal to regulate surrogacy, which would in effect have legalised it, while in December the European Parliament approved a report condemning surrogacy. In August, India announced plans to outlaw commercial surrogacy and surrogacy between non-family members. It also is banned in France. Ms Dahl says Irish politicians should follow their lead.

By Kitty Holland, published in the Irish Times 26th October 2016

RESPONSE...

A ban is unlikely

In reply to Kitty Holland's article on the call for a ban on surrogacy in Ireland, advocated by campaigner Jennifer Lah, it strikes me that adopting this stance will inevitably lead us to the familiar policy of exporting yet another important social issue.

Instead, what is needed is a measured response involving a deeper public debate. Ms Lah expresses the very real concerns that most people would share about surrogacy, such as the commodification of children and the impact upon the gestational mother's mental health. These are issues that need to be addressed. But while a total ban on surrogacy may silence the conversation, desperate couples and individuals will continue to travel to other countries where the practice is legal, unregulated or permitted, depending on their destination.

As India seeks to ban commercial surrogacy it is unlikely people will continue to travel there.

However, they will travel. An effective global ban is both unreasonable and unlikely. As such, there will inevitably be somewhere to travel to. If Ireland fails to recognise children born abroad through surrogacy, we may find ourselves in conflict with the European Court of Human Rights. In what circumstances will it be in the best interests of the child to separate them from their genetic parent (where sperm and egg are provided by the intended parents), to be returned to a woman who has relinquished her parental rights? Almost never, or at the very least nearly never.

This is only one aspect of surrogacy arrangements that need to be explored. There are a number of other issues but shutting the door will go no way to addressing these concerns.

We need to engage with these issues. We need to learn from other countries. We need to consider the views of all the people involved, and decide as a country the best way forward for us.

Hayley Mulligan, published in the Irish Times 1st November 2016

Please see www.aidswest.ie for the debate in full.

This has to STOP

Alice Duggan

'THIS HAS TO STOP'. These are the words of the mother of Audrie Pott. Audrie was a 15-year-old girl, who lived in Saratoga, California, and she was a victim – not only a victim of a horrific sexual assault, but of a barrage of abuse and bullying in the aftermath, which ultimately caused her to take her own life. Her story is told in a film called *Audrie and Daisy*, by Bonni Cohen and Jon Shenk, released on Netflix in September of this year.

The film is harrowing and compelling, but perhaps the most frightening thing is the fact that Audrie's story is not a tragic anomaly. It is not an isolated incident; rather it is one of several similar cases which have been reported in the USA in recent years, and doubtless one of many more that go unreported.

In the film, three other teenage girls tell their stories – Delaney Henderson, Daisy Coleman and Paige Parkhurst – all of whom were between the ages of 13 and 16 when they were assaulted. Cohen and Shenk include numerous photographs from the girls' social media profiles, as well as some home videos, which act as reminders that these are real young women who have had real experiences. Parts of the stories are also told through Facebook message exchanges. This acts as a chilling contextualisation of the events, and highlights the centrality of the internet and social media in teenagers' negotiation of their social world.

The descriptions of the appalling and dehumanising assaults committed against these girls make for extremely difficult viewing, but what is striking is the similarity of response to each of them. There was no universal sympathy for these victims of such trauma. Instead, pictures of the assaults were widely shared on social media, abusive and aggressive hashtags were created to attack the victims and defend the perpetrators. In the cases of Daisy and Paige, the charges of sexual assault were dropped. The boys were athletes, small town heroes from well-known families with political connections. The girls were called liars, Daisy's house was vandalised and her mother lost her job. The film clearly shows how the trauma goes beyond the sexual assault because of the broader social environment. The suffering is continuous and pervasive and has had enduring effects on the psychological, emotional and physical health of the victims and their families.

However, the film is not completely devoid of hope – a particularly moving scene involves several young women sharing their experiences in a support group, and, as Audrie Pott's mother says 'the subject is out there now'. The fact that people are talking about this at all is hopeful, but there is a sense from the film that it is a fragile hope, tinged with caution.

Audrie and Daisy raises a number of questions – how and why do assaults like this continue to happen? Why are rape victims made to feel ashamed and responsible? Why do political motives override the pursuit of justice? Local officials in Maryville, the home of Daisy and Paige, are depicted as condescending and callous; more concerned with maintaining a positive image of their town than addressing the problems there. The mayor wonders out loud why there was such a high level of media interest in the sexual assaults, but nobody came to Maryville to report on their recently-developed premier golf course. That he considers these two things equally newsworthy is baffling, at best. The sheriff is indignantly defensive of boys, saying that inequality affects them too, and people need to stop focussing on girls so much. When the filmmakers point out that, in this case, the crimes were committed by boys, the sheriff laughs and says, 'were they?' His patronising smugness in the context of such serious crimes is almost beyond belief.

That being said, in the past month we have seen a number of other news items which are almost beyond belief, and yet, they are true: an Irish jury in a case of alleged rape requested to see the skirt the woman had been wearing at the time of the assault, a football team at Harvard University was found to have made a 'report' in which members offensively and explicitly rated women's sexual appeal, and, of course, a man who admitted to repeatedly sexually assaulting women and brushed it off as 'locker room talk' was elected president of the USA. There is a shot in *Audrie and Daisy* where the camera pauses on a sentence written on the wall of a gym: 'Monsters are made, not born'. It prompts us to think about how societal attitudes and behaviours are unexamined and normalised, and how toxic this can be.

This has to stop.

An Introduction to GiG Society,
and a look at our year so far!

Megan Reilly

GiG (Gay in Galway) is the LGBTQA Society of NUI Galway. We have 500 members and a twelve strong committee who plan and run weekly events for our members, but the society is much more than that. We pride ourselves on being a community that educates and informs, as well as providing a safe space for those who come to us.

This year has been a whirlwind of activity thus far. In twelve weeks, we have managed to squeeze in at least one event every week, as well as three themed weeks and many daytime events. We are a society that aims high; there is a long standing tradition in the college that GiG Soc is one of the most active and enjoyable societies to be part of. Our themed weeks included Bi Week, Mental Health week, and Trans week. These three or four day campaigns were all crammed full of workshops, speakers, and interactive events. We have also had an exhibition of Coming out stories, a drag workshop, and a Halloween murder mystery night, to name a few. We recently celebrated the one year anniversary of the first same sex marriages in Ireland with our mass marriage; a fun event where you could get married to whoever you wanted, surrounded by balloons and glitter! We held a bake sale during this event for AIDS West, and it was one of many fundraisers we have planned throughout the year

This year, we were delighted to pick AIDS West as our charity of the year, not just for the work the charity does around AIDS, but for their work around consent and sexual health. These are two big issues for us. Many of our members are young people who might not have received the best education in either of these areas. As such, we endeavour to provide education and information in a not too serious manner. This semester we held a Sex Positivity workshop with a sexologist, who taught us a lot about sex positive experiences and consent. During our themed weeks, we always make sure to have a focus on sexual health, and this is aimed at educating and also breaking down the stigma attached to talking about such things. For example; during our Bi Week we had a specific talk about Bisexual mental and sexual health, and the same during our Trans week about Trans sexual health. We see it as a responsibility of ours, to continue to work towards a more open society, one where sex is not taboo. The work AIDS West does really compliments ours and our organisations have very similar goals.

Next semester is looking to be even busier for us, and our biggest project is just around the corner. On the 16th February, we will be hosting the Rainbow Rave in the Loft, and will be giving the proceeds of this night to AIDS West. Anyone is welcome to this event; it promises to be a hell of a party, and the tickets for this are going on sale on the 11th January. You can get in touch with us to reserve some.

If you have any questions about tickets, the society or the work we do please get in touch at gigsoc@socs.nuigalway.ie

THE PROBLEM WITH PORN RESEARCH
a brief overview of research methodologies

Kate Dawson

MUCH OF WHAT WE READ and learn about porn and its effects on people, comes from the media and its interpretations of findings from research studies. A lot of the information that is presented to us, is often taken at face value. This article is a brief critique of the commonly used research methodologies, used in porn research, that media outlets often report the findings, as fact and generalisable to the rest of the world, when the may not be.

A growing body of research suggests that there is now more accumulative evidence to support the link between pornography use and various sexual attitudes and behaviours. However, much of the evidence is preliminary and many inconsistencies exist within it. One of the characteristics of such research is that the majority of studies employ cross-sectional survey methods. Cross-sectional studies, collect data from a sample of the population, at one point in time. There are a few problems associated with such methods. Firstly, the timing of the snapshot (of the point in time) may not be guaranteed to be representative of the rest of the population. Secondly, this method can't be used to assess attitudes or behaviours over a period of time. This is important when it comes to exploring one of the current issues surrounding pornography exposure; exposure at a young age. Using this type of survey method, we cannot see the development of a porn users trajectory over time, how their preferences may change and whether that may be associated with specific outcomes. And finally, we cannot determine if there is a cause (e.g., porn) and effect (e.g., negative attitudes) from this method of data collection.

Various studies have employed short-term, laboratory-based exposure to test the 'cause and effect' of porn exposure. Laboratory setting experiments are flawed in that they often rely on small, convenience samples of volunteers. Research has shown that individuals who volunteer to participate in sex research, have been found to be more sexually experienced, hold less traditional sexual attitudes, report higher on measures for sexual esteem and sexual sensation seeking, than non-volunteers (Wiederman, 1998). Findings from these samples may not

be applicable to wider populations. Further limitations to conducting porn research in an experimental setting, relates to the level of participant's arousal in a laboratory setting, compared to a private setting. Past findings from laboratory based studies have found increased male to female aggression, post porn exposure (Fisher & Barak, 1991). Viewers in a laboratory setting are not allowed to masturbate and to engage with the content as they would in their everyday lives. This may increase frustration, as participants may become aroused, but are unable to get a release. It is possible that participant's frustration may have been interpreted as aggression. In addition, it is likely that watching porn in a room full of people may induce anxiety for many people. Anxiety decreases sexual arousal (Maters & Johnson, 1970). Arousal has been shown to increase the processing of imagery and may be more likely to guide behaviours. Thus, exposure to sexualised content in a laboratory setting may increase anxiety, decrease arousal and have a lesser effect on behaviour.

Macro-level porn studies have often compared the availability of porn in a country or region and the rates of sexual violence; whether reports of sexual crimes increase with the increasing accessibility of sexually explicit content. Reviews of the literature have reported mixed findings; increases in sexual offences, alongside increased pornography availability, with other studies reporting a decline. Macro level studies are problematic as they cannot control for important behavioural influences, such as personality factors and a person's socialization, as well as the culture of an area and attitudes towards women. In addition, macro-level studies cannot discern whether the perpetrators of sex crimes had watched pornography or not.

Longitudinal studies can provide greater insight into the relationships between porn use and individual outcomes, yet few longitudinal studies exist. A longitudinal design involves conducting research with the same group of people over long periods of time, often decades. Longitudinal studies can be useful in determining how patterns develop and to learn more about potential cause and effect relationships. Conducting longitudinal porn research, means that researchers can assess the outcomes of long term porn exposure. This has the potential to yield stronger correlations and perhaps, a greater influence on sexual attitudes, behaviours and beliefs. Unfortunately, the nature of longitudinal studies means that they are often costly, both with time and with money. They also rely on large sample sizes, sometimes, with high rates of participant attrition, at each stage of data collection.

In writing this piece, my aim was not to deter you from trusting research findings, rather to provide insight into some of the commonly used methods and how the data is collected, how the findings may be presented and interpreted, and hopefully allow for an understanding and deeper critique of future porn-related articles.

Annual Cryptic *Quiz*

Neil Wilson

CRYPTIC CLUES

JANUARY : Hybrid blue extra-terrestrials record at the US box office is taken by Ars Warts? (4,4)

FEBRUARY : Who was declared the winner in a game of 'hide and seek' with the world's media lasting 38 years when he was pronounced as officially deceased ? (4,6)

MARCH: Kamikazi outbreak in New Hampshire (4,5)

APRIL: Sporting start made at the Temple of Hera, Greece (7,5)

MAY: King Claudio outfoxes the big guns (9,4)

JUNE : Join horn boss for a referendum victory (5,7)

JULY: Whose voice sells a lot of tickets at the Galway arts festival ? (5,8)

AUGUST : A sweet bread towers over this South American city ? (5,4)

SEPTEMBER : What may have Rick Blaine have said following a visit to Croke Park ? (4,2,5,3)

OCTOBER: Who said 'Hello' after a three year hiatus ? (5)

NOVEMBER: Name Lord Damp Nut's wife (7,5)

DECEMBER : What first appeared in the New York World on 21 / 12 / 21 ? (8,6)

SIMPLEX CLUES

JANUARY : Which film broke US box office records this month ?

FEBRUARY : Who was declared dead 38 years after going on the run following a murder charge?

MARCH : Which virus broke out in the US after beginning in Brazil ?

APRIL : What was lit in Greece to begin its journey to Rio de Janeiro ?

MAY : Which football team won the Premiership in the UK ?

JUNE : Who helped to lead the 'Leave' vote leading to Brexit ?

JULY : Which singer headlined at the Galway Arts festival ?

AUGUST : Name the mountain in Rio de Janerio.

SEPTEMBER : Which line from the film Casablanca is often misquoted ?

OCTOBER : Which singer launched a new album after three years away ?

NOVEMBER : What is the name of Donald Trump's wife ?

DECEMBER : What type of puzzle, often seen in newspapers, was first published over 100 years ago ?

ANSWERS Jan : Star Wars. Feb : Lord Lucan Mar : Zika Virus Apr : Olympic flame May : Leicester City June : Boris Johnson July : Elvis Costello Aug : Sugar Loaf Sept : Play it again Sam Oct : Adele Nov : Melania Trump Dec: Crossword puzzle.

Contact AIDS WEST
at Ozanam House Galway

AIDS WEST SUPPORT SERVICE offers to anyone concerned about their sexual health and HIV in particular . . .

- Free/Confidential counselling and information
- Support to individuals (and their families) living with HIV
- Buddying programme for people living with HIV (PLHIV)
- Alternative treatment therapies for PLHIV
- Confidential helpline

AIDS WEST OFFERS A WIDE VARIETY OF SEXUAL HEALTH EDUCATION PROGRAMMES

Schools Programmes

Secondary Schools*	Senior Cycle	Positive Sexual Health
Secondary Schools*	Junior Cycle	Negotiating Relationships
Primary School*	6th Class	Basic Facts of Life
Secondary Schools**	Senior Cycle	Risky Behaviour

* These programmes provide the students with age appropriate knowledge about positive sexual health. Topics include puberty, relationships, gender roles, contraception and both the positive/negative consequences of sexual behaviour. Duration 3x 1.5 hours sessions

** This programme focuses on how misuse of alcohol and drugs can lead to various risky behaviour

Parenting Seminar: "I am a parent get me out of here!" Provides information and advice to parents on how to support their teenager through the minefield that is Sexual Health Education, Drugs, Alcohol, Social Media and related risky behaviour. Duration -2 hours

Much Much more ...

- "Risky Behaviour and You - A guide to negotiating student life around Sex, Drugs and Alcohol." Third Level College Workshop –Duration - 1 hour.
- Sexual health programmes tailored to meet needs of Professional groups , Youth groups , Youth Workers and at Risk groups.

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e: info@aidswest.ie
w: www.aidswest.ie
f: facebook.com/aidswest

APP
For iTunes:
http://itunes.apple.com/ie/app/sexual-health-guide
For Android:
https://market.androidcom.grabradioworld.sexualhealthguide

The STI Clinic Opening Hours

Monday Afternoon
14.00-15.30 New Patients' Clinic *By Appointment Only*
16.00-17.45 STI Review & Treatment Clinic *By Appointment Only*

Tuesday Morning
Results (telephone) *Telephone at time advised*
Attendance for Results *By Appointment Only*

Wednesday Morning
'Walk In' STI Clinic* *Doors Open at 8.50am*
Wednesday Afternoon
14.00-17.00 STI Review & Treatment Clinic *By Appointment Only*

Friday Morning
'Walk In' Clinic* *Doors Open at 8.50am*
Friday Afternoon
Results (telephone) *Telephone at time advised*
Attendance for Results *By Appointment Only*

The clinic is located in a self-contained building to the left of the main hospital. As you enter the grounds of the hospital, take the first left, then follow signs for Genito-urinary Medical Clinic, Infectious Diseases and hepatology – in front of maternity services.
Tel: 091-525200.

* This clinic is based on a 'first come, first served' basis with a maximum quota that can be seen at any one time.

AIDS West are to offer Free Confidential Rapid HIV Testing on the last Tuesday of each month starting Tuesday 31 January 2017
At: Teach Solais Centre, Merchants Road, Galway
From: 5:00pm - 8:00pm

USEFUL SERVICES

AIDS WEST
(091) 566266

STI Clinic Galway
(091)525200

STI Clinic Portiuncula
Hospital, Ballinasloe 09096-48372

STI Clinic Mayo
General Hospital, Castlebar, Co Mayo 09490-21733

STI Clinic Sligo
Regional hospital, The Mall, Sligo 071-9170473

STI Clinic Limerick
Hospital, Dooradoyle 061-482382

G.U.I.D.E Clinic Dublin
St. James' Hospital 01-4162315/2316

STI Clinic Letterkenny
Letterkenny, Co. Donegal 074-9123715

GOSHH Limerick
Redwood Place, 18 Davis Street, Limerick (061) 314354

Sexual Health Centre
16 Peters' Street, Cork, 021-4276676

HIV Ireland
70 Eccles Street, Dublin 7, 01-873 3799

If you would like your organisation to be included in our list of useful services please phone, email, or contact us.

AIDS WEST

AIDS WEST ARE OFFERING FREE CONFIDENTIAL RAPID HIV TESTING ON THE LAST TUESDAY OF EACH MONTH STARTING TUESDAY 31 JANUARY 2017 AT: TEACH SOLAIS CENTRE, MERCHANTS ROAD, GALWAY FROM: 5:00PM - 8:00PM

CONTACT AIDS WEST ON 091 566266 OR EMAIL INFO@AIDSWEST.IE TO FIND OUT MORE AND TO BOOK AN APPOINTMENT