

# National **HIV/AIDS** Strategy

*Revitalising Australia's Response* **2005-2008**

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# FOREWORD

This new Strategy is timely as the number of diagnoses of HIV in Australia has started to increase in recent years. The Strategy has identified five priority areas for action to be addressed over the next three years: development of a targeted prevention education and health promotion program for HIV; improving the health of people living with HIV/AIDS; developing an effective response to changing care and support needs; a review of the HIV Testing Policy; and the provision of a clearer direction for HIV/AIDS research.

The *National HIV/AIDS Strategy* sits within a communicable diseases framework alongside other complementary Strategies, most notably the *National Sexually Transmissible Infections (STIs) Strategy 2005-2008*, the *National Hepatitis C Strategy 2005-2008* and the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008*. These four Strategies have the common goal of preventing and reducing the transmission of infectious diseases and improving treatment, care and support for those affected.

Groups such as people who inject drugs, young people, people in custodial settings and Aboriginal and Torres Strait Islander people may be at risk of HIV, STIs and hepatitis C. Interventions aimed at these groups must account for this multiple risk and offer prevention, testing, treatment and support services that recognise and address the possibility of co-infection with other conditions.

The Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis and its three subcommittees will oversee the implementation process of the Strategies and report to me on the progress with all four Strategies. Other groups, including State and Territory Governments and community based organisations will be central to the successful implementation of the Strategies.

The *National HIV/AIDS Strategy 2005-2008* should reinforce the cooperative national approach to HIV/AIDS that has been the key to Australia's success in managing this epidemic.

TONY ABBOTT  
*Minister for Health and Ageing*



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# 1 Introduction

The *National HIV/AIDS Strategy 2005–2008* (the Strategy) continues the work that was begun in 1989 when Australia developed the first coordinated national approach to the HIV/AIDS epidemic. The first four strategies have acted as templates for action throughout Australia and have provided international leadership to our regional neighbours. The earlier Strategies broke new ground in public health, clinical medicine, the law, and research. They led to the development of what is widely referred to as ‘the partnership’ between the affected communities, government, service providers and researchers. This allows for a high level of consultation and collaboration between these groups in their work to prevent, manage and treat HIV/AIDS in the community.

Australia can be proud of its network of HIV/AIDS primary care providers, its specialist referral centres, its world-class research, its innovative health promotion and education and its active and engaged community sector. Australia has also made HIV/AIDS treatments available that have significantly increased the survival rates of people living with HIV/AIDS (PLWHA). These things did not appear by accident but through the deliberate planning that followed the development of a national strategy for action.

The job is not over—HIV/AIDS has not, and will not disappear from Australia while the HIV epidemic continues. Rises in new HIV infections in recent years have shown the need for a revitalised approach to HIV/AIDS in Australia by adapting to the changing epidemiological and social features of the epidemic. In formulating this Strategy the following issues have been of major importance:

- From the low levels achieved in the late 1990s, the number of new HIV diagnoses has shown increases throughout Australia, still principally in gay and other homosexually active men and more recently among the Aboriginal and Torres Strait Islander population.
- Rates of sexually transmissible infections (STIs) in gay and other homosexually active men have shown marked increases in the past five years.
- Individuals who were born overseas are overrepresented in new HIV diagnoses.
- Although another blood borne virus, hepatitis C, is endemic in those who inject drugs, that population has avoided a significant HIV/AIDS epidemic. This may be explained by the fact that needle and syringe programs (NSPs) were introduced before HIV/AIDS became endemic in this population of injecting drug users. Should the emphasis on harm reduction and peer education diminish, there remains potential for HIV/AIDS to spread among injecting drug users.
- The lifespan of individuals infected with HIV/AIDS has increased since the introduction of highly active antiretroviral therapy in the mid 1990s. This has led to a change in the focus of HIV/AIDS management from acute intervention for opportunistic infections to chronic management of therapy related side effects and non-infectious complications of HIV/AIDS (such as lymphoma, metabolic disturbances and neuropsychiatric disturbance).

## 1.1 Goal of the fifth National HIV/AIDS Strategy

To reduce HIV transmission and to minimise the personal and social impacts of HIV/AIDS infection.

### **Objectives:**

- To reduce the number of new HIV/AIDS infections nationally, through health promotion, harm minimisation, education and improved awareness of transmission and trends in infections.
- To improve the overall health and wellbeing of PLWHA in Australia through equitable access to treatments and improved continuum of care in health and human services.
- To reduce HIV-related discrimination that impacts upon PLWHA and affected communities in Australia.
- To develop and strengthen links with other related national strategies.



## 2

# Background – the HIV/AIDS story so far

## 2.1 Global significance

Australia's efforts and experience of HIV/AIDS needs to be viewed in the context of the significant global crisis of HIV/AIDS.

The following figures have been published by UNAIDS in its *2004 Report on the Global AIDS Epidemic*:

- by the end of 2003 there were 38 million people globally living with HIV/AIDS;
- a further 20 million have died from AIDS, establishing it as the leading cause of death among adults aged 15–59 years worldwide;
- in 2003 there were 4.8 million new infections – translating to over 13,000 new infections a day;
- young people (i.e. 15–24 year olds) account for nearly half of all new HIV infections worldwide;
- in 2003 around 630,000 children under 15 years became infected; and
- in 2003 some 2.9 million people died from HIV/AIDS-related illnesses.

The UNAIDS *2004 Report on the Global AIDS Epidemic* states:

***The epidemic in Asia is expanding rapidly. This is most evident with sharp increases in HIV infections in China, Indonesia and Viet Nam. ... Home to 60% of the world's population, the fast-growing Asian epidemic has huge implications globally.***

The vast majority of infections occur in the developing world where HIV/AIDS is eroding achievements in child survival and life expectancy and reversing and further impeding development gains. Some of the principal factors contributing to the spread of HIV/AIDS globally include increased international movement of people, poverty, low levels of education and literacy, emphasising the need for integrated approaches to overcome the devastating impact of HIV/AIDS worldwide.

Recently, there have been substantial increases in HIV infections in the Asia/Pacific region. About 1.1 million people in this region acquired HIV in 2003. It is estimated that a total of 6.5 million people are now infected. An estimated half a million people died of AIDS in the region in 2003.

Two of Australia's nearest neighbours, Indonesia and Papua New Guinea, have rapidly expanding HIV/AIDS epidemics. In Indonesia, after many years of consistently low HIV prevalence, rapid increases in HIV prevalence in sex workers and injecting drug users have been reported. In Papua New Guinea, the HIV prevalence in pregnant women attending antenatal clinics in Port Moresby is almost 1 per cent, and HIV prevalence in some populations of sex workers is more than 15 per cent.

The fact that Australia's nearest neighbours, such as Papua New Guinea, are among the countries experiencing rapid growth in the number of new infections presents enormous challenges for the effectiveness of our own national response as well as for Australia's international aid program. The

Australian Agency for International Development (AusAID) is conducting several projects in these regions to address this issue, under the auspices of Australia's International HIV/AIDS Strategy.

## 2.2 Australia's successes in HIV/AIDS prevention

Australia's prompt and rational actions have placed it at the forefront of best-practice population health responses to HIV/AIDS in the world.

Australia's record in HIV/AIDS prevention has been strong. The level of HIV infections diagnosed fell from a peak of 1700 in 1984 to current averages of around 700–800 per year. In the five years between 1994 and 1999 alone, there was a major decrease of over 30 per cent in the number of new HIV diagnoses. The estimated adult HIV prevalence in Australia is now about one sixth that of the United States and one third that of Canada and France.

The fall in the overall number of diagnoses was primarily due to declining numbers of diagnoses among gay and other homosexually active men in Australia between the mid 1980s and the late 1990s. The mobilisation and action of affected communities, particularly the gay community, has been central to the effectiveness of our response. Education and prevention is linked with non-discriminatory HIV/AIDS testing, treatment and care.

One of the most dramatic factors contributing to Australia's success in HIV/AIDS prevention has been the success of the NSPs in keeping HIV/AIDS rates low among injecting drug users. In the United States and Canada, about 25 per cent of newly acquired HIV infections are attributed to injecting drug use, whereas less than 5 per cent of newly acquired infections occur among injecting drug users in Australia. The *Return on Investment in Needle and Syringe Programs in Australia* report (Commonwealth Department of Health and Ageing, 2002) indicates that by the year 2000, an estimated 25,000 HIV/AIDS infections had been prevented among injecting drug users, and that the return on investment exceeded, by many times, the original investment in NSPs.

Australia has the lowest rate of HIV/AIDS among sex workers in the world, due to the work of community-based sex worker organisations and projects conducted in partnership with State and Territory and Australian Governments, and with other agencies. Peer education has been a significant focus of the work of community-based sex worker organisations and has included the provision of information on safe sex practices, up-skilling new workers to implement these practices, and outreach services.

The rate of AIDS diagnoses and deaths in Australia has declined considerably since the mid 1990s. Between 1994 and 1999 there was an 80 per cent decrease in the number of new AIDS cases diagnosed. This decline is predominantly due to the widespread uptake of antiretroviral therapy.

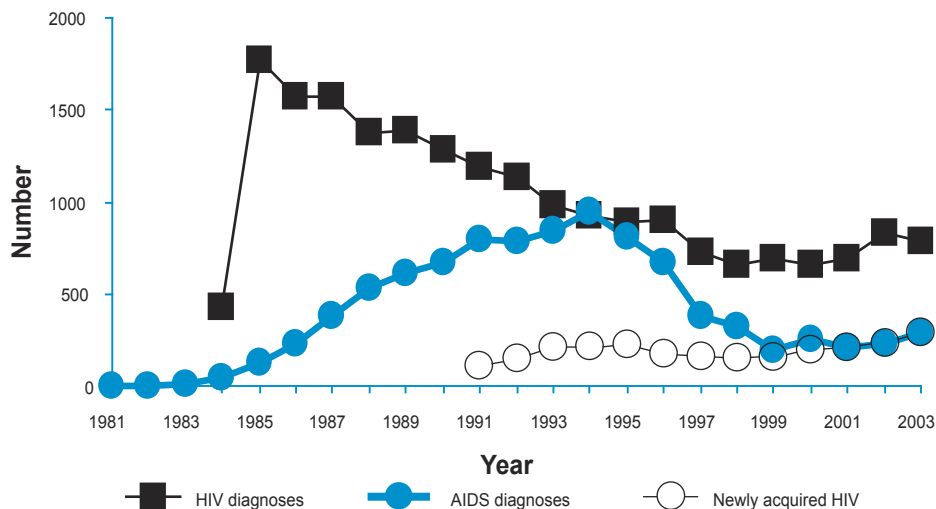
The reduced death rate is accompanied by a persistent rate of new HIV/AIDS infections, which means the number of people living with HIV and AIDS is constantly increasing. At the end of 2003, it was estimated that there were 13,630 people living with HIV in Australia and, up to the end of 2003, there has been a cumulative total of 6372 deaths.

Despite these successes, it is of concern that in the last few years rates of HIV diagnoses have increased in Australia.

## 2.3 Current epidemiology of HIV and AIDS in Australia

The latest available surveillance data shows that new HIV diagnoses and diagnoses of other STIs are increasing in Australia. The annual number of new HIV diagnoses has increased over the past five years and this trend of increases is a reversal of the downward trend in the previous five-year period. However, in the most recent year there has been a decrease in new HIV diagnoses.

**Graph 1: Number of new diagnoses of HIV infection and AIDS in Australia 1981 to 2003**



**Note:** HIV diagnoses adjusted for multiple reporting. AIDS diagnoses adjusted for reporting delays.

Source: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2004.

Nationally, there was a reduction in the total number of new HIV diagnoses from 831 cases in 2002 to 782 in 2003. This reduction is in contrast with the substantial increase of 20 per cent in 2002 (from 692 cases in 2001).

The annual number of diagnoses of newly acquired HIV infection (infection within the previous 12 months) has also steadily increased over the past six years from 151 diagnoses in 1998 to 277 diagnoses in 2003.

It is important to note that there are differing trends in each jurisdiction, and increases have been identified in several States in recent years. In Victoria, the number of new diagnoses of HIV infection increased from around 130 in 1998–1999 to around 190 in 2002–2003. Diagnoses of newly acquired HIV infection have doubled in Victoria from around 35 in 1998–1999 to around 70 in 2002–03. In New South Wales, new HIV diagnoses increased from around 330 in 1999–2000 to around 380 in 2003. Diagnoses of newly acquired HIV infection in New South Wales also increased from around 90 in 2000–2001 to around 150 in 2003.

The increase in newly diagnosed HIV infection has predominantly occurred among homosexually active men, who continue to comprise the great majority of new HIV infections and new HIV diagnoses in Australia. In 2003, 85 per cent of diagnoses of newly acquired infection and around 74

per cent of new HIV diagnoses occurred in this population.

Although the proportion of new HIV diagnoses in women has been stable for several years (at around 10 per cent), there has been an increasing trend towards diagnoses in women who are from high prevalence countries, or whose partners are from a high prevalence country.

A similar pattern of increasing rates of HIV infection among homosexual men has been reported from several other industrialised nations including Canada, the United States, the United Kingdom and Spain. It is likely that similar increases are happening elsewhere, but surveillance of HIV infection, as opposed to AIDS, is inadequate in many industrialised countries. It is difficult to compare the size of the increase in different countries due to differences in HIV testing behaviour and differences in HIV surveillance systems. However, the annual HIV incidence in the Sydney-based *Health in Men* cohort of gay and other homosexually active men appears to be lower than in similar gay men's cohorts in the United States, Canada, and Europe.

Overall, the population rate of diagnosis of HIV infection in the Indigenous population has been similar to that in the non-Indigenous population. The overall number of HIV infections among Indigenous people remains small (185 since 1994), but has tended to increase in recent years. Differences between Indigenous and non-Indigenous populations were also observed in the pattern of exposure to HIV. In 1999–2003, the most frequently reported source of exposure to HIV in the non-Indigenous population was male homosexual contact, whereas in the Indigenous population male homosexual contact (38 per cent) and heterosexual contact (37 per cent) were reported almost equally frequently. A higher proportion of Indigenous cases were attributed to injecting drug use (21 per cent among Indigenous cases versus 3 per cent among non-Indigenous cases) and a higher proportion of infections were among women (34 per cent among Indigenous cases versus 10 per cent among non-Indigenous cases).

People from culturally and linguistically diverse (CALD) backgrounds now make up a significant proportion of new diagnoses in Australia. People born in non-English speaking regions of the world accounted for 20 per cent of HIV notifications nationally in 2002–2003. People born in higher prevalence regions of the world are overrepresented, with people born in Asia and Sub-Saharan Africa making up 13 per cent of HIV notifications in 2002–2003. The pattern of HIV exposure among people from CALD backgrounds is different from other priority groups, as heterosexual contact is more frequently reported as the mode of transmission. Consequently, there is a higher proportion of women among these diagnoses than in other priority populations. Internationally, the United Kingdom and several other countries in the European Union have, in recent years, experienced major increases in HIV among people born in high prevalence countries. Countries deemed to be high prevalence have an estimated population prevalence of more than 1 per cent.

The reasons for increases in the number of new HIV diagnoses and diagnoses of newly acquired HIV infection are multiple and complex. Although there is limited evidence to explain the increases, some proposed reasons include:

- increasing risk behaviour among gay and other homosexually active men and an association of risk behaviour with optimism about the apparent effectiveness of new treatments;
- the issue of late presentation and diagnosis among people from CALD backgrounds, leading to increased infectivity in these untreated individuals;
- increasing rates of STIs that act as co-factors in HIV transmission;
- increasing prevalence of HIV as HIV therapies improve the survival of PLWHA; and

- current health promotion and prevention initiatives not reaching some sectors of the community that are at risk of HIV/AIDS infection.

The increase in new HIV diagnoses demonstrates that renewed and innovative effort is needed to promote and reinforce safe sexual and injecting practices.

## **2.4 The role of sexually transmissible infections (STIs) in the transmission of HIV**

After the onset of the HIV/AIDS epidemic in the mid 1980s, rates of most STIs decreased rapidly among gay and other homosexually active men and the general community. Almost certainly, this was related to the widespread reduction of unsafe sexual behaviour, as well as increased testing and greater awareness of HIV/AIDS and other STIs. Since the mid 1990s, there has been evidence of increasing unprotected anal intercourse with casual partners among gay and other homosexually active men, and evidence of high rates of unprotected sex in the general population. These behaviours are contributing to the increasing STI rates in Australia.

In recognition of the increasing rates of STIs, a separate national STIs Strategy (*the National STIs Strategy 2005–2008*) has been developed and addresses the rise in STIs in Australia in three main priority areas, namely STIs in gay and other homosexually active men; STIs in Aboriginal and Torres Strait Islander communities; and chlamydia control and prevention.

The National Notifiable Diseases Surveillance System (NNDSS) showed that from 1999 to 2004 the notification rate of chlamydial infection increased from 76.1 to 179.7 per 100,000 population. Increasing rates of diagnosis of gonorrhoea from 1999 to 2004 have also been documented – from 30.0 to 32.4 per 100,000 population respectively. The increase in gonorrhoea has been concentrated among gay men. Since 2001, increasing numbers of gay and other homosexually active men in Sydney and Melbourne have been diagnosed with infectious syphilis, a condition that was almost eradicated from this population in the early 1990s. Aboriginal and Torres Strait Islander people have a much higher rate of syphilis notifications than non-Indigenous populations. Rates of syphilis notification vary significantly within different Aboriginal and Torres Strait Islander communities, with more isolated communities reporting the highest rates of infection. There is less data on other STIs, but clinic-based samples suggest very high infection rates of the other common ulcerative STI, herpes simplex virus type 2, particularly among HIV-positive homosexually active men.

The high rates of STIs in gay and other homosexually active men and in the Aboriginal and Torres Strait Islander population is of great concern because of the epidemiological association between STIs and HIV transmission. The presence of certain STIs significantly increases the risk of HIV transmission. Currently, gay and other homosexually active men have higher rates of HIV transmission and higher rates of STIs than other populations in Australia. Reducing the prevalence of these infections through education, screening and treatment programs may contribute to lower rates of HIV transmission. In jurisdictions where accurate data exists, Aboriginal and Torres Strait Islander communities experience higher notification of STIs, the presence of which puts them at risk of an accelerated HIV/AIDS epidemic.

Many of these STIs may be asymptomatic or cause only minor symptoms. For this reason, in those at high risk of STIs, such as gay and other homosexually active men who have multiple partners, improved knowledge about STIs and regular testing is an important means of HIV/AIDS prevention.

In New South Wales, increased testing for STIs was a specific aim of the *NSW HIV/AIDS Health Promotion Plan 2001–2003*, and community education about the need for frequent STI testing has been targeted at gay and other homosexually active men. Additionally, the Australasian Chapter of Sexual Health Medicine of the Royal Australasian College of Physicians recommends at least annual screening for STIs among gay and other homosexually active men, and more frequent testing for highly sexually active men.

While screening programs have been successful in reducing the prevalence of STIs in some Aboriginal and Torres Strait Islander communities, a number of communities continue to have high rates of STIs and inadequate access to appropriate screening programs. If prevention of HIV/AIDS in these communities is to remain successful, the prevalence of STIs must fall quickly.

In addition to reducing the harm caused by specific STIs, testing and treatment for a range of STIs among gay and other homosexually active men and the Aboriginal and Torres Strait Islander population may also reduce:

- HIV transmission among gay and other homosexually active men; and
- the potential for accelerated HIV transmission among Aboriginal and Torres Strait Islander people.

# 3

## Previous HIV/AIDS strategies

The foundation of Australia's successful response to HIV/AIDS has been the close collaboration of affected communities, all levels of government, and the health and research sectors. Efforts by States and Territories and community-based organisations have been focused, mobilised and given direction through a series of national strategies, with strong Australian Government support.

Central to Australia's response in all of these strategies has been the notion of partnership between affected communities, governments, researchers, educators, and health care professionals, as well as the adoption of innovative education and prevention initiatives. This partnership has fostered a significant degree of policy and program integrity across government, community, researchers and service providers, ensuring the early and effective response to emerging changes in the epidemic. Furthermore, strategies have been firmly based on evidence. The success of Australia's partnership-based response is recognised worldwide.

Australia's first National HIV/AIDS Strategy was released in 1989, following extensive consultation. This was followed by a further three successive strategies running from 1993 to June 2005. These national strategy documents embodied the commitment of all Australian governments to a nationally coordinated response to HIV/AIDS.

The third strategy extended the experience gained in responding to HIV/AIDS to other diseases that are transmitted through similar risk behaviours or that affect similar target groups, or both. That strategy was articulated in the document *Partnerships in Practice* (Department of Health and Family Services, 1996) which emphasised the need to link and integrate related responses in an effort to sustain and maximise the population health benefit.

This emphasis on greater integration and more effective links with related programs and policies was consolidated and extended in the fourth National HIV/AIDS Strategy: *Changes and Challenges*.

### 3.1 The review of the fourth National HIV/AIDS Strategy

In 2002, at the instigation of the then Minister for Health and Ageing, Senator Kay Patterson, independent reviews were undertaken of the fourth National HIV/AIDS Strategy and the National Hepatitis C Strategy together with the quinquennial reviews of the National Centres in HIV Research.

The report of the *2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research* (Commonwealth of Australia, 2003) (the review report) draws the following conclusion:

***The Review Panel found that the fourth National HIV/AIDS Strategy has been effective in working towards its stated goals. It has continued Australia's very cost effective public health approach to HIV/AIDS, has built on the basic tenets of previous strategies, and has reaffirmed the partnership approach. It has also tackled important challenges such as the creation of a supportive, non-discriminatory legal, social and economic environment. Additionally, significant progress has been made in increasing the length and quality of life of people living with HIV and AIDS.***

However, the review report also called for a fifth National Strategy to revitalise Australia's response and to 're-energise our efforts' in HIV/AIDS prevention and develop clarity around the direction of research. The review report also supported a re-evaluation by key community-based organisations of their constituencies, roles in the response and priorities in the prevention of HIV/AIDS and STIs. The intention is to re-energise their members' involvement in prevention and support programs.

A number of issues emerged from the review of the National HIV/AIDS Strategy. The responses to these are reflected in Section 5 of this document, which identifies priority areas for focused activity over the next three years.

The Australian Government response to the review report stated that the Government is committed to focusing the fifth National HIV/AIDS Strategy on re-energised efforts in policy coordination and leadership, education, prevention and treatment, and care and support. The Australian Government recognises that the partnership approach has been crucial to Australia's past success in the fight against HIV/AIDS, and remains committed to sustaining this approach. The health needs of the priority groups outlined later in this Strategy will remain the focus of Australia's response to HIV/AIDS. The Australian Government is committed to improving the health and wellbeing of all Australians.



## 4 Guiding principles for this Strategy

The principles informing this Strategy are those that have underpinned the effectiveness of Australia's response to HIV/AIDS in all previous national strategies. Continued adherence to these principles is essential to support achievement of the Strategy's two overarching goals of eliminating the transmission of HIV and minimising the personal and social impacts of HIV/AIDS. These guiding principles are:

- leadership;
- the HIV/AIDS partnership;
- the centrality of PLWHA;
- an enabling environment;
- non-partisan response; and
- health promotion and harm minimisation.

In 2001, Australia endorsed the *UN General Assembly Declaration of Commitment on HIV/AIDS* (United Nations General Assembly, 2001). The six principles highlighted in this Strategy will support Australia in meeting the commitments expressed in the declaration that are of particular relevance to Australia's national response.

The complexity of HIV/AIDS medicine, the sensitivity of the personal and social issues involved, and the constantly changing medical and social dimensions of the disease create the potential for HIV/AIDS policy and programs to be characterised by conflict rather than consensus, and for strategic momentum to be lost as a result.

The principles underlying this Strategy are intended to provide a framework for collaborative consensus building, through which conflict can be resolved productively by focusing on common goals, a shared commitment to evidence-based policy and programming, and role delineation based on strategic planning. The principles also facilitate increased policy and program reach and enable policies and programs to adapt effectively to changing social and policy contexts.

### 4.1 Leadership

Strong and visible leadership has always been of critical importance to the success of Australia's HIV/AIDS response. With increased rates of new HIV infections and serious concerns raised in the review report of the fourth National Strategy about the need for a revitalised national response, leadership is re-emphasised in this Strategy as the pre-eminent principle to guide an effective response.

The *UN General Assembly Declaration of Commitment* requires governments to commit to leadership that involves personal commitment and specific actions, emphasising that strong leadership from governments and civil society is essential for an effective response to the epidemic.

The Australian Government is committed to providing strong national leadership in working across portfolios and jurisdictions and in partnership with communities and the health and research sectors to achieve the aims of this Strategy.

Leadership was a focus at the 15<sup>th</sup> International AIDS Conference in Bangkok in 2004. The leadership program and the Leadership Statement that was issued supported the assurances stated in the *UN General Assembly Declaration of Commitment*, and hold governments, communities and international organisations accountable for the implementation of HIV-related programs. Concern was voiced in the Leadership Statement that the worldwide response to the epidemic so far has not been effective and that some of the response to date has been motivated by value judgements. The Australian Government supports the commitment to actions based on evidence.

An important aspect of leadership in Australia's response to HIV/AIDS has been non-partisan support for the provision of appropriate prevention information, education and treatment, care and support. The re-establishment of the Parliamentary Liaison Group will also contribute to successful leadership by the Australian Government. In evaluating this Strategy, leadership will be monitored and outcomes documented to ensure effectiveness and accountability.

## 4.2 The HIV/AIDS partnership

The *UN General Assembly Declaration of Commitment* commits governments to multi-sectoral responses involving partnerships with civil society and the full participation of people living with HIV and AIDS as well as affected communities. It recognises that the involvement of affected communities is vital to the successful design and delivery of effective prevention and education messages on HIV/AIDS, and that it is necessary to support organisations and partners to be actively involved in addressing the epidemic facing so many communities.

This Strategy will strengthen the partnership approach that has characterised Australia's response to HIV/AIDS. Partnership continues to be at the core of the national strategic response. The HIV/AIDS partnership:

- has contributed to a focused approach in which the expertise of different sectors has been effectively combined;
- is a valuable, cooperative effort between all levels of government, community organisations, PLWHA and affected communities, and the medical and scientific communities; and
- is based on a commitment to consultation and joint decision-making in all aspects of the response.

The Australian Government recognises the significant effort made by community-based organisations over the course of the previous strategies. Organisations such as the Australian Federation of AIDS Organisations (AFAO), the National Association of People Living with HIV/AIDS (NAPWA), the Australian Injecting and Illicit Drug Users' League (AIVL) and the Scarlet Alliance have all played a major role in the success of Australia's response to HIV/AIDS so far. These community-based organisations have key leadership responsibilities in the community sector, including roles such as policy analysis, advice and liaison with the Australian Government, design of appropriate educational messages and advocacy on behalf of their members.

This Strategy accords a priority to strengthening partnerships between governments and the community-based organisations representing PLWHA, gay and other homosexually active men, drug users, sex workers and Aboriginal and Torres Strait Islander populations. This Strategy emphasises the involvement of these communities in decision-making and policy formulation.

### 4.3 Centrality of people living with HIV/AIDS (PLWHA)

This Strategy recognises the overriding importance of the participation of PLWHA in policy and program development, implementation, monitoring and evaluation. This participation is necessary for the effectiveness of responses, because it ensures that policies and programs are informed by the experiences of PLWHA, are responsive to need, and take adequate account of the full range of personal and community effects of policy directions.

The involvement of PLWHA and affected communities in shaping policies and programs has been critical to the success of Australia's national HIV/AIDS response. To ensure continued community engagement in the national HIV/AIDS strategy, PLWHA must be placed at the centre of the national response and be supported in providing a leadership role that guides and supports the national response.

This Strategy also recognises that sustaining the involvement and leadership of PLWHA in the national response requires the provision of ongoing support to individuals and these organisations representing PLWHA. This Strategy recognises the importance of the continuance of this role.

NAPWA is the peak body representing PLWHA. NAPWA has several key portfolios including treatments, legal, women, Indigenous, international, care and support and education. The AIDS Treatment Project Australia delivers information and capacity building prospects to PLWHA communities, and operates under the auspices of NAPWA.

The value of involving PLWHA in the national response to HIV/AIDS is demonstrated by the effective prevention strategies and messages that have been developed with the benefit of personal knowledge and experience. Such insights are crucial to developing meaningful and useful messages.

### 4.4 An enabling environment

The success of the national strategy is dependent on sustaining a supportive social, legal and policy environment that encourages PLWHA and affected communities to:

- support and promote education and prevention;
- respond to education;
- access voluntary testing and treatment services; and
- participate effectively in all levels of the response.

This requires ongoing scrutiny of the impact of policies across government on PLWHA and affected communities including in areas such as mental health, welfare, housing, human rights, criminal justice, housing and income support.

The *UN General Assembly Declaration of Commitment on HIV/AIDS* requires governments to:

- eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, PLWHA and members of vulnerable groups; and
- develop strategies to combat stigma and social exclusion connected with the epidemic.

This Strategy gives priority to the development of approaches to reduce stigma and discrimination

experienced by PLWHA in Australia, aimed particularly at improving their access to clinical care and health services. Programs to highlight and challenge discrimination will continue to be supported, as well as efforts in individual and systemic advocacy and access to effective complaint systems.

Policies and laws of governments at all levels should be reviewed to ensure that all areas support improved health outcomes and that they combat and resolve, rather than compound, stigma, discrimination and social exclusion.

Social research indicates that PLWHA may experience difficulty accessing health care services, and with housing, insurance, employment, education and other aspects of public life that contribute to social exclusion. The cost burden of care on PLWHA is also significant.

There is a need for nationally consistent guidelines for the management of people who knowingly place others at risk of infection. Most States and Territories have legislation that allows for people to be managed either through Health Department processes or through the courts under a Crimes Act. This Strategy supports an approach that emphasises counselling and community management rather than immediate criminal processes and calls for the States and Territories to develop a common approach in this area. The National Public Health Partnership has developed a legislative tool on this topic, *Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk* (2003).

## 4.5 Non-partisan response

Non-partisan support has been important to the success of Australia's response to HIV/AIDS to date. It involves support for pragmatic social policy and for innovative interventions that effect sustainable behaviour change among more marginalised groups in society.

This approach will continue throughout the term of this Strategy, primarily through the re-establishment of the Parliamentary Liaison Group (PLG). HIV/AIDS in Australia is a health issue and HIV-related policy responses—for example, the work done with marginalised communities and the delivery of targeted HIV/AIDS prevention messages—should be handled in a non-partisan way.

## 4.6 Health promotion and harm minimisation

### Health Promotion

The *UN General Assembly Declaration of Commitment* commits governments to strengthening national strategies through participatory approaches that promote the health of communities, and to supporting efforts to prevent and minimise harm related to drug use.

Australia's approach to HIV/AIDS will continue to be set within the overall framework of the *Ottawa Charter for Health Promotion* (World Health Organization, 1986). The charter defines health promotion as the process of enabling people to increase control over, and thereby improve, their health.

Health promotion includes disease prevention, education, social mobilisation and advocacy as well as an emphasis on a complete state of wellbeing. Health promotion acknowledges that vulnerabilities can be influenced only by a holistic approach addressing the total experience, not just

individual behaviour(s).

The Ottawa Charter requires health promotion action to be taken on five fronts:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- re-orienting health services.

At the heart of this process is the empowerment of communities to take action to improve health and welfare. The Australian Government supports Australia's previous approaches to prevention and health maintenance in the context of HIV/AIDS.

HIV/AIDS health promotion includes strategies that enable people to increase their control of conditions affecting HIV/AIDS. Such health promotion encompasses working on a range of levels including: interpersonal, group, organisational and societal, addressing any HIV/AIDS issue, from primary prevention to treatment and social policy.

Health promotion activities for PLWHA should address the contextual realities of living with treatments, aim to maintain emotional wellbeing, develop necessary skills in self care, as well as understanding and awareness of the networks and systems of clinical and community support, and, as suggested by the Ottawa Charter, those areas of life skills for PLWHA that relate to broader areas of work, socialisation and wellbeing. Such activities should also respond to the specific needs of all target populations such as Aboriginal and Torres Strait Islander communities and people from CALD backgrounds living with HIV/AIDS.

The Australian Government acknowledges the centrality of PLWHA in all aspects of HIV/AIDS health promotion. It also recognises the previous success and continued value of health promotion models such as peer education and community development, and the important role community-based organisations and affected communities have played in their implementation.

### **Harm minimisation**

Harm reduction has been and will continue to be the basis of Australia's public health response to the transmission of HIV and other blood borne viruses through injecting drug use. It is one of three elements that make up the principle of harm minimisation that is the basis of Australia's approach to drug use, as recognised by the National Drug Strategy—supply reduction, demand reduction and harm reduction. Harm reduction encompasses a variety of strategies, including NSPs, peer education about safer drug use practices and drug treatment programs.

The Australian Government does not support or encourage drug use and, in conjunction with law enforcement agencies in the States and Territories, is working to reduce drug-related harm. However, it is acknowledged that this behaviour occurs and that damaging consequences can result. Public health measures should be designed to reduce the harm that drug use can cause, both to individuals and to the community. The objective of this approach is to reduce the transmission of disease, and so reduce the personal and social impact and the loss of quality of life caused by ill health.

The principle of harm minimisation supports access to any necessary and proven technologies to

help achieve this, such as new and safer injecting equipment (through NSPs), condoms, and any other interventions shown to be effective in preventing HIV transmission. The success of Australia's NSPs has greatly limited the potential impact of HIV/AIDS. Similarly, condoms have been repeatedly demonstrated to be the cheapest, most readily accessible, safe and practical way to prevent sexual transmission of HIV and some other STIs.

## 5 Priority areas for action

Some of the main priorities to emerge from the reviews and the Government's response to the reviews for the next three years have been identified as follows:

- continuing to develop a targeted prevention education and health promotion program for HIV/AIDS, in consultation with organisations representing PLWHA and other community-based organisations;
- improving the health of PLWHA by increasing the effectiveness of new treatments, improved targeting of treatments and increased availability of clinical information;
- responding to changing care and support needs;
- reviewing the HIV testing policy;
- further development of the surveillance system for HIV/AIDS; and
- providing a clearer direction for HIV/AIDS research.

### Priority target groups

The following groups have been identified as priorities for prevention education and health promotion initiatives under this Strategy. These groups are not mutually exclusive.

#### Gay and other homosexually active men

Most people living with or at risk of HIV infection in Australia are gay or other homosexually active men, and in view of this, this Strategy maintains the direction of previous strategies in recognising this group as the highest priority for health promotion. Gay and other homosexually active men have borne the greatest burden of the HIV/AIDS epidemic in Australia. In 2003, transmission of HIV continued to be mainly through sexual contact between men, and more than 85 per cent of newly acquired HIV infections between 1999 and 2003 were reported to be the result of this mode of transmission. The effectiveness of peer-based responses to HIV/AIDS has been clearly demonstrated in gay communities. The challenge for this Strategy will be to maintain and reinforce the safe behaviour message among gay and other homosexually active men in the broader context of health promotion and the changing nature of Australia's gay community. It should also respond to the cultural diversity of gay and other homosexually active men including Aboriginal and Torres Strait Islander gay men, transgender people, Sistergirls, and gay and other homosexually active men from CALD backgrounds.

#### PLWHA

PLWHA have played an important and effective role in the implementation of previous national HIV/AIDS strategies, and the beneficial roles played by PLWHA in health promotion, treatment, research, and care and support initiatives are the best evidence of the value of this group in the national response. With the number of PLWHA in Australia continuing to grow, the response to HIV/AIDS in Australia needs to recognise that PLWHA are crucial to providing insight into effective and meaningful social and clinical interventions. Health promotion efforts for PLWHA should focus on initiatives relating to broader health education and improved quality of life as well as on treatments

and health maintenance initiatives. These efforts should also respond to the specific needs of all priority populations such as Aboriginal and Torres Strait Islander people and people from CALD backgrounds living with HIV/AIDS.

### **Aboriginal and Torres Strait Islander people**

Aboriginal and Torres Strait Islander people are recognised as a priority group under this Strategy, both in terms of prevention and education, and care and support, as there are particular issues arising for HIV-positive Aboriginal and Torres Strait Islander people within their communities. These include high levels of concern about stigma and discrimination, particularly in smaller and remote communities, which lead to fears of disclosure and heightened secrecy.

HIV/AIDS continues to pose a serious threat to Aboriginal and Torres Strait Islander people and the potential for a rapid-spreading generalised epidemic in this population remains, sustained by high rates of STIs occurring in Aboriginal and Torres Strait Islander communities. The nature of the epidemic in Aboriginal and Torres Strait Islander communities is different to that in the non-Aboriginal and Torres Strait Islander population. This difference includes lower numbers of infections through male homosexual contact, and higher numbers through heterosexual contact. A higher proportion of cases are attributed to injecting drug use. While the overall number of Aboriginal and Torres Strait Islander people living with HIV and AIDS is small, the diagnoses more than doubled between 1999 and 2003.

In addressing these challenges, this Strategy recognises the needs of children and other family members affected by HIV/AIDS and identifies some of the associated problems of isolation, lack of appropriate services and the need to travel to reach services.

Cross-border issues are an emerging concern. While this is an area addressed more comprehensively in the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008*, it is important that this National HIV/AIDS Strategy acknowledges the heightened risk of HIV and STIs transmission associated with the movement and interaction of people between Australia and the Western Province of Papua New Guinea, across the Torres Strait. The increased burden on health services and the coordination of public health programs in these areas are just two of the issues that need to be addressed.

### **People who inject drugs**

HIV/AIDS prevention among people who inject drugs has, to date, been very successful in Australia's response to HIV/AIDS. These HIV/AIDS prevention efforts have not just been in the provision of new injecting equipment through NSPs but also through peer education on safer injecting practices, blood awareness, safe sex practices, drug treatment options including pharmacotherapy treatment and harm reduction strategies.

However, the need to improve access to clinical care and to reduce the level of discrimination experienced by injecting drug users within the health care system still exists. It is also important to provide additional support for the group of people who inject drugs who may have difficulty adhering to complex treatment regimens. These issues should be addressed through community education, training programs for health care workers and the development of systematic approaches at local levels.

There is also a need for better understanding of the interactions that can occur between HIV



treatments and other drugs being injected. This information needs to be available to health care workers, and targeted to people who inject drugs, especially those who are also members of other priority population groups such as gay and other homosexually active men, Aboriginal and Torres Strait Islander people, sex workers, people from CALD backgrounds, and people in custodial settings.

### **People in custodial settings, including young people in detention**

In the correctional environment, there are often systemic and other impediments to best-practice prevention and standards of care. These problems are exacerbated by higher levels of co-infection with HIV and hepatitis C in this population. This group is a target for priority action in this Strategy due to the risk of a rise in HIV/AIDS among people in correctional facilities as well as the increased risk of transmission by inmates on their return to the community. The high levels of needle sharing, the availability of drugs and the rate of transfer of inmates between and within custodial settings increases the risk of a rise in HIV among people in correctional facilities. Prevention and education on safe sex and safe injecting practices should be central elements of any effort to reduce and prevent the spread of HIV/AIDS in custodial settings. The physical and mental health needs of young people in custodial settings should also be taken into account when considering education and service provision in custodial settings.

### **Sex workers**

There is a relatively low prevalence of HIV/AIDS among Australian sex workers, and there has been no recorded case of HIV transmission in a sex industry setting in Australia. Sex workers are able to negotiate high levels of condom use in their work and voluntary testing has also been an effective component of the response to HIV/AIDS.

The potential for an increase in HIV/AIDS in this priority group remains. Implementation of the Scarlet Alliance National Training Project has provided some national support and opportunities to sex worker peer educators to extend and receive accreditation for their skills. However, the high turn over of staff in this industry remains a challenge to peer education.

Additionally, prevention efforts are often affected by resource constraints and sex industry legislation, including legislation around anti-discrimination, occupational health and safety and privacy. The different regulatory frameworks that govern sex work in Australia have the potential to have an effect on trends in HIV infections. Sex workers working in the regulated industry have a much increased capacity to negotiate condom use and other safer behaviours as opposed to those working in less safe, unregulated settings.

### **People from priority CALD backgrounds**

People from CALD backgrounds constitute a growing component of PLWHA in Australia. Within this population there is considerable diversity in terms of culture and language and also in terms of risk behaviours as this population includes gay and other homosexually active men men, heterosexual men, women and injecting drug users.

People from CALD backgrounds are more likely to have a late diagnosis of HIV/AIDS and associated poorer health outcomes. There are also complexities in care and support arising from cultural and linguistic issues and their impact on health literacy, social disadvantage and social isolation.

Among some CALD communities, HIV/AIDS awareness levels are low and there are significant cultural impediments to seeking testing or information about HIV/AIDS. These issues demand a greater and more targeted response from all parts of the HIV/AIDS sector to reduce health inequalities experienced by people from CALD backgrounds. This response should be in partnership with the communities themselves and their representative ethnic organisations, in order to develop interventions that are relevant and culturally appropriate.

Within the broad population of people from CALD backgrounds, some communities are considered to be at greater risk than others. Priority CALD communities for targeted HIV/AIDS prevention can be identified by giving consideration to a range of evidence, including: ethnicity data in HIV and AIDS surveillance; immigration data and trends; the recency of arrival in the community; the immigration trends of the community (increasing or decreasing); and consultation with CALD community organisations and multicultural health services. Australia can learn from other countries' experience in this area although we have to be cognisant of the different profile of migration that exists in Australia.

## 5.1 A program of targeted prevention education

The context in which Australia currently finds itself regarding HIV/AIDS education is one of change and new challenges. The issues influencing communities affected by HIV/AIDS include:

- increased prevalence of HIV/AIDS in gay communities and subsequent impacts;
- broader social developments with the impact of rapid rises in STIs and their potential as co-factors in HIV transmissions;
- emerging trends in recreational drug and alcohol use associated with sexual risk taking, such as reduced condom usage;
- the impact of the Internet on gay men's lives and sexual practices; and
- varied strategies adopted for managing HIV/AIDS risk in both casual sexual encounters and sero-discordant relationships.

### Development of a targeted prevention program

The recent increases in HIV notifications have given rise to a need for a revitalised prevention education effort. The Lead Review Team for the review report commented that:

***... the primary challenge for the next national strategy will be to overcome complacency produced by past successes and revitalise Australia's efforts to control HIV.***

In order to tackle that issue, the review's recommendations on development of the next national HIV/AIDS strategy give prominence to a major prevention education program focusing on gay and other homosexually active men (as the group at greatest risk).

The objectives of the proposed new education program are to prevent the spread of STIs and HIV/AIDS and to maximise the quality of life for those living with HIV/AIDS by:

- increasing awareness of trends in HIV diagnoses and increases in STIs amongst communities most affected by HIV/AIDS;
- promoting safer practices and healthy living;

- reinforcing the need for condom use; and
- reducing late presentations, in order to reduce AIDS illness.

In developing the targeted prevention program for priority groups, it will be important to:

- draw on experience from responses by States and Territories to recent increases in HIV notifications;
- continue efforts to provide high quality information specific to the needs of young people including the value of delaying the commencement of sexual activity, preparedness for the first sexual encounter and targeted messages about safe sex; and
- ensure that the development and delivery of education and prevention messages and programs take account of the changing nature of communities and society, so that these programs reinforce safe practices.

In developing education initiatives, it is health promotion best practice to use language appropriate to the target group, as well as culturally and linguistically appropriate resources for people from CALD backgrounds.

### **Priority populations in prevention**

The population groups identified above are currently considered most vulnerable to HIV/AIDS transmission. Gay and other homosexually active men make up the majority of people diagnosed with HIV infection. Where accurate data exists, Aboriginal and Torres Strait Islander people are noted as having higher rates of STIs than other Australians. The rates of HIV/AIDS among people who inject drugs remain low, due to the success of NSPs and peer education. However, it is vital that people who inject drugs remain supported in regard to harm minimisation for HIV/AIDS prevention through strengthening the role of harm reduction programs (including peer education, drug treatment programs and NSPs) and through aiming to reduce the onset of drug use. It is also important that peer-based drug user organisations continue to be supported to deliver peer education. Similarly, rates of HIV/AIDS among sex workers remain low, but the potential for increase remains and it is important to continue to support peer education and targeted programs.

The prevalence of HIV/AIDS among people in custodial settings remains low, but the potential exists for it to increase in this setting. PLWHA in correctional facilities have a right to treatment and care services equivalent to those available to all other people with HIV and AIDS. Effective HIV/AIDS prevention and health promotion requires a whole-of-government approach enlisting those concerned with juvenile justice as well as the adult correctional sector. In the correctional environment there are often systemic and clinical impediments to obtaining best practice and standards of care.

Beyond and within these groups and settings are a range of factors that may contribute to higher prevalence or increased risk of HIV/AIDS. People from high prevalence countries and those for whom English is a second language are in need of specific attention.

This Strategy also acknowledges the difficulties in providing support to PLWHA to adhere to complicated treatment combinations, particularly in environments where disclosure is a major concern. Such environments include people living in rural and remote locations, in both Aboriginal and Torres Strait Islander communities and non-Aboriginal and Torres Strait Islander communities.

PLWHA are a priority group in terms of their specific treatment, care, and health-maintenance requirements and education needs. They also remain central to effective prevention efforts. PLWHA are an essential and valuable part of the HIV/AIDS prevention effort. Overwhelmingly, PLWHA have acted with great care and responsibility in the prevention of HIV transmission. Positive people play an important education role in maintaining and reinforcing the practice and understanding of safe sex. It is crucial that as the number of PLWHA increases, programs are developed to focus on the benefit of education about prevention for PLWHA.

Prevention education and health promotion programs for young people are managed across all jurisdictions and within the community sector. These programs should include the importance of emotional support in sexual relationships, programs to ensure young people are prepared and fully informed for safe sexual activity, and programs developed to highlight the importance of avoiding premature sexual activity. Programs such as these take into account the social context in which young people live and make decisions while also assisting young people to make decisions they are comfortable with and are appropriate to their individual development at their first and subsequent sexual encounters.

### **Current HIV prevention education in Australia**

HIV/AIDS prevention education programs in Australia are primarily delivered by community-based organisations, with some being delivered by State and Territory Governments and other health system agencies. The Australian Government currently supports the Australian Federation of AIDS Organisations (AFAO), the National Association of People Living with HIV/AIDS (NAPWA) and other community-based organisations to conduct education and health promotion programs and activities.

The combined AFAO and NAPWA Education Team (ANET) program aims to provide national leadership and best practice in HIV/AIDS education and health promotion. ANET activities include:

- the development of campaign and other information resources to reduce HIV/AIDS transmissions among gay and other homosexually active men;
- provision of annual training opportunities for State and Territory AIDS Councils, focusing on skills building and information sharing opportunities;
- production, distribution and evaluation of up to date information resources in HIV treatments and quality of life issues for PLWHA;
- capacity building with member organisations to undertake education and health promotion activities;
- development of national policy on key issues relevant to HIV/AIDS prevention education and health promotion as they relate to gay and other homosexually active men and PLWHA.

The National Indigenous Gay and Transgender (Sistergirl) Project is managed by AFAO. Key activities of the project include:

- working collaboratively with AIDS Councils at the State, Territory and national levels to encourage continual partnership with Aboriginal and Torres Strait Islander gay and other homosexually active men and Sistergirls in order to promote sexual health, assist in the prevention of HIV/AIDS and work towards the improvement of the quality of life for Aboriginal and Torres Strait Islander Australians living with HIV/AIDS; and

- effectively working with members of the AFAO National Gay, Sistergirl and Transgender Strategic Alliance for HIV/AIDS – Sexual Health Promotion (ISA) to enhance and promote their work at the State and Territory level. The ISA aims to work in collaboration with HIV/AIDS and Aboriginal and Torres Strait Islander health organisations to provide up-to-date knowledge, guidance and support to the AFAO Indigenous Project in achieving improved sexual health status for Indigenous gay Sistergirl and transgender communities.

NAPWA manages the HIV Living Project with support from the Australian Government. This project was developed to identify and articulate the point at which social policy and HIV health issues intersect with the experiences of PLWHA. This project addresses several priority areas, including:

- HIV/AIDS health promotion;
- HIV social research;
- welfare, care and support policy;
- positive education development; and
- capacity building with PLWHA groups and supporting diversity and identity in PLWHA's lives.

The AIDS Treatment Project Australia operates under the auspices of NAPWA, and is dedicated to the promotion of health monitoring and treatments for PLWHA. The project consists of a series of outreach treatment information sessions and workshops conducted around Australia. Activities conducted under the project include:

- production and distribution of up-to-date fact sheets in response to emerging HIV/AIDS health issues;
- improved community use of up-to-date clinical research; and
- maintenance of the National Treatments Officers Network to provide HIV/AIDS treatments information to PLWHA.

This Strategy acknowledges the significant contribution of these projects to the overall HIV/AIDS prevention education effort in Australia.

### **Mapping of current activity**

In early 2004, the Australian Government commissioned a project to map current HIV/AIDS health promotion and prevention activities being delivered through community and service organisations across Australia. This report found that well-planned and strategic education was being carried out at a variety of sites across Australia. In terms of the provision of prevention, education and health promotion initiatives to priority groups (as documented in the fourth National HIV/AIDS Strategy: Changes and Challenges), there appeared to be no significant gaps, with education being directed at all groups. There were, however, indications that some groups such as young people, Aboriginal and Torres Strait Islander communities, and sex workers had limited resource availability. Education, both in schools and in other settings such as prisons, was inconsistent across the country.

The Australian Government funds and manages a range of HIV/AIDS-related health promotion projects through different community and service organisations. Individual States and Territories also have their own prevention education initiatives. These include action plans in response to recent increases in HIV notifications in New South Wales, Queensland and Victoria.

## Emerging issues

New approaches to prevention such as pre-exposure prophylaxis (PREP) have the potential to affect risk behaviour and therefore impact on the HIV/AIDS prevention education messages addressed in this Strategy. Should a drug be found to be safe and effective in trials completed overseas and become available locally for PREP in Australia, there is potential for this to result in a decrease in condom use by gay and other homosexually active men. Australia may be approached to conduct trials of PREP during the life of this Strategy. A decision on the response to this issue requires informed debate about whether this will occur, and if so, how it will be managed. The Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH), its HIV/AIDS and STIs Subcommittee and the Intergovernmental Committee on AIDS, Hepatitis and Related Diseases (IGCAHRD) will discuss issues associated with trials of PREP in Australia, and will provide the Australian Government with advice on any trials and appropriate management of PREP.

The provision of post-exposure prophylaxis (PEP) currently varies between States and Territories. It is important that PEP be universally available and that it be provided in a way conducive to ensuring treatment adherence and that acknowledges the responsibility of the individual in seeking PEP rapidly and appropriately. The HIV/AIDS and STIs Subcommittee will provide advice on management of PEP in Australia.

Other emerging issues will be examined by the MACASHH and the relevant Subcommittee, to allow for an appropriate policy response to be developed and recommended to the Minister for Health and Ageing. The workplans of the MACASHH and Subcommittees are flexible documents that allow for the addition of emerging issues.

### **Area for priority action in prevention education:**

- Developing a culturally appropriate targeted national education and health promotion program aimed at prevention of HIV infection in priority groups, especially gay and other homosexually active men by:
  - ensuring current education and prevention messages are refocused to address the rises in HIV and STI infections;
  - achieving the early and comprehensive involvement of community organisations (such as gay, injecting drug user and sex worker organisations) and the Aboriginal and Torres Strait Islander community to ensure that programs are appropriately designed and delivered;
  - identifying specific initiatives for each of the priority target populations; and
  - ensuring the continued involvement of PLWHA as key partners in prevention education.

## 5.2 Improving the health PLWHA

The availability of an increasing range of effective antiretroviral treatments for HIV/AIDS has had a profound effect on the rates of HIV-associated mortality and morbidity. With the advent of combination antiretroviral treatments in 1996, median survival following AIDS diagnosis in Australia has increased from 16.8 months in 1995 to 32 months for cases diagnosed in 2000. Combination antiretroviral treatments became widely available in Australia from mid 1996. It is estimated that there have been 530 fewer AIDS diagnoses since 1995 than would have been expected if use of

potent combination therapies had not reduced the rate of progression to AIDS.

However, there are very serious limitations to HIV/AIDS antiretroviral therapy and these have unique and urgent implications for PLWHA, as well as health care providers, carers and policy makers.

### **Priority responses are required for the following issues:**

- managing the side effects of antiretroviral treatment including longer term adverse events;
- maximising opportunities for general practitioners to participate in HIV/AIDS management;
- the importance of adherence to treatments;
- improving the drug monitoring of therapies in PLWHA on treatments;
- addressing the issue of late HIV/AIDS presentation;
- strengthening clinical research related to treatment; and
- addressing the particular treatment needs of several priority groups – pregnant women with HIV/AIDS, people in custodial settings with HIV/AIDS, people co-infected with HIV/AIDS and hepatitis B or C, people who inject drugs, people from priority CALD backgrounds and Aboriginal and Torres Strait Islander people.

### **Managing the side effects of antiretroviral treatment**

The emergence of serious long-term side effects raises important clinical and policy issues. It is vital that people on HIV/AIDS treatments maintain a high degree of adherence for their treatments to be effective. This Strategy supports the development of initiatives to address long-term toxicities of HIV/AIDS treatments, such as lipodystrophy and lipoatrophy, and their impact on the physical and mental wellbeing of PLWHA. Initiatives and measures to improve and retain adherence to treatment regimes will also be developed, while ensuring continued prompt access to new treatments, particularly for people experiencing treatment failure and/or having toxicity problems.

Other issues that can assist in the successful management of treatments include correct selection of first and subsequent therapies, maximising adherence and facilitating ready access to new treatments.

### **Monitoring of therapies**

The last several years have seen some important new tools developed for better management of HIV/AIDS antiretroviral therapies. These include genotypic tests to identify resistance to antiretroviral treatments, and therapeutic drug monitoring.

Such tools have the capacity not only to improve clinical outcomes for PLWHA, but also to ensure that available expensive antiretroviral therapies are being used in the most targeted and cost-effective ways.

It is not uncommon for some PLWHA to choose to take treatment breaks for several reasons, including side effects, travel or work plans, or for other events that may take place over a short period of time. Women with HIV/AIDS who are trying to become pregnant may review their treatment options and drug combinations at such a time.

Side effects are one of the most common reasons that people with HIV/AIDS choose to take a break from HIV treatments. HIV/AIDS treatment breaks should always be carefully monitored by

the managing clinician, as the risk of drug resistance and a rapid increase in viral load is significant. The practice of treatment breaks is not commonly discussed, as it is not a well researched area, and the data that exists shows overwhelmingly that, after stopping treatment, HIV begins to reproduce. Short treatment breaks, such as over a weekend, considerably increase the risk of developing drug resistance. However, with the growing number of people in Australia living with HIV/AIDS and on treatments for a substantial period of time, treatment breaks do occur. Any such breaks should be done in consultation with the treating doctor to allow close monitoring of possible adverse effects. This Strategy supports the informed choices of PLWHA to take breaks from treatments.

Some PLWHA report that when they are having problems with adherence to treatments, their doctors may recommend a monitored break from treatment, to allow time to address and develop a strategy around this. Therapeutic drug monitoring is one technology that may help to address this, by ensuring that blood drug levels are appropriate, and side-effects are being minimised. This Strategy is committed to helping facilitate timely availability of such technologies.

### **Strengthening clinical and other research related to treatment**

New research into HIV/AIDS treatments recognises that it is not only new treatments but new treatment approaches that will represent the greatest strides forward in managing HIV. New pharmacologic approaches may minimise the current problems of widespread resistance to existing classes of treatments, but also provide important insights for the development of new HIV/AIDS prevention technologies, such as microbicides. Research on treatments should also include behaviour related to treatment adherence and social research on treatment breaks.

New treatment approaches include:

- targeting different places in the replication and life cycle of HIV than the current antiretroviral drugs; and
- treatments that focus on protecting and augmenting the immune system, such as immunomodulating agents or treatment (therapeutic) vaccines.

It is also important that PLWHA continue to have affordable access to new HIV treatments as they emerge.

This Strategy recognises that the treatment needs of some groups of PLWHA raise requirements of their own. These are outlined below.

### **Women**

In general, there are lower rates of HIV infection among Australian women than men. This has resulted in lower levels of awareness among many women and health care professionals about potential risks for HIV transmission. Lower HIV testing rates are also common in women. As a result, women are more likely to be diagnosed with HIV/AIDS later in the course of infection, once they have developed an HIV-related illness. Additionally, women who have partners from high prevalence countries are at an increased risk of HIV/AIDS transmission, and are not always in a position to negotiate safer sex, or access education about testing and treatments.

This Strategy acknowledges that HIV-positive women and children have specific care and support needs and for HIV-infected children, psychosocial issues and HIV-related medical complications should be recognised and addressed as important factors to quality of life. While the total number



of children infected with HIV in Australia is small, the provision of adequate specialist paediatric services is important.

Access to appropriate services for positive women and, where appropriate, their families, is a key priority under this Strategy.

Other particular challenges that will also be addressed under this Strategy include:

- reducing the incidence of discrimination and poor service, particularly in regional or remote settings;
- supporting initiatives aimed at decreasing the isolation experienced by HIV-positive women, particularly opportunities for peer support including innovations such as online networks;
- increasing the visibility of HIV-positive women, and encouraging the involvement of women with HIV/AIDS in the development and delivery of HIV/AIDS services, educational interventions and policy; and
- increasing awareness of the risk of HIV/AIDS transmission in women with particular emphasis on the following priority groups where heterosexual transmission is more common:
  - Aboriginal and Torres Strait Islander communities; and
  - people from CALD backgrounds including people from high prevalence countries.

The availability of antiretroviral therapies for HIV/AIDS has meant that many HIV-positive women can and do choose to have children. However, the treatment needs of HIV-positive women who are pregnant or considering pregnancy are complex, and all positive women should be supported in their decision making with appropriate counselling and access to information about their options and choices for pregnancy and childbirth.

During the term of this Strategy consideration will be given to the development of:

- national standards of care for HIV-positive women and their children, which encompass the entire spectrum of antenatal and postnatal care, for use by general practitioners and specialists;
- national counselling guidelines for HIV-positive women to support appropriate choices around fertility, family planning and antiretroviral therapy during pregnancy and birth; and
- antenatal testing protocols, within the review of the HIV Testing Policy (see section 5.5).

### **People co-infected with HIV and hepatitis B and/or C**

It is estimated that about 11 per cent of PLWHA are also infected with hepatitis C, 6 per cent with hepatitis B and 1 per cent with both hepatitis B and C. This group of people have poor health outcomes compared with people infected with HIV/AIDS alone. Co-infection with HIV and hepatitis B significantly increases mortality in the co-infected individuals. This group also faces stigma and discrimination when accessing treatment.

Liver-related mortality has now become the leading cause of mortality in co-infected PLWHA in the United States. There is also strong evidence that controlling hepatitis C infection is an important factor in obtaining better clinical outcomes for co-infected people. This Strategy emphasises the importance of ensuring that all people co-infected with HIV/AIDS and hepatitis B and/or C have priority access to best-practice treatment, as supported by current research.

During implementation of this Strategy, consideration should be given to developing a policy promoting additional options, such as vaccination for individuals against hepatitis A and hepatitis B, when a diagnosis of HIV/AIDS and/or hepatitis C is made.

### **People with HIV/AIDS in custodial settings**

People who are in custodial settings do not have access to HIV/AIDS treatments subsidised under the Pharmaceutical Benefits Scheme (PBS), and consequently the cost of treatment must be covered by State and Territory Governments. Harm reduction measures such as peer education, vaccination, the provision of condoms and access to treatment are not standardised across jurisdictions. Testing availability also varies, as does the provision of pre and post test counselling. People in custodial settings should have access to prevention, treatment and care services equivalent to those available to other PLWHA in Australia. This Strategy supports measures to address gaps in prevention, care and support for people in custodial settings.

### **Maximising opportunities for general practitioners to participate in HIV/AIDS management**

As the numbers of PLWHA have increased, changes have occurred in the duration and type of care required. With increasing numbers of positive people living longer and not progressing to AIDS, general practitioners are playing a greater role in the care of PLWHA. Attention needs to be given to ensuring there is sufficient support for general practitioners to be able to effectively practice HIV medicine and also resources to help them with the complex case management and care coordination that can be required. Less experienced general practitioners should be encouraged through existing training programs to case consult with general practitioners who are more experienced in HIV medicine when they have HIV-positive patients with complex care needs.

In recent times, the supply of HIV drug prescribers has not kept up with the demand created by an increased number of HIV-positive patients in some areas. One reason for this has been lower remuneration for high HIV caseload general practitioners due to the number of PLWHA requiring frequent, long consultations and complex follow-up.

To assist in ensuring general practitioners are willing to take on this role as primary care providers, general practitioners should be encouraged to make use of recent developments that support better management of chronic disease in the primary care sector. For example, the enhanced primary care program (EPC) provides scope for general practitioners to better manage specific diseases such as HIV/AIDS. The EPC program provides opportunities and support for interdisciplinary, coordinated approaches to care of people with chronic conditions and complex needs.

### **Equitable access**

All governments at the State and Territory and Australian Government levels have policies that commit to equitable access to health care for all Australians, regardless of gender, sexuality, cultural differences or geographical location. This Strategy supports this principle. Some issues impacting upon this and requiring consideration in the development of appropriate approaches in this Strategy are:

- changes in resource distribution leading to a centralisation of key services in many areas; and
- the significant cost of accessing specialist services – States and Territories with fewer PLWHA lack the specialist resources and expertise to provide the range of services available in larger States.

To counter the difficulties encountered by areas with small caseloads, it is imperative that there is cooperation between mainstream services and agencies to develop suitable training for staff and

care and support for PLWHA including people from marginalised communities. Under this Strategy, initiatives and programs that offer opportunities to share innovative approaches between States and Territories are encouraged.

#### **Areas for priority action in maximising the health of PLWHA:**

- Maximising opportunities for HIV strategic research to devise better ways to use current therapies, and better options for side effects management.
- Updating of the 'Models of Care for HIV Management in Adults' including allied health support and a specific focus on the psychosocial and physical wellbeing of PLWHA.
- Strengthening current training programs and continuing medical education in HIV/AIDS for general practitioners, recognising the differing needs of general practitioners with low and high HIV caseloads.
- Ensuring that HIV practitioners delivering complex care are appropriately supported.
- Ensuring there is an appropriate level of dialogue and consultation between the MACASHH, the Therapeutic Goods Administration and the Pharmaceutical Benefits Advisory Committee in regard to approving and listing advantageous new technologies.
- Ensuring that important new diagnostic and management tools can be incorporated into routine clinical care, with appropriate national clinical management guidelines for their use.
- Ongoing research into adherence strategies, treatment breaks and the role of treatments in the lives of PLWHA.
- The MACASHH to continue to play a central role in monitoring and advocating for best practice standards of care for PLWHA in correctional facilities.
- Consider the possibility of a national summit of all involved parties and stakeholders to discuss approaches to ensuring quality treatment and care in correctional facilities.
- Establish a collaboration of State and Territory Governments to develop and implement HIV/AIDS education and prevention in custodial settings and to encourage sharing models of care between jurisdictions.

### **5.3 Responding to changing care and support needs**

PLWHA continue to face a range of complex challenges to their health and wellbeing. In many communities, people with HIV/AIDS continue to report social isolation and discrimination. The complexities of clinical disease in many cases incorporate drug toxicities, psychiatric illness, and drug and alcohol dependency issues. Low income, accommodation difficulties, challenges in re-entering the workforce after periods of illness, and other issues of stigma and discrimination, disclosure, establishing and maintaining primary and specialist care relationships, treatment adherence, prophylaxis for opportunistic infections, welfare, housing and travel are other challenges faced by PLWHA.

The clinical and medical situation of PLWHA can fluctuate. For many people, periods of wellness are punctuated by periods of illness, caused, for example, by treatment side effects or clinical changes. The care and support needs of PLWHA may therefore also increase or decrease during these periods. Additionally, people who have been living with HIV/AIDS for a long period have different needs to people who are newly diagnosed, especially regarding management of therapies.

Services therefore need to be flexible enough to accommodate these changing needs. Additionally, there needs to be appropriate coordination of services, so that they are readily accessible for people who require them. This Strategy acknowledges there may be gaps in the care and support services available for PLWHA in Australia, and supports the need to address these gaps.

The changes in care and support needs over recent years have been brought about by several factors including the development of long-term responses to HIV treatments, the longer life spans and ageing of people living with HIV and AIDS, the growing complexity of mental health impacts and the pressures of inadequate accommodation and income levels. Living with HIV/AIDS has become more medicalised for some people in the era of antiretroviral therapies as the side-effects of therapies can lead to complications such as diabetes, increased coronary risk, osteopenia, arthritis and metabolic disorders.

It is imperative that there is cooperation between mainstream services and agencies to develop suitable training programs for staff, as well as care and support for PLWHA. Under this Strategy, it will be important to encourage initiatives and programs that offer opportunities to share innovative approaches between States and Territories.

Priority responses are required for the following issues:

- the cost burden of care and support on PLWHA;
- addressing the specific care and support needs of particular groups;
- workforce development; and
- making mainstream services more accessible.

### **The cost burden of care and support on PLWHA**

Managing HIV/AIDS and its side effects often requires high levels of medication and clinical monitoring, which can prove a substantial cost burden for PLWHA. The Medicare Benefits Schedule (MBS) and the Pharmaceuticals Benefits Schedule (PBS) includes measures that assist with affordability of care. These include incentives for general practitioners to bulk bill consultations for concession card holders and children under 16 years of age; safety nets to assist patients with high out-of-pocket costs for out-of-hospital services and prescriptions and MBS rebates for certain allied health and dental services for people with chronic conditions and complex care needs who are being managed through an Enhanced Primary Care multidisciplinary care plan.

### **PLWHA with high support needs**

Some PLWHA may have high support needs for many reasons. These may be ongoing, or occur over a short period. Situations that may lead to intensified support needs include:

- a new HIV diagnosis;
- a diagnosis of AIDS or serious HIV-related illness;
- persistent failure of antiretroviral therapy to suppress HIV or development of resistance to treatment;
- the development of major side effects such as renal or liver failure, peripheral neuropathy, myelosuppression and morphological (body shape) changes;
- diagnosis of a second major illness such as hepatitis C infection;

- alcohol and other drug dependency issues (particularly with reference to a mental health co-morbidity); and
- psychiatric illness such as depression that may or may not relate to HIV/AIDS infection.

It is important that PLWHA have adequate access to mental health services. An awareness of interactions between HIV and psychiatric medications, and an understanding of the nature of AIDS illnesses, are important components of training for mental health care workers.

The appropriate management of people with HIV/AIDS-related cognitive illness remains a particular challenge for services. AIDS Dementia Complex (ADC) presents less frequently than when the use of antiretroviral drugs was less common. However, with more PLWHA, the number of people presenting with ADC will increase with time. Situational or behavioural psychosocial dysfunction coincident with and affected by HIV is as much of a problem as ADC.

This Strategy recognises that people with cognitive illness have priority care and support needs. Community agencies can often not provide the intensive levels of care required for this condition and paid attendant care services can be required. Supported accommodation is often a necessary requirement but appropriate accommodation is often not available.

### **Workforce development**

It is critical to examine the ongoing training requirements of health care workers and other service providers for the following reasons:

- the increased mainstreaming of services for PLWHA through resource allocations;
- the decline in skills related to the recognition, diagnosis and treatment of HIV/AIDS within some health services; and
- to reduce discriminatory practices that continue to occur within parts of the health care sector.

It is also important to stress that all staff training should reinforce the need for strong protection of privacy and adherence to privacy principles in any electronic sharing of health and other client information.

Appropriate remuneration for HIV practitioners delivering complex care is important. HIV practitioners should also be provided with up-to-date and ongoing information on new methods of managing chronic diseases in the primary care sector.

### **Making mainstream services more accessible to PLWHA**

This Strategy supports the need to make mainstream services more accessible and appropriate for PLWHA. Improved access to the mainstream health system—in addition to the maintenance of designated HIV/AIDS inpatient, outpatient and ambulatory care services—is important, as is encouraging mainstream health care service providers to consider the specialist needs of PLWHA. Throughout the term of this Strategy it is important that appropriate health care services operate in a way that is relevant to PLWHA and affected communities.

An understanding of the specific needs of PLWHA is important, given the fact that a small number of PLWHA are likely to present complex challenges for on-the-ground service providers and workers. Variable changes in health will also have implications for welfare support and assistance.

Australian Government and State and Territory service delivery agencies should consider the need for HIV/AIDS awareness to be included in the training programs which are delivered to relevant staff of State/Territory and National service agencies.

Further opportunities for improving access may also be progressed through mechanisms such as:

- Home and Community Care Agreements;
- Commonwealth State Housing Agreement; and
- Commonwealth-State /Territory Disability Agreement.

**Areas for priority action in care and support:**

- Ensure that PLWHA can access appropriate treatments, care and support including appropriate income support, disability support and carer allowances.
- Improve collaboration between mental health, clinical and welfare services to address the care and support needs of PLWHA with cognitive illness and drug and alcohol dependency issues.
- Develop long-term support for PLWHA who are ageing or have chronic disabilities.
- Strengthen existing programs to encourage HIV testing for people from CALD backgrounds who may be or have been at risk of exposure to HIV.
- Appropriate training and skills development for staff of HIV/AIDS health services to improve service accessibility for people from CALD backgrounds.
- Support for the HIV/AIDS community sector to improve its capacity to work with people from CALD backgrounds.
- Sharing of innovative strategies across jurisdictions to provide support to gay and other homosexually active men from CALD backgrounds.
- Development of culturally effective health promotion programs to increase the awareness of HIV/AIDS risk among Aboriginal and Torres Strait Islander people in rural/remote and urban settings, including specific programs focused on gay and other homosexually active men, women and people who inject drugs.
- HIV-positive peer support for Aboriginal and Torres Strait Islander PLWHA.
- Recognition of the importance of Aboriginal and Torres Strait Islander input and the role of community-based organisations in advocating for improved HIV/AIDS health services appropriate to Aboriginal and Torres Strait Islander communities and frameworks.
- The development of mechanisms to enable cohesive work across State and Territory jurisdictions as well as international borders in relation to the Torres Strait.
- Access to appropriate HIV health care for Aboriginal and Torres Strait Islander people.
- Workforce development for health care workers and for other services with the aim of maintaining high quality expert knowledge and skills in relation to HIV/AIDS and STIs in both government and non-government health and community services.

## 5.4 Surveillance for HIV/AIDS

The objectives of HIV/AIDS surveillance programs are to:

- collect sufficient good quality and relevant data nationally to be able to monitor the number of new diagnoses and health consequences of HIV/AIDS; and
- assist with planning of appropriate public health strategies.

The review report of the fourth National HIV/AIDS Strategy concludes that currently Australia's surveillance of HIV/AIDS is world class but further development of surveillance programs nationally is needed in response to the latest developments.

### Current surveillance of HIV/AIDS in Australia

HIV/AIDS surveillance is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR) at the University of New South Wales. The Centre collaborates with, and coordinates input from, State and Territory health authorities. Cases of HIV infection are notified to the National HIV Database. At the same time, cases of AIDS are notified through the health authorities at the State and Territory level to the AIDS Registry. Personal information is protected but name codes allow checking for duplicate notifications.

National surveillance occurs for the following conditions:

- **AIDS and AIDS deaths** – in the era of effective HIV/AIDS therapies, surveillance of AIDS and deaths following AIDS provides data on individuals who do not access therapy, and individuals for whom anti-HIV therapies are not working effectively. In Australia, the diagnosing doctor notifies of the onset of AIDS.
- **HIV diagnoses** – HIV is a notifiable condition in Australia, and testing laboratories are required to notify newly diagnosed HIV to State and Territory health authorities.
- **Newly acquired HIV** – newly acquired HIV infection is defined as a diagnosis of HIV within 12 months of an HIV-negative test, or a diagnosis based on a clinical diagnosis of HIV seroconversion illness. This national system, unique in the world, provides a more accurate assessment of HIV incidence, as opposed to new HIV diagnoses, in Australia.

Additionally, under the World Health Organisation (WHO) guidelines for second generation surveillance for HIV infection (WHO, 2000), systems have been set up for the surveillance of the risk behaviours of two of the highest risk populations, gay and other homosexually active men and injecting drug users, and the HIV seroprevalence among injecting drug users. The NCHECR coordinates HIV surveillance in populations at low and high risk of HIV. The low-risk populations include blood donors and entrants to the Australian defence force, and the high-risk populations include prison entrants and injecting drug users. Active surveillance of HIV among high-risk groups occurs in a national sentinel network of metropolitan sexual health clinics.

Patterns of health care and disease progression among PLWHA are monitored through the Australian HIV Observational Database, a clinic-based study, and through community-based studies of PLWHA.

The review reports the following:

*Although a great deal of excellent work has been done at the national level and in some jurisdictions over many years, some States still do not have active surveillance systems that can provide good information about the dynamics of the spread of HIV, which would in turn provide information about the epidemic and guide decisions about what can and should be done.*

This Strategy encourages all States and Territories to ensure active surveillance occurs throughout their jurisdictions.

### **Priorities for further development of surveillance systems**

One of the principles underlying the WHO's second generation surveillance for HIV is that surveillance should be dynamic and respond to the changing HIV epidemic. As a part of the renewed effort under this Strategy, there is a need to work on further development of surveillance programs to ensure that they are consistent with the latest developments. Areas for development of HIV surveillance, consistent with the findings of the review (page 00), may include:

- further investigation of the possibility of introducing new technologies such as detuned ELISA testing to help identify the proportion of new HIV diagnoses which are newly acquired, and thus to more accurately determine trends in HIV incidence; and
- investigation of refinements to behavioural surveillance of unprotected anal intercourse, which will help determine trends in high-risk behaviours.

Development could also include the investigation of a national program to improve data collection protocols regarding Indigenous status. This should be consistent with the National Aboriginal Community Controlled Health Organisation's guidelines for data collection, and should take Aboriginal and Torres Strait Islander sensitivities (cultural and ethical) into consideration.

Investigation of the collection of nationally consistent data on ethnicity would enhance the ability to identify trends in HIV notifications among overseas born people, as well as among Australian born ethnic communities. This data is currently collected in New South Wales and Victoria, and national collection would significantly enhance Australia's surveillance system.

Work in this area needs to be undertaken jointly by the Australian Government together with States and Territories, the National Centres in HIV Research and the MACASHH.

## **5.5 HIV testing**

The first HIV antibody tests were developed in the mid 1980s, when the natural history of HIV infection was not understood, there was no effective antiretroviral treatment and the stigma associated with the infection was at its peak. As a result, a carefully considered approach to HIV antibody testing was developed which became known as HIV pre- and post-test counselling. This approach minimised the possibility of those seeking testing suffering negative impacts from the testing experience, and took advantage of a valuable opportunity to provide health promotion information. Since that time there have been substantial changes in the social, clinical, epidemiological and technical aspects of HIV. The 1998 revision of the Australian National HIV Testing Guidelines Policy reiterated the guiding principles of HIV testing. These included:



- voluntary testing with counselling and confidentiality is fundamental to Australia's HIV/AIDS response;
- testing should be of the highest possible standard;
- testing is accessible to those at highest risk of HIV infection; and
- testing policy is critical to determining the extent and location of HIV infection in the community.

Australia maintains a high level of testing for HIV due largely to the principles of informed consent and confidentiality, and this remains central to the management of the epidemic in Australia. A coordinated, accessible and affordable HIV testing system allows the following:

- institution of antiretroviral treatment for infected individuals to optimise therapeutic effects;
- minimisation of sexual transmission through partner notification;
- protection of the blood supply and of organ and tissue donation;
- prevention of transmission from HIV-infected mother to foetus and newborn; and
- mapping of the epidemic to aid the development of evidence-based public health interventions.

HIV surveillance is predicated on high quality testing. More recently a number of new testing technologies have been introduced that are not currently licensed in Australia but have implications for surveillance activities and access to testing in some circumstances. Saliva antibody testing has been shown to be accurate and very convenient and may have a place in sero-survey activities. In late 2002 the US Food and Drug Administration registered a rapid HIV test (Orasure), which has identical performance to laboratory-based tests and can be performed in 20 minutes. The introduction of either of these tests in an unregulated manner would have significant effects on Australia's ability to monitor HIV testing rates, performance of tests and the context of HIV testing. Nevertheless, the value of these tests in Australia needs to be formally determined.

Investigation of the possibility of placing the HIV antibody test on the MBS is a priority during implementation of this Strategy. In any consideration of such a change, the principles of confidentiality and pre- and post-test discussions will be maintained.

Since the widespread adoption of antiretroviral therapy, HIV disease progression has been slowed in the majority of PLWHA. Concurrently, an increasing proportion of all AIDS diagnoses have occurred in people who have not previously been diagnosed with HIV and who have therefore not had an opportunity to benefit from therapy. In Australia, around 50 per cent of AIDS diagnoses now occur in people whose HIV diagnosis was less than three months prior, defined as 'late HIV diagnosis'. Late HIV diagnosis occurs disproportionately among people who have low testing rates for HIV, including women, people who have acquired HIV through heterosexual contact, and people from priority CALD backgrounds.

Late diagnosis of HIV infection has been recognised as a problem in many developed countries. Late diagnosis may compromise the individual's response to antiretroviral treatments and has implications for the spread of HIV/AIDS infection, especially in populations that do not have a perception of HIV risk. Improving access to, and uptake of, HIV testing is therefore an important goal. Outside of the gay community and sex worker networks, most HIV testing is performed at the instigation of health practitioners. The 1998 Guidelines identified a number of potential barriers to testing.

There is no uniform approach to antenatal HIV testing in Australia despite the fact that the risk of HIV/AIDS transmission can now be dramatically reduced by control of HIV in the mother. The prevalence of HIV/AIDS infection in the antenatal population remains extremely low but targeted screening, based on risk-factor assessments, has not been successful in other developed countries.

**Area for priority action around the review of the HIV Testing Policy:**

- The 1998 HIV Testing Policy will be reviewed and revised in accordance with the changing epidemiology, technology and social context of the HIV epidemic in Australia. Special attention should be given to the following:
  - the appropriateness of current funding mechanisms, while protecting and maintaining the capacity for free and anonymous tests;
  - pre- and post - test information procedures;
  - the clinical role of new rapid testing technologies, and formal guidelines for use;
  - non-blood testing e.g. saliva;
  - antenatal testing protocols;
  - improved access for priority populations;
  - consideration of targeted testing in priority groups with higher rates of late HIV presentation;
  - consideration of targeted testing for people who present with an STI;
  - surveillance; and
  - testing of individuals from high prevalence countries.

The review of the HIV Testing Policy and antenatal HIV testing policy should occur with full public consultation.

## **5.6 A clearer direction for HIV/AIDS research**

Research plays a critical role in providing much of the evidence base for policies and programs at all levels. Research also produces valuable data to enable monitoring of the effectiveness of national public health strategies, while making a substantial contribution to the international effort to control these diseases. Throughout the life of this Strategy, it is important that research remains focused on strategic priorities so policy and programs continue to be supported by a strong evidence base. Social research should also continue to inform health promotion and education activities.

Responsibility for funding the research efforts in this area lies predominantly with the Australian Government. The Government is committed to the maintenance of research activities conducted through the National Centres in HIV Research, while also developing improvements in the processes for targeting research activity. States and Territories also contribute funding to the National Centres.

The framework for supporting research in these areas will continue to be based on the following principles:

- commitment to supporting and maintaining strategy-related research and surveillance conducted through the infrastructure of the National Centres in HIV Research;
- the encouragement of enhanced collaboration between the National Centres in HIV Research and other relevant research institutions to increase the dissemination of information between research areas and allow for more effective research practices, reducing duplication and maximising the return on research investment; and
- a competitive environment for the funding of investigator-initiated research.

### **Current arrangements**

Currently, the Australian Government contributes approximately \$14 million annually to the national research effort in HIV/AIDS, hepatitis C and STIs. States and Territories also contribute to research in these areas, and the National Centres receive some funding from international sources for specific research projects.

These funds are mainly directed to:

- four national recurrently-funded centres in HIV, hepatitis C, and STIs research;
- competitive grants and training awards for individual researchers;
- research commissioned by the Government on the advice of the advisory body (now the MACASHH); and
- investigator-initiated funding grants from the National Health and Medical Research Council (NHMRC).

The National Centres are:

- the National Centre in HIV Epidemiology and Clinical Research;
- the National Centre in HIV Social Research;
- the Australian Centre for HIV and Hepatitis Virology Research; and
- the Australian Research Centre in Sex, Health and Society.

A principal role of the National Centres is to develop a comprehensive program of strategic research aimed at:

- limiting the spread of HIV/AIDS and hepatitis C;
- reducing harm to individuals and the community; and
- improving the quality of life of PLWHA and hepatitis C.

Section 5.2 also refers to additional research priorities into treatments and adherence.

### **New arrangements for setting research priorities**

The review report recommended that new arrangements, involving consultation with stakeholders, be developed for setting priorities for strategic research into HIV/AIDS, STIs and hepatitis C.

The Australian Government supports this approach and is committed to ensuring that strategic

research remains relevant and addresses current needs and priorities. An annual research roundtable will be convened to consult with key stakeholders and other community-based organisations on research priorities, in the light of current and emerging issues. This roundtable will be facilitated by the MACASHH and the identified research priorities will inform research workplans.

The MACASHH will advise on the National Centres' proposed workplans, through temporary working groups established for this purpose. These working groups will advise whether the proposed workplans adequately address issues of strategic priority under this Strategy. The working groups will be made up of representatives from all areas of the partnership, along with people with relevant expertise in research.

### **Research in HIV/AIDS and STIs**

To ensure that necessary and valuable research into HIV/AIDS is undertaken, the following issues need further consideration at the Australian Government level:

- the possibility of sourcing further funding for research into HIV/AIDS and STIs through the NHMRC;
- the need for specific STI research initiatives to be developed in addition to HIV research; and
- interaction and collaboration with State-based funding programs for HIV/AIDS and STIs.

Collaboration and interaction between the National Centres, and between each of the national centres and researchers in Aboriginal and Torres Strait Islander health and viral hepatitis is essential. The MACASHH and its Subcommittees will develop mechanisms to promote this.

#### **In the research arena priority areas for consideration are:**

- Establish consultative mechanisms and processes to set the agenda for the National Centres in HIV Research.
- An annual roundtable consultation on research priorities for HIV/AIDS, STIs and hepatitis C. This will be facilitated by the MACASHH, and will occur early each year to allow the roundtable to inform the National Centres' workplans.
- Identify priority areas for the research agenda including ordering priority areas according to greatest need.
- Consider ways to build capacity to analyse the economic costs and benefits to government and the community of HIV programs.
- Consider ways to create opportunities for increased interaction and collaboration between the National Centres, and between each of the National Centres and researchers in Aboriginal and Torres Strait Islander health.
- Review of the criteria and constituencies of the Scientific Advisory Committees for the National Centres.

## 6 Linkages with related strategies

Commonalities exist between this Strategy and a number of other national strategies. Specific mechanisms must be identified to ensure the necessary connections, opportunities and linkages are recognised and acted upon.

Specific Strategies include:

- the National Sexually Transmissible Infections Strategy;
- the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy;
- the National Hepatitis C Strategy;
- the National Drug Strategy: Australia's Integrated Framework; and
- Australia's International HIV/AIDS Strategy.

### **National Sexually Transmissible Infections Strategy 2005–2008**

This is the first national strategy addressing STIs. It is recognised that the National STIs Strategy is not comprehensive and does not consider the broader issues of sexual health. During the term of this National STIs Strategy, further work will be conducted on the development of the next, more comprehensive Strategy. The objectives of the first National STIs Strategy include: to improve awareness of STIs; to establish a foundation for coordinated national action on STIs now and for the future; to improve access to diagnosis and treatment of STIs; and to enhance surveillance and research activities in order to guide the implementation of prevention initiatives. The three main priority areas within the STIs Strategy are STIs in Aboriginal and Torres Strait Islander communities, STIs in gay and other homosexually active men, and chlamydia.

### **National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008**

The National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy outlines a national approach to preventing the spread of hepatitis C, HIV/AIDS and other STIs in Aboriginal and Torres Strait Islander communities. It is important to recognise that the Aboriginal and Torres Strait Islander Strategy is complementary to the National HIV/AIDS and STIs Strategies rather than being a substitute Strategy for this identified population group. The National HIV/AIDS Strategy recognises Aboriginal and Torres Strait Islander people as a priority group at risk of HIV infection, and is committed to working towards the goals and objectives outlined by the Aboriginal and Torres Strait Islander Strategy. Key action areas of the Aboriginal and Torres Strait Islander Strategy include: partnerships; health promotion; treatment, care and support; workforce issues; research; and data collection. These areas are being addressed through joint programs by two areas of the Australian Government Department of Health and Ageing – the Office for Aboriginal and Torres Strait Islander Health and the Population Health Division. This work is also being progressed through the MACASHH and the Indigenous Australians' Sexual Health Committee.

## National Hepatitis C Strategy 2005–2008

This National HIV/AIDS Strategy also recognises the need for people in the community as well as in all levels of government to be aware of programs and information available on the transmission of blood borne viruses. The second National Hepatitis C Strategy aims to minimise the personal and social impacts of hepatitis C infection by developing effective responses to priority areas. These are areas such as prevention of discrimination, assistance to people with hepatitis C to maintain health, and provision of care and support to those affected.

The Population Health Division of the Department of Health and Ageing funds and administers programs alongside the States and Territories on health promotion and education around transmission, treatment and care of people affected by hepatitis C.

The MACASHH will advise on health promotion activities for priority groups such as people who inject drugs who are at risk of both HIV/AIDS and hepatitis C infection. Co-infection is the basis of significant overlap between the HIV/AIDS and Hepatitis C Strategies. As stated previously, people co-infected with HIV and hepatitis C often have poor health outcomes due to heightened care requirements and issues associated with drug interactions. Guidance from the HIV and Hepatitis C Strategies regarding education messages and treatment and care and support is necessary to achieving optimal health outcomes for people co-infected with HIV and hepatitis B and/or C.

## National Drug Strategy

There are further linkages between the National HIV/AIDS Strategy and the National Drug Strategy, particularly through shared priority groups such as people who inject drugs. The National Drug Strategy links with priorities in other national strategies as it sets out broad principles, policies and priority areas for reducing the harm caused by illicit drugs in the Australian community. The approach relies on cooperation between all levels of government. Linkages will be strengthened between advisory structures, especially the MACASHH and the Australian National Council on Drugs through mechanisms such as common membership.

## Australia's International HIV/AIDS Strategy

Since the last national HIV/AIDS Strategy, we have seen expanding epidemics in our neighbouring countries. Providing urgent assistance to our neighbours, particularly Papua New Guinea and Indonesia, has become much more important, not only for those countries but also in Australia's own interest.

The Australian Agency for International Development (AusAID) has developed Australia's International HIV/AIDS Strategy to coordinate the international work of partnership members, and establish priorities for HIV/AIDS activities within Australia's international development cooperation program. A number of Australia's partnership members have a part to play in Australia's international HIV/AIDS-related initiatives. AusAID remains responsible for coordinating policy advice on development matters and providing most of Australia's financial support for international HIV/AIDS programs.

Australia's approach in HIV-related programs internationally focuses on five priority areas:

- strengthening leadership and advocacy;
- building capacity;

- changing attitudes and behaviour;
- addressing HIV transmission associated with injecting drug use; and
- supporting treatment and care.

It is important that the Australian Government Department of Health and Ageing and AusAID continue to interact closely on HIV/AIDS issues to ensure that Australia's international strategies are consistent with Australian domestic interests, and that Australia is able to maximise its contribution to the region.

### **Further opportunities for linkages**

There are several other national public health strategies in Australia that relate to service provision and the complex care needs of people living with HIV or AIDS. These include:

- the National Mental Health Action Plan 2003–2008;
- Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians;
- the Rural Health Strategy;
- the National Aboriginal and Torres Strait Islander Health Strategic Framework;
- the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework; and
- the National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003–2006.





# 7 Roles and responsibilities

## 7.1 The Australian Government – the need for leadership

National leadership is critical in order to effectively coordinate national efforts against HIV/AIDS. The Australian Government is committed to providing strong national leadership by working across portfolios and jurisdictions to further the aims of this Strategy. The Australian Government Department of Health and Ageing (the Department) is the principal Australian Government agency responsible for coordination of the national response to HIV/AIDS. The Department will continue to coordinate the national response to HIV/AIDS, and has primary carriage of the National HIV/AIDS Strategy.

Most aspects of direct HIV/AIDS program planning and delivery lie with the State and Territory Governments. The role of the Australian Government continues to be:

- to facilitate national policy formulation and coordination;
- to commission research into key areas of strategic relevance such as surveillance and data collection;
- to monitor and evaluate the National HIV/AIDS, STIs and Hepatitis C Strategies and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy;
- to subsidise treatment for HIV and AIDS through the MBS and the PBS;
- to regulate medicines, blood and medical devices, including tests for the diagnosis and monitoring of blood borne viruses; and
- to administer funding to the States and Territories, national community-based organisations and the National Centres in HIV Research.

Several other Australian Government agencies also contribute to Australia's response to HIV/AIDS, within Australia and also internationally, and they include: the Department of Foreign Affairs and Trade; the Department of Family and Community Services; AusAID; and the Department of Immigration and Multicultural and Indigenous Affairs. The role of pre-arrival testing is recognised; however, it is not included in the focus of this Strategy. This Strategy supports continuation of the whole-of-government response.

The Public Health Outcome Funding Agreements (PHOFAs) channel broadbanded Australian Government funding to States and Territories to support nominated population health programs and strategies. The Agreements ensure a shared commitment between Australian and State and Territory Governments to work towards nationally agreed outcomes by implementing national strategies and programs. The PHOFAs include funding for State and Territory HIV/AIDS-related programs. A range of agreed performance indicators assist in tracking how programs are implemented. In 2004–2005 the PHOFAs allocated a total of \$152.4 million nationally for the broadbanded (pooled) funds and \$812.1 million nationally over five years.

The Australian Health Care Agreements (AHCAs) channel Australian Government funding to the States and Territories for the provision of free public hospital services to eligible persons on the basis

of clinical need. These services can occur either on site in a public hospital or as part of hospital outreach services. The AHCA's commit the Australian Government and the States and Territories to work in partnership to progress the health reform agenda as agreed to by all Health Ministers in 2002.

There are a number of mechanisms in place to monitor, develop and implement policy relating to HIV/AIDS in Australia.

### **National Public Health Partnership (NPHP)**

The National Public Health Partnership (NPHP) has a significant role to play in the coordination of national efforts against HIV/AIDS and other STIs. The NPHP provides a formal structure for the Australian and State and Territory Governments to come together to develop a joint Australian intergovernmental agenda for public health into the future. The NPHP enhances national efforts in public health and clarifies the respective roles and responsibilities of the Australian and State and Territory Governments. The NPHP will cover areas such as strategic coordinated approaches to communicable disease control (including HIV/AIDS) and health system integration focused on consumers.

There are a number of committees and working groups that report to the NPHP, including the Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD) and the Communicable Diseases Network Australia (CDNA). Opportunities for establishing closer links between the NPHP and the work of the MACASHH need to be more actively sought. These can include initiatives such as inviting observers from IGCAHRD to the relevant MACASHH Subcommittee meetings.

### **MACASHH**

The MACASHH is responsible for providing independent and expert advice to the Minister for Health and Ageing on the implementation of this National HIV/AIDS Strategy, the National STIs Strategy, the National Hepatitis C Strategy and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy. The MACASHH reports annually on the appropriateness of current priorities and efforts. This advisory structure consists of the MACASHH and three expert Subcommittees – the HIV/AIDS and STIs Subcommittee, the Hepatitis C Subcommittee and the Indigenous Australians' Sexual Health Committee. A key role for the Subcommittees is to provide specialist advice to inform the Australian Government's response to HIV/AIDS, STIs and hepatitis C. These Subcommittees also identify emerging issues and ways these may be addressed.

The membership of each Subcommittee reflects the partnership approach, consisting of experts from relevant medical specialities, non-government partners, and specialists in public health, health promotion, research and evaluation. The MACASHH oversees and consolidates the advice of the Subcommittees.

### **Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD)**

IGCAHRD is responsible for coordinating efforts under the National HIV/AIDS Strategy, the National STIs Strategy, the National Hepatitis C Strategy and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy across all State and Territory jurisdictions and for

developing nationally consistent reporting standards. This committee has a critically important role to play in the implementation of this Strategy, and is made up of jurisdictional representatives from State and Territory Governments along with representatives of key peak stakeholder organisations.

This Intergovernmental Committee and the MACASHH will collaborate on important aspects of the management of the HIV/AIDS, STIs and Hepatitis C Strategies. Collaboration will be facilitated by cross-membership between committees and via the development of an implementation plan for this Strategy.

IGCAHRD is a subcommittee of the Communicable Diseases Network Australia, the peak national advisory body on communicable disease control, which itself reports to the NPHP.

## 7.2 The community sector

PLWHA and affected communities and their community organisations have played a crucial leadership role in Australia's strategic response to HIV/AIDS. This Strategy recognises the continued fundamental role of the community sector in ensuring the success of the national response.

The community sector brings unique and invaluable expertise to the partnership response. Community involvement in all aspects of the response is critical to its effectiveness. Community engagement in policy development, and planning and delivery of services, ensures that policies and services are at the forefront in identifying emerging issues, are responsive to need and are informed by the values and lived experiences of affected communities.

The Australian response has benefited greatly from the existence of the national organisations representing HIV/AIDS-affected communities. The Government will continue to seek policy input from peak bodies in the HIV/AIDS sector.

Overall, community organisations participate in the national response in a variety of ways:

- advocating for the interests of affected communities in decision making and policy formulation;
- delivering and evaluating policies and programs;
- participating in and devising health promotion initiatives, including peer education and social mobilisation projects;
- providing counselling, support and care for and by people living with or affected by HIV/AIDS and their partners, carers, families and friends through networks of volunteers and staff; and
- delivering HIV/AIDS health promotion and primary health care services to Aboriginal and Torres Strait Islander people, including through Aboriginal community controlled health services.

### **Australian Federation of AIDS Organisations (AFAO)**

AFAO is the peak body representing Australia's community response to HIV/AIDS. Its membership comprises State and Territory AIDS Councils, the National Association of People Living with HIV/AIDS (NAPWA), the Scarlet Alliance and the Australian Injecting and Illicit Drug Users' League (AIVL). AFAO's activities include policy analysis and formulation on HIV issues; advocacy; participation on

HIV advisory bodies; education and program development; and promotion of best practice in HIV/AIDS prevention and health promotion for PLWHA. AFAO also hosts the National Indigenous Gay and Transgender (Sistergirl) Project.

AFAO develops and advocates strategic policy responses and interventions in the international HIV/AIDS epidemic with a particular focus on the Asia/Pacific region. It is a member of the Asia Pacific Council of AIDS Service Organisations and a range of other international HIV bodies.

### **National Association of People Living with HIV/AIDS (NAPWA)**

NAPWA is the peak body representing PLWHA. NAPWA works with government and others to advocate on behalf of PLWHA and their issues. The volunteer HIV-positive board has responsibility for managing the response to national HIV issues in several portfolios, each led by elected HIV-positive convenors: treatments, care and support, legal, women, Aboriginal and Torres Strait Islander, education and international issues. Representatives from NAPWA participate in many other HIV/AIDS committees and working groups both nationally and internationally.

Nationally, this includes the work of the National Centres in HIV Research, the Australasian Society for HIV Medicine (ASHM) and IGCAHRD.

Internationally, this includes the Australian membership of the Asia Pacific Network of Positive People, the Global Advisory Board of the Collaborative Fund, the International Treatment Preparedness Coalition Board and the Community Review Panel of the South-East Asia Region.

### **Scarlet Alliance**

Scarlet Alliance is the peak body for sex worker organisations and related sex worker networks. Scarlet Alliance represents issues affecting its members, as well as those affecting sex workers at a national level. Since the beginning of the HIV epidemic in Australia, sex workers in Australia have responded quickly to the threat of HIV/AIDS infection. Rates of condom usage rose, and the formation of information sharing networks ensured that sex workers and clients alike were educated about HIV transmission.

### **Australian Injecting and Illicit Drug Users' League (AIVL)**

AIVL is the peak body in Australia representing State and Territory peer-based injecting drug user groups. On a national level, AIVL represents the needs of people who use drugs illicitly and facilitates the development of nationally consistent education resources and information. A key function of AIVL is to advocate for its constituency with governments at all levels by providing policy advice. The very low level of HIV infection among Australia's injecting drug user population is evidence of AIVL's success with peer education initiatives and prevention programs.

### **Other agencies**

#### **Multicultural HIV/AIDS and Hepatitis C Services (MHAHS)**

MHAHS is funded by NSW Health and, implements health promotion interventions with CALD communities in the context of HIV/AIDS and hepatitis C prevention, care and support. MHAHS works with CALD communities and other community and government agencies to develop and

implement culturally appropriate responses to HIV/AIDS and hepatitis C in Australia. MHAHS has received funding from the Australian Government to develop culturally appropriate responses to HIV/AIDS and hepatitis C through specific projects.

Other multicultural health and support services available in each State and Territory provide a range of services including advocacy, clinical support, interpreters and education.

## 7.3 The States and Territories

State and Territory Governments are responsible for providing leadership in the response to HIV/AIDS in their jurisdictions. This is primarily through health departments, which encompass both public health and the provision of health services through hospitals, community health and other primary care facilities, drug and alcohol and mental health facilities. However, other State and Territory government departments also need to be involved in the response to HIV/AIDS.

State and Territory Government responsibilities include the following:

- investigating, analysing and monitoring the epidemiology of HIV/AIDS within their jurisdiction;
- developing, funding, delivering and evaluating a range of services (such as health promotion and treatment and care services provided by community-based organisations) that reflect the prevalence and changing needs of populations at risk;
- establishing advisory committees or structures with representation from all members of the partnership in their jurisdiction;
- establishing public policy and legislative frameworks consistent with the aims and objectives of this Strategy;
- establishing State and Territory HIV/AIDS strategies that complement and build on this National Strategy;
- ensuring that resources are allocated in accordance with the guiding principles expressed in this Strategy;
- measuring and reporting on the Strategy's implementation and agreed performance indicators within their jurisdictions;
- participating in relevant national forums;
- management of custodial settings; and
- ensuring effective inter-sectoral cooperation between State and Territory and local government agencies.

### Local Government

In the light of the changing needs of people living with or affected by HIV/AIDS, the provision of services at the local and community levels has become increasingly important. Local Government is involved in a wide range of agencies and services that care for and support PLWHA and can respond promptly and effectively to particular local needs.

Furthermore, Local Government is responsible for urban planning and development that affects the location and operation of health services and initiatives such as NSPs and available housing.

The principles and priorities of this Strategy should be reflected in these processes and, where appropriate, activities at the local level should be monitored and reported on by the respective State or Territory Government.

## **7.4 Research, medical, scientific and health care workers**

Research, medical, scientific and health care professions play an essential role in treatment, care, health promotion, training, research, and policy development in this arena.

The contribution of professionals working in these areas should be maximised through inter-sectoral cooperation at all levels. Among the bodies responsible for contributing to the response to HIV/AIDS are the National Centres in HIV Research and the societies and colleges of health care professionals.

Research, medical, scientific and health care professionals are also vitally important in the development and maintenance of standards for workforce development and training, for both professional and volunteer health care workers, to ensure high-quality service provision.

### **Australasian Society for HIV Medicine (ASHM)**

ASHM is a professional medical society with members comprising doctors, scientists and other health care workers who are involved in the prevention of HIV transmission and the treatment and care of PLWHA. ASHM is an important partner in the Australian response to HIV/AIDS, hepatitis and related diseases. It works closely with government, advisory bodies, community agencies and other professional organisations. ASHM conducts a broad education program in HIV/AIDS and viral hepatitis for medical practitioners, health care providers and allied health workers and manages a program of continuing medical education in HIV/AIDS and viral hepatitis.

## **7.5 Parliamentary groups**

The Parliamentary Liaison Group (PLG) was first established in 1985 as an informal non-partisan forum to build support for and to disseminate accurate information on HIV/AIDS. The PLG allowed Members and Senators to be briefed informally about the latest HIV-related developments. In 1996, the PLG's terms of reference were broadened to include related communicable diseases, such as hepatitis and STIs.

Under this Strategy, the PLG will be re-established and revitalised to ensure that the Australian Parliament is informed regularly about the latest HIV/AIDS related developments in Australia and to provide a non-partisan forum for policy discussion. State and Territory Governments are encouraged to develop similar mechanisms for fostering a non-partisan approach to HIV/AIDS-related matters.

## 8 Implementation, monitoring and evaluation

Monitoring and evaluation mechanisms are required to ensure policy and practice are based on the best available evidence. Systematic monitoring and evaluation across all jurisdictions will ensure that activity contributes to the overall objectives and priorities of this National HIV/AIDS Strategy, and will provide an accountability mechanism for use by all levels of government. Monitoring and evaluation of the effectiveness of this Strategy will ensure priorities can be continually informed by the best available social and epidemiological evidence.

### Implementation plan

An implementation plan will be developed by the Australian Government, in consultation with the State and Territory Governments and peak community-based organisations. This will occur through a joint forum held between the MACASHH and IGCAHRD, with subsequent development by the Australian Government. Progress against the priority action areas identified in this Strategy will be monitored through regular reports to MACASHH, its Subcommittees, IGCAHRD, and other relevant bodies at the jurisdictional level.

Performance measures and targets are essential sources of insight for evaluation of this Strategy. Such measures could include quantitative and qualitative benchmarks such as:

- the trend in new HIV diagnoses;
- levels of awareness and knowledge around these trends in Australia, and knowledge around prevention among people at risk of HIV/AIDS infection; and
- the number of general practitioners acting as HIV drug prescribers.

### Reporting

Monitoring and evaluation contribute to improved health outcomes by measuring the Strategy's performance in relation to its stated purpose and priorities at all levels of implementation, and with particular reference to the Strategy's efficiency in terms of health outputs and outcomes.

Some evaluation mechanisms that could form the basis of an evaluation framework for this Strategy include:

- the MACASHH annual report to the Australian Government Minister for Health and Ageing on this Strategy's implementation;
- the annual and other HIV/AIDS Surveillance Reports of the National Centre in HIV Epidemiology and Clinical Research, and the HIV/AIDS, Hepatitis C and Related Diseases in Australia: Annual Report of Behaviour by the National Centre in HIV Social Research;
- an independent, external review of the Strategy;
- the annual and other communicable diseases surveillance reports of the Communicable Diseases Network of Australia and New Zealand;

- State and Territory Governments' monitoring and evaluation of their plans for this Strategy's implementation in their respective jurisdictions; and
- State and Territory Governments reporting annually to the Australian Government against the performance indicators of the Public Health Outcome Funding Agreements (PHOFAs).

Responsibility for evaluation of individual programs and initiatives lies with the jurisdiction that funds or manages the program. It is important to ensure that the results are readily available to all relevant groups within a consistent national framework.

Under this Strategy priority should be given to identify the resources, products and outcomes from investment in prevention programs for HIV/AIDS. This could be achieved through the establishment of a Learning Exchange to store information and evaluations of HIV/AIDS prevention programs. This would build on information gathered from the HIV Health Promotion/Prevention: Mapping of Current Activity across Australia project.





# GLOSSARY

## **Acquired immunodeficiency syndrome (AIDS)**

A syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immunosuppression.

## **Antiretroviral**

An agent that is active against a retrovirus. In this context, any medication that is designed to inhibit the process by which HIV replicates.

## **Best practice**

On the evidence available, the best intervention to produce improved outcomes for an identified problem.

## **Blood borne virus**

A virus that may be transmitted via blood or body fluids that contain blood. Such transmission can result from sharing injecting equipment.

## **Capacity building**

An approach to working with the community that aims not only to involve the community in dealing with the problem at hand but also to increase the community's capacity to deal with any future problems that arise. In the context of HIV/AIDS, such an approach is used to establish community norms and standards that support health-enhancing behaviours.

## **Clinical research**

Health research relating to individual patients as well as the development and evaluation of treatments for diseases.

## **Clinical trial**

A research activity designed to test a drug or treatment in humans and so establish its efficacy and safety and to identify groups of patients who can be expected to benefit from such a drug or treatment.

## **Co-infection**

In this context, the term used to describe the circumstance in which a person is concurrently infected with HIV and another blood borne virus such as hepatitis C.

## **Combination therapy**

The use of two or more types of treatment in combination, alternately or together, to achieve optimum results and reduce toxicity.

**Communicable diseases**

An illness caused by a specific infectious agent or its toxic products that arises through transmission of that agent or its product from an infected person, animal or other reservoir to a susceptible host.

**Communicable Diseases Network Australia (CDNA)**

The CDNA is a Australian body with representatives from the Australian and State/Territory health agencies and other government and research bodies. CDNA meets on a regular basis and keeps track of disease outbreaks within Australia and New Zealand.

**Community development**

Community development is the name given to processes that empower people in the community to take action to improve their own and their community's health. More specifically, it involves providing assistance to a defined target group, whereby the group through processes such as consultation and needs assessments identify their own health needs and develop the appropriate skills and strategies to respond to and address these needs.

**Continuum of care/coordinated care**

An integrated, client-oriented system of care consisting of services and integrating mechanisms that support clients over time, across a comprehensive array of health and social services, and spanning all levels of intensity of care.

**Culturally appropriate**

A term used to describe activities and programs that take into account the practices and beliefs of a particular social group, so that the programs and activities are acceptable, accessible, persuasive and meaningful.

**Custodial setting**

Refers to the various settings in which adults and juveniles can be detained or imprisoned, including prisons, juvenile justice centres, remand and other detention facilities.

**Deoxyribonucleic acid (DNA)**

The chemical inside the nucleus of a cell that carries the genetic instructions for making organisms.

**Discrimination**

Any unfavourable treatment on the basis of known or imputed disease status. Any action or inaction that results in a person being denied full or partial access to otherwise generally available services or opportunities because of known or imputed disease status. The definition includes discrimination on the grounds of known or imputed membership of particular groups that are commonly associated with the related disease.

**Epidemiology**

The study of the distribution and determinants of health-related states or events (such as likely routes of transmission of disease and trends in epidemics) in specified populations and the application of knowledge to deal with health problems.

**Evidence-based practice**

Integrating the best available evidence with professional expertise to make decisions.

**Gay man**

A homosexually active man who identifies himself as gay or is attached to the gay community, or both. Individuals can alter both their self-definition and the level of their community attachment over time. Education and prevention programs typically distinguish between gay men and other homosexually active men.

**Harm minimisation**

A primary principle underpinning the National Drug Strategy; the term refers to policies and programs aimed at reducing drug-related harm. Underlying the principle is the intention to improve health, social and economic outcomes for both the community and the individual. Wide ranges of approaches are involved, including abstinence-oriented strategies. Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy. Harm minimisation includes preventing anticipated harm and reducing actual harm. It is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction.

**Harm reduction interventions/strategies**

Interventions designed to reduce the impacts of drug related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use, but they acknowledge that these behaviours occur and that they have a responsibility to develop and implement population health measures designed to reduce the harm that such behaviours can cause.

**Health maintenance**

In this context, promoting approaches, interventions and lifestyle choices that support continued management and monitoring of a person's health with the intention of reducing the severity and side effects of HIV infection and deferring the progression to AIDS.

**Hepatitis C virus**

A Ribonucleic Acid (RNA) virus transmitted through blood-to-blood contact.

**Homosexually active man**

A man who engages in male-to-male sexual behaviour, regardless of whether he identifies himself as gay, heterosexual or bisexual.

**Human immunodeficiency virus (HIV)**

A human retrovirus that leads to AIDS.

**Incidence rate**

The number of new cases of a disease in a defined population within a defined period.

## **MACASHH**

The MACASHH provides advice to the Australian Government on emerging issues and priorities in relation to HIV/AIDS, STIs, hepatitis and Aboriginal and Torres Strait Islander sexual health. The MACASHH is supported by three expert Subcommittees – an HIV/AIDS and STIs Subcommittee, a Hepatitis C Subcommittee, and an Indigenous Australians' Sexual Health Committee.

## **Mainstreaming**

An approach to service delivery characterised by a move from specialist HIV/AIDS services towards increasing the capacity of the entire system to deliver appropriate services.

## **National Public Health Partnership (NPHP)**

A broad, multilateral intergovernmental framework that enables cooperative approaches to the improvement of the population health system and clarifies the roles and responsibilities of its principal partners. Membership consists of senior health officials from the Australian and State and Territory Governments, the Australian Institute of Health and Welfare, and the National Health and Medical Research Council.

## **Needle and syringe programs (NSPs)**

A public health measure to reduce the spread of blood borne viruses such as HIV and hepatitis C. NSPs provide a range of services that include the provision and disposal of injecting equipment, education, counselling and referral for people who inject drugs.

## **Parliamentary Liaison Group**

A non-partisan forum through which information is provided to members of the Australian Parliament and in which policy discussions can occur.

## **Peer education**

Usually members of a given group working to effect change amongst other members of the same group. This model of education is based on social learning and health behaviour theories, and has been proven to be an effective method of imparting information, skills and knowledge to others (peers). Peer education also recognises the influence that peer pressure and the behaviours of a peer group have on the decisions an individual makes.

## **Pharmacology**

The use of drugs to treat disease. In this context, the use of HIV antiretrovirals.

## **Prevalence rate**

The total number of all individuals who have an attribute or disease at a particular time or period divided by the populations at risk of having the attribute or disease at that time or midway through the period.

## **Public Health Outcome Funding Agreements (PHOFAs)**

The PHOFAs provide broadband funding to States and Territories to support their role in the achievement of nationally agreed outcomes in population health. States and Territories have the

flexibility to use this Australian Government assistance according to local needs and priorities, while ensuring that specific outcomes are met.

**Retrovirus**

A virus that inserts a DNA copy of its genome into the host cell in order to replicate. HIV is a retrovirus.

**Safe sex, safe sexual practice**

Sexual activity in which there is no exchange of body fluids such as semen, vaginal fluids or blood.

**Seroconversion**

The development of a detectable level of antibodies that occurs after a person has been exposed to and become infected by a micro-organism such as HIV or the hepatitis C virus.

**Sexually transmissible infection**

An infection –such as HIV, gonorrhoea, syphilis or chlamydia – that is transmitted through sexual contact.

**Sistergirl**

Sistergirl is an Aboriginal and Torres Strait Islander sexual and cultural identity. Sistergirls are most often transgender, which may include sex change. An individual who cross dresses can also claim Sistergirl identity.

**Surveillance**

In this context, the continuing scrutiny of all aspects of the occurrence and spread of a disease. The main purpose is to detect changes in trends or distribution in order to initiate, investigative or control measures.

**Therapeutic drug monitoring**

Therapeutic drug monitoring is measuring the level of some drugs in a patient's system as a way to determine the most effective dose and to avoid toxicity.

**Vaccine**

A preparation of antigenic material administered to induce a specific immunity to infection by the organism from which the antigenic material has been prepared.

**Viral load**

The amount of virus present per cubic millilitre of blood, as measured by a viral-load test.

**Virology**

The science of investigation of virus structure, mode of action and disease processes and the identification of possible interventions at the cellular level. Developments in virological research can also contribute to the development of drug and vaccine therapies.





# ABBREVIATIONS

AFAO	Australian Federation of AIDS Organisations
AHCA	Australian Health Care Agreement
AIDS	Acquired Immunodeficiency Syndrome
ANCD	Australian National Council on Drugs
ANET	AFAO/NAPWA Education Team
ARCSHS	Australian Research Centre in Sex, Health and Society
AusAID	Australian Agency for International Development
CALD	culturally and linguistically diverse (background)
CDNA	Communicable Diseases Network Australia
DNA	deoxyribonucleic acid
HAART	highly active antiretroviral therapy
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	Human Immunodeficiency Virus
IGCAHRD	Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases
MACASHH	Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis
MBS	Medicare Benefits Schedule
NAPWA	National Association of People Living with HIV/AIDS
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NHMRC	National Health and Medical Research Council
NPHP	National Public Health Partnership
NRL	National Serology Reference Laboratory
NSP	needle and syringe program
PBS	Pharmaceutical Benefits Scheme
PHOFA	Public Health Outcome Funding Agreement

PLG	Parliamentary Liaison Group
PLWHA	people living with HIV/AIDS
STI	sexually transmissible infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
WHO	World Health Organization



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