colleagues so they often limit their empathy with MSM within the hospital context. MSM, trusting in the confidentiality of caregivers feel safe in the care facilities but are afraid to be seen by others. Stigmatising factors limiting access to care include : (1) fear of meeting a relative, (2) difficult relationships with technical support staff (mainly security guards), (3) HIV status disclosure and (4) potential conflicts with other MSM.

Conclusion The hospital is divided into several areas of stigmatisation. It is important to map out the MSM in their care trajectories and spaces, identify all types of staff working within them, including technical staff to enroll them in stigma reduction interventions.

Theme: Global perspectives: trust and truth in health-related settings

Day 1: Thursday 18th March – 13.35-14.55

16 UNPACKING THE 'TRUTH' ABOUT THE HEALTH GAP: DECOLONISING METHODOLOGIES, CULTURAL ARCHIVES AND THE NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PLAN 2013–2023

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Truth and authority are key concepts in settler colonial knowledge systems that inform Aboriginal health policy: 'truth' about policy 'problems' and authority in who can determine policy solutions. The growing emphasis on evidence-based policy means that policymakers increasingly draw on research and western knowledge as their sources of truth and authority. In this way, policymakers construct policy as an objective 'solution' to Aboriginal health 'problems'. However, drawing upon Foucault's notion of the 'cultural archive' or 'storehouse', Linda Tuhiwai Smith (2012) shows that western research has generated representations of, and stories about Indigenous peoples (particularly 'problems') that claim 'truth' and 'authority' but are instead embedded in white, western ways of knowing and categorising the world – and serve colonial power structures.

We used Bacchi's (2009, 2015) 'What's the problem represented to be' framework to analyse 'problems' represented within the Australian *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The Plan acknowledges that the health and well-being of Aboriginal and Torres Strait Islander people is connected to 'trauma', 'dispossession', and the 'interruption of culture'. However, in the Plan, western knowledge, described as 'clinical' and 'evidence based', is given primacy over Aboriginal and Torres Strait Islander people's 'cultural' knowledges. What is left unproblematic in the *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023* is the way this 'cultural' versus 'clinical' knowledge binary draws upon settler colonial hierarchies of knowledge, obscuring the ways even health policy serves settler colonial power structures. We conclude that, while positive, growing awareness of the role of colonisation in producing health disparities across settler and Indigenous populations has not translated into unsettling the knowledge systems upon

which policy is created. We provide some reflections on how decolonising research methodologies may also inform policy-makers seeking to 'unsettle' the truth and authority, particularly 'evidence', that influences policymaking.

17 AN INTERSECTIONAL ANALYSIS OF STORIES FROM COMMUNITIES IN PAKISTAN

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As part of its strategy, the Community Engagement Centre (CEC) – a joint venture of Indus Health Network's Global Health Directorate and Interactive Research and Development, Pakistan – collects communities' stories from program catchment populations. These include challenging, life-changing incidents and narratives of agency which offer valuable insights into organic systems and barriers as well as the nuances of power and access.

Nine stories were analysed to reveal a 'catalyst'; these stories included a person or group holding the trust of community members, that demonstrated agency to act either for themselves or their communities. These catalysts may or may not have been successful in achieving the desired change, but studying these narratives revealed the lived experiences, mechanisms of trust and dynamics of power in communities: how healthcare workers, individuals, and communities interact, utilise their agency to own positions in society, and build trust to enable change – within themselves or the larger collective. We investigated the levels at which low-resourced communities experienced challenges while aspiring towards change and whether certain social categories enabled more agency than others. To examine the stories, we developed and applied an intersectional framework that was able to dissect the stories down to their elements.

Findings yielded that classism and sexism were significant barriers for communities and individuals, while trust was a powerful facilitator for agency and action. The analysis demonstrates that conducting an intersectional analysis on these stories aids in dispelling the 'symptomised' perspective of poor communities as non-agentic and helpless in the face of difficulties. Furthermore, by understanding communities' organic responses to collective problems and health concerns, programs can integrate with existing local systems for long-term solutions.

18 TRUSTED MESSAGES? EXPLORING THE ROLE OF TRUST IN MHEALTH FOR DIABETES PREVENTION IN RURAL BANGLADESH

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Background The prevalence of type 2 diabetes is rising rapidly in Bangladesh, and there is an urgent need to engage populations in preventing and controlling diabetes. Mhealth may offer a scalable way to deliver educational advice, information and motivation for behaviour change. We conducted qualitative research to explore how a population-based mobile health