

**REVIEW OF THE NATIONAL HIV/AIDS STRATEGY
1999–2000 TO 2003–04**

**GETTING BACK ON TRACK ...
REVITALISING AUSTRALIA'S RESPONSE
TO HIV/AIDS**

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2.1 SUMMARY AND RECOMMENDATIONS

2.1.1 Summary

In January 2002 the Minister for Health and Ageing, Senator the Hon Kay Patterson, decided that a review of the National HIV/AIDS Strategy 1999–2000 to 2003–04 should be undertaken, to provide a clear picture of achievements thus far under the Strategy and to guide the next phase of Australia's public health response to the HIV/AIDS epidemic.

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.

But HIV/AIDS continues to be a serious cause of preventable morbidity and mortality, both in Australia and in our region. Despite the gains made during the past three years, the Review Panel is convinced that a major revitalisation of Australia's response to HIV/AIDS is required. A fifth National Strategy is warranted in order to re-energise our efforts, and the Panel recommends the establishment of new governance structures and processes to advise the Minister and the Commonwealth Department of Health and Ageing. The Panel considers that the partnership approach remains the most effective and efficient way of ensuring an adequate response to HIV/AIDS in Australia.

The following are some of the more notable challenges we still face:

- ◆ the changing nature of the HIV/AIDS epidemic in Australia and in the region, including significant increases in HIV diagnoses in some states
- ◆ continuing unacceptably high levels of unprotected anal intercourse and of gonorrhoea among men who have sex with men
- ◆ developing the ability to measure the adequacy of program activity at the local level and to account for funding for this purpose at the state and territory level
- ◆ diminished support for harm-reduction approaches and the potential for an explosive spread of HIV among injecting drug users
- ◆ 'prevention-free' custodial settings
- ◆ the inadequacy of and lack of consistency between surveillance systems for HIV and STIs
- ◆ the declining leadership role of the Commonwealth
- ◆ the need for more effective ministerial advisory mechanisms

- ◆ the increasing need for the Commonwealth to develop and implement a whole-of-government approach to many matters associated with HIV/AIDS domestically, as well as the need to do more about HIV in our region.

The Review Panel discusses these challenges in this report and makes recommendations designed to provide the basis for finding effective solutions through the development of a fifth National HIV/AIDS Strategy.

2.1.2 Recommendations

The Review Panel recommends as follows:

29. That a major new national education program on prevention be developed with the states and territories and key stakeholders—for the term of a fifth National HIV/AIDS Strategy and beyond—to decrease rates of unprotected anal intercourse, related STIs (gonorrhoea and chlamydia) and HIV transmission among men who have sex with men. This program should include, among other things:
- ◆ development and enforcement of agreed codes of conduct within all ‘sex on premises’ venues—including prevention education, condom distribution, promotion of HIV and STI counselling and testing, and promotion of non-occupational post-exposure prophylaxis for men
 - ◆ development of new communication and community-based programs to reach young gay men, men who have sex with men but are not attached to the gay community, and gay men living in rural and remote areas
 - ◆ development of a national annual sexual health check-up program for men who have sex with men, along with continuing public campaigns to increase the availability of and participation in counselling and testing
 - ◆ review and updating of HIV-testing guidelines.
30. That harm-reduction approaches, in their broadest sense, be strongly supported from the funding and policy level-perspectives. This includes:
- ◆ needle and syringe programs
 - development of best-practice models for needle and syringe programs—for example, referral systems and local community management systems involving police, traders, residents, pharmacists, local government, non-government organisations and magistrates courts
 - support for expanded hours
 - provision of sterile water
 - workforce development
 - ◆ availability of medical detoxification

- ◆ a broad range of substitution therapies—methadone, buprenorphine, and so on
 - ◆ availability of abstinence-based therapies
 - ◆ connections to and from the prison systems—see also recommendation 32
 - ◆ peer education programs
 - ◆ an education program for decision makers and the general community.
31. That new approaches to harm reduction—such as the use of supervised injecting facilities, syringes with retractable needles, and medically prescribed heroin—be rigorously evaluated.
 32. That, in close collaboration with the states and territories, a national HIV prevention and care program for prisons be developed. This should include:
 - ◆ increased availability and uptake of both substitution-based and abstinence-based treatments for drug users in prisons
 - ◆ strong continuing engagement with prison officers and their unions to develop programs—for example, in-prison needle and syringe exchange programs—that benefit the officers as well as the prisoners.
 33. That culturally and linguistically diverse communities at high risk of HIV transmission be added to the other priority groups in the current Strategy—Aboriginal and Torres Strait Islander peoples, people who inject drugs, people in custodial settings, sex workers, and the male and female partners of these people—and that a national program be developed with the states and territories to reduce transmission in these communities.
 34. That the next-generation national program of epidemiological, behavioural and clinical surveillance be developed. This should include new testing technologies, such as the detuned ELISA test, and indicators such as HIV testing patterns, viral load, unprotected anal intercourse, condoms, and needles and syringes.
 35. That one of the main performance indicators for the National Centre in HIV Epidemiology and Clinical Research be the extent to which the Centre builds surveillance capacity with the states and territories.
 36. That a national workforce-development program be designed and implemented with the states and territories and key stakeholders.
 37. That the Commonwealth revitalise its national leadership role through enhanced funding, policy development, research, overall coordination, support for the partnership, and international assistance.

38. That the current governance structure be dissolved and that four advisory committees be established—HIV, Hepatitis C, a Legal Committee, and an Indigenous Australians' Sexual Health Committee—with coordination achieved through a committee of Chairs and Deputy Chairs.
39. That a Governance Charter be developed to clearly define the respective roles of the different elements of the new governance structures—for example, advisory committees, working groups and government departments.
40. That the Commonwealth Parliamentary Liaison Group be revitalised and supported and be seen as a very important element of the national response.
41. That consideration be given to developing a national strategy for STIs, to rekindle interest in working with Australia's young people.
42. That a framework for continuing evaluation of the National HIV/AIDS Strategy be developed and implemented.
43. That a biennial, comprehensive study to identify, document and track over time the responses to HIV/AIDS at the national, state and territory and local levels be developed and carried out.
44. That resources be specifically dedicated to the establishment of new and continuing capacity to analyse and monitor the economic benefits and costs to government and the community of HIV programs and their components and sub-components.
45. That the National Centres in HIV Research commit increased effort and resources to understanding changing trends in unprotected anal intercourse, gonorrhoea and HIV infection in Victoria and South Australia.
46. That the agenda for the National Centres in HIV Research be set by means of a consultative process at three-year intervals, with provision for rapid responses to emerging problems as they arise.
47. That a cross-sectoral working group—with representation from the Department of Health and Ageing, AusAID (the Australian Agency for International Development), the Department of Foreign Affairs and Trade, and the Department of Immigration and Multicultural and Indigenous Affairs, plus co-opted external experts—be established to expand and coordinate Australia's international role in HIV/AIDS. The working group should report to the HIV Committee of the new governance structure.
48. That the Department of Health and Ageing work with AusAID to develop a mechanism for improving the participation of Australian experts in our international response.
49. That task-focused, time-limited working groups—reporting to the HIV Committee—develop national approaches to complex cross-government questions such as:

- ◆ income support for people living with HIV/AIDS
 - ◆ access to therapies
 - ◆ models of care for people living with HIV/AIDS, including evaluation of the GP Enhanced Care Pilot Project in New South Wales
 - ◆ mental illness services
 - ◆ supported accommodation and housing for people living with HIV/AIDS
 - ◆ Medicare ineligibility.
50. That a fifth National HIV/AIDS Strategy be developed to further develop and implement the foregoing recommendations. The Strategy should cover the three years from 2004–05 to 2006–07 and should be reviewed in mid-2006.

2.2 CONTEXT

2.2.1 Introduction

The National HIV/AIDS Strategy 1999–2000 to 2003–04, called *Changes and Challenges*, was launched in June 2000. It stresses the need for monitoring and evaluating Australia's response to the HIV/AIDS epidemic, to ensure that policy and practice are based on the best available evidence and information, and it proposes an independent, external mid-term review as an important mechanism for this purpose. In January 2002 the Commonwealth Minister for Health and Ageing, Senator the Hon Kay Patterson, decided that a review of the National HIV/AIDS Strategy 1999–2000 to 2003–04 would be carried out in 2002, to guide the next phase of the public health response to the epidemic.

The HIV/AIDS Section of the Communicable Diseases and Health Protection Branch in the Commonwealth Department of Health and Ageing developed the Terms of Reference for the review in consultation with ANCAHRD, which is the Minister for Health and Ageing's principal advisory body on implementation of the Strategy. Key stakeholders such as the Australian Federation of AIDS Organisations, the National Association of People Living with HIV/AIDS and the National Centres in HIV Research were involved in the development process through their representation on ANCAHRD.

Section 2.5 (Appendix A) shows the Review's Terms of Reference.

The review was conducted by an independent Panel whose members were:

- ◆ Dr Rob Moodie—Chair
- ◆ Professor Anne Edwards
- ◆ Senator Marise Payne.

2.2.2 Australia's response to the HIV/AIDS epidemic

The Commonwealth Government launched Australia's first National HIV/AIDS Strategy in August 1989. The Strategy reflected the principles espoused in the 1986 World Health Organization (WHO) Ottawa Charter for Health Promotion, and it provided a framework for an integrated response to the HIV epidemic and a plan for action across a range of policy and program activities. The primary aim was to stop the spread of HIV in Australia and to provide care and support for people affected by HIV.

The second National HIV/AIDS Strategy 1993–94 to 1995–96 (released in 1993) retained and refined the core elements of the first Strategy. The foundation continued to be a nationally coordinated approach underpinned by a partnership between government, affected communities, researchers, scientists and health professionals, and the strong focus on HIV education and prevention was maintained. The Strategy was implemented in the context of the Special Funding and Matched Funding

arrangements that existed between the Commonwealth and the states and territories for health financing.

At the request of the Federal Cabinet, a comprehensive review of the second Strategy was conducted in 1995, to assess the Australian response to the HIV epidemic to that point and to determine whether another national strategy was necessary. Professor Richard Feachem was appointed to lead the evaluation and his report, *Valuing the Past ... Investing in the Future*, was published in September 1995.

On the basis of epidemiological, economic and behavioural data, extensive community consultation and analysis of outcomes, Professor Feachem concluded that Australia's response to the HIV/AIDS epidemic had been effective, appropriate and achieved at reasonable cost. His report underlined the importance of having a third National HIV/AIDS Strategy—with adequate funding and for a longer term. It recommended maintenance of the core aims of the former Strategies, with refined objectives; it also recommended situating HIV within the context of a broader communicable diseases and sexual health framework.

Following the Feachem report, the third National HIV/AIDS Strategy 1996–97 to 1998–99, called *Partnerships in Practice*, was developed and released in 1996. Like its predecessors, the third Strategy set out to reduce the number of HIV infections as well as HIV's impact on people affected by the virus. It was based on three principles: working towards or maintaining non-partisan political support; the HIV partnership; and involving those communities most affected by HIV in all elements of the response. The five priority areas of activity that were identified—education and prevention, treatment and care, research, legal and ethical matters, and international assistance and cooperation—maintained and built on the central elements of the earlier Strategies.

The third National Strategy was implemented at a time of far-reaching reform in the health sector, especially in public health. Of particular relevance to HIV/AIDS was the change in Commonwealth–state funding arrangements for national public health programs: there was a move away from the earlier issue-specific funding arrangements to the development of Public Health Outcome Funding Agreements (PHOFAs) and broad-banded funding.

The Australian National Council on AIDS and Related Diseases (ANCARD) reviewed the third National HIV/AIDS Strategy in 1999. It found that the third Strategy had been effective in working towards its stated goals but that much remained to be done. At the same time, treatment options for HIV-positive people were greatly expanding, creating a number of new challenges for the prevention and treatment and care components of the national response. The review concluded that a national strategy approach continued to be the most effective and efficient way of ensuring an adequate response to HIV/AIDS and that, despite the many achievements of the previous Strategies, further concerted action was essential to effectively contain and treat HIV in Australia.

The fourth National HIV/AIDS Strategy 1999–2000 to 2003–04 was developed in response to ANCARD's recommendations and in consultation with key stakeholders in the HIV partnership.

2.2.3 The National HIV/AIDS Strategy 1999–2000 to 2003–04: an overview

The National HIV/AIDS Strategy 1999–2000 to 2003–04 builds on the achievements of its three predecessors by retaining the underlying partnership approach, which involves affected communities; governments at all levels; medical, scientific and health care professionals; and, importantly, non-partisan political support. Like the third Strategy, the fourth Strategy is framed in the context of related communicable diseases and sexual health. It also emphasises the need for greater coordination of effort across the partnership and greater integration with related government policies such as the National Drug Strategic Framework and the first National Hepatitis C Strategy.

As with the previous National HIV/AIDS Strategies, the fundamental purpose of the current Strategy is to safeguard the health of all Australians in relation to HIV/AIDS by eliminating the transmission of HIV and minimising the personal and social impacts of HIV infection. The Strategy identifies five priority areas of activity to guide implementation:

- ◆ HIV/AIDS-related health promotion—including disease prevention
- ◆ treatment, care and support
- ◆ research
- ◆ international assistance and cooperation
- ◆ development of a legislative and policy framework that facilitates access to useful information for people at risk of HIV infection and people living with HIV/AIDS and that protects the human rights of those people—an ‘enabling environment’.

Six population groups are specified as priorities for prevention, education and health-promotion activities:

- ◆ gay and other homosexually active men
- ◆ Aboriginal and Torres Strait Islander peoples
- ◆ people who inject drugs
- ◆ people in custodial settings
- ◆ sex workers
- ◆ people living with HIV/AIDS.

2.2.4 HIV/AIDS program funding

Sustained commitment of resources by the Commonwealth and the state and territory governments has been an essential component of Australia’s relative success in

combatting HIV/AIDS. In 2001–02 the Population Health Division of the Commonwealth Department of Health and Ageing committed approximately \$14 million to support nationally focused HIV/AIDS education and prevention, research, and treatment and care programs and activities. (Additional funding is allocated through the Department's Office for Aboriginal and Torres Strait Islander Health to assist with implementation of the National Indigenous Australians' Sexual Health Strategy.) In the Commonwealth's response to the HIV/AIDS epidemic, care has always been taken to ensure that key priorities and objectives are met and that the benefits and economies of scale to be gained from collaboration with related health initiatives are realised.

In addition, a notional figure of \$25 million, based on allocations made under the previous Matched Funding arrangements for HIV/AIDS, was incorporated in the broad-banded PHOFAs with the states and territories at the beginning of 1997–98. The broad-banding is designed to give the states and territories greater flexibility to respond appropriately to public health concerns in their regions: the amount of funding for each public health program is not separately identified. For 2001–02, the PHOFA base funding to the states and territories for national public health programs was approximately \$120.1 million.

It should be noted that the Review Panel was unable to obtain reliable information on Commonwealth and state and territory funding in recent years, making it impossible to discern trends and to validate claims made by several Review participants that the level of resources being expended on HIV is diminishing.

Public hospital services (delivered on site in a public hospital or as outreach services) and general practitioner services are funded through the Australian Health Care Agreements (1998 to 2003) and Medicare respectively. The Pharmaceutical Benefits Schedule and the Pathology Services Table of the Medicare Benefits Schedule offer affordable access to HIV treatments and funding for the investigation of HIV infection.

2.2.5 The changing HIV/AIDS epidemic

From 1990 to the end of 2000 consistent declines in the number of new HIV diagnoses were recorded in Australia. But this situation is changing: there were 774 new diagnoses in 2001, a 4.6 per cent increase on the 740 reported in 2000 (National Centre in HIV Epidemiology and Clinical Research 2002b). Other evidence suggests that there are serious grounds for concern that the number of HIV notifications will continue to rise if we do not considerably reinvigorate our response.

Victoria has witnessed the greatest and most persistent recent rises in the number of new HIV diagnoses: in that state 218 cases of HIV were diagnosed in 2001, a 56 per cent increase on the 1999 total of 139 cases. Within this, there was an 88 per cent increase in diagnoses among men who have sex with men—from 80 in 1999 to 150 in 2001. This increase continued into the first quarter of 2002. In South Australia the number of HIV notifications increased from 23 in 2000 to 42 in 2001 (National Centre in HIV Epidemiology and Clinical Research 2002b).

In the last few years there has also been a continuing, steady increase in diagnoses of gonorrhoea, especially in men who have sex with men. The number of notifications of rectal isolates of gonorrhoea in New South Wales rose from 73 in 1996 to 182 in 2000; in Victoria the number rose from 56 in 1996 to 91 in 2000 (National Centre in HIV Epidemiology and Clinical Research 2001).

Studies examining the sexual behaviour of gay men have found high and increasing levels of unprotected anal intercourse, the levels being higher in Sydney and Adelaide than in Melbourne, Perth and Brisbane.

Why have there been significant rises in HIV in Victoria over the past two years and in South Australia in the past year and not in other states, despite the fact that levels of unprotected anal intercourse and gonorrhoeal rectal isolates are highest in Sydney? Some researchers and educators have argued that gay men in New South Wales have a very sophisticated approach to 'negotiated safety' and 'strategic positioning' and are using their knowledge of their 'low' viral load to diminish their risk. Such an approach requires knowledge of one's own HIV status and that of one's partner. The concept of 'negotiated safety' is patently not working in Victoria, where one of the worrying features of the current increase in HIV infections is the relatively low level of testing and counselling, despite the greater availability of information about increased levels of infection in the past 12 months. Many people who are at risk are unaware of their status: this is attested to by the fact that 41 per cent of those diagnosed during 2001 had not previously been tested for HIV.

The availability of HAART has not only changed the survival rates of people with HIV: it has also changed the nature of HIV/AIDS, from a rapidly terminal disease to a complex, chronic one. The consequent change in perceptions of the disease is thought to be an underlying factor in the increasing rates of unprotected anal intercourse. With the success of HAART also comes increasing toxicities, as well as increasing viral loads resulting from resistance to therapy. Management of the many medical and social factors affecting people living with HIV is becoming ever more complex.

HIV rates among Aboriginal and Torres Strait Islander peoples remain relatively low, despite very high levels of STIs. Why this is still the case—many years after the first reported case of HIV in this population group—remains a puzzle. It seems that it is a matter of good luck rather than good management. One argument is that the high STI rates are attributable to repeated re-infection in quite a small number of people; this is often associated with serious social disintegration and alcohol abuse, and HIV has simply not entered these sexual networks.

HIV levels among entrants to prison are also still relatively low, as are the rates among injecting drug users generally and among Indigenous injecting drug users. This contrasts with the consistently high rates of hepatitis C infection in these groups.

Concern has been expressed about the potential for emerging heterosexual transmission in culturally and linguistically diverse communities and rural and remote communities. The national HIV data do not yet seem to reflect this:

While the total number of new HIV diagnoses has declined steadily, from 910 in 1996 to 745 in 2000 ... the number of diagnoses attributed to heterosexual contact has remained relatively stable at around 150 per year, with approximately 60–70% attributed to people from a high prevalence country or with partners from a high

prevalence country. (National Centre in HIV Epidemiology and Clinical Research 2002a)

Changes in the political and social environment

Several challenges have arisen from changes in the political and social environment, suggesting that, to some extent, Australia has become a victim of its own success.

As the number of new diagnoses of HIV and the mortality from AIDS have declined so too has the public profile of HIV/AIDS in this country. This has been accompanied by a waning in public discussion about HIV and AIDS and greatly reduced interest in events such as World AIDS Day—other than interest in the epidemic in Africa and in Southeast Asia, although this interest is still small when one considers the magnitude of the epidemic.

Not surprisingly, given the success of prevention efforts and HAART after many years of high mortality and ‘emotional exhaustion’, a perception has arisen that AIDS is ‘over’. This has resulted in a degree of disengagement on the part of the gay community. In some states at least, there has been a reduction in the intensity and coverage of prevention and education programs.

It appears that in the past 15 years human resources within departments at the federal level and in Victoria and New South Wales have decreased, coincident with an increase in community capacity. If the wherewithal within government is reduced too much, the ability to coordinate and lead a whole-of-government approach could be seriously compromised.

The Commonwealth and state and territory governments have also evinced growing interest in, and emphasis on, evidence, outcomes and value for money.

Why invest in public health approaches to HIV?

In the last 20 years or so Australia’s response to HIV/AIDS has produced dramatic results: the peak of 1700 new HIV infections diagnosed in 1984 has fallen to an average of about 700 new infections a year in recent times. But, like many other public health programs requiring difficult and sustained behaviour change—examples are campaigns to reduce tobacco smoking, road trauma and skin cancer—substantial ongoing resources (human, financial and technological) need to be applied if we are to avoid significant increases in HIV infection rates in the coming years. In addition, and in contrast, HIV by its nature is a complex disease from the technical, behavioural, developmental and political perspectives, dealing as it does with sexuality, commercial sex, illicit drugs, human rights and marginalised groups.

The report of the recent Applied Economics review of Australia’s investment in HIV/AIDS public health programs states:

[The programs] have returned substantial positive net benefits. For all exposure groups, the present value of expenditures on education and prevention programs in 2000 prices discounted back to 1984 is \$607 million. The estimated present value of the benefits derived from these programs is \$3.149 billion. The estimated net benefit is therefore \$2.541 billion. The conclusion that the HIV/AIDS education and

prevention programs provided positive net benefit is robust to changes in all three key underlying assumptions. (Applied Economics 2001)

This is consistent with the findings of the evaluation of the third National Strategy, which confirmed the very positive net outcome of Australia's investment in HIV prevention (Department of Human Services and Health 1995).

Why have separate governance, and funding, for HIV and hepatitis C?

It is apparent to the Review Panel that the anticipated synergies to be derived from combining the governance of HIV and hepatitis C (and related diseases) have not eventuated. No evidence was presented to demonstrate the leadership or efforts made to realise such synergies. The Panel can only conclude that little or nothing has been done to make combined governance for HIV and hepatitis C actually work.

Another important factor is that the organisations working on HIV, apart from those working on HIV among injecting drug users, have little in common with those working on hepatitis C, and there is little overlap in communities of interest. If one were looking for synergies, it might make more sense to look for them between hepatitis C and the National Drug Strategic Framework, or between HIV/AIDS and a strategy dealing with STIs.

In addition, the HIV/AIDS governance structures have had little impact on 'related diseases': apart from the Indigenous Australians' Sexual Health Strategy, these related diseases have never been operationally defined or appropriately resourced.

2.3 ANALYSING THE EVIDENCE

The Review Panel had neither the time nor the capacity to evaluate in detail all facets of the current National HIV/AIDS Strategy. Instead, it has relied on evidence presented to it through written submissions, oral presentations, interviews and background material to formulate its views. This section analyses and discusses the evidence within the scope of the Terms of Reference.

Overall, the submissions were relevant and well prepared; those from non-government organisations were of a particularly high standard. In addition, the Panel appreciated the written comments provided by the health departments of New South Wales, South Australia, Western Australia and Queensland. It is disappointing that Tasmania, Victoria and the two territories did not make submissions.

The Review Panel considers that one of the main shortcomings of this Review is the lack of an evaluation framework for the fourth Strategy and the lack of evaluation studies. There seems to be little information about the resources (inputs), products (outputs) and outcomes from investments in HIV/AIDS during the fourth Strategy.

2.3.1 Effectiveness

The first term of reference requires the Review Panel to:

Assess the extent to which the current National HIV/AIDS Strategy has been effective, having particular regard to

- ◆ the Strategy's position in a broader communicable diseases context;
- ◆ the degree to which it has been implemented;
- ◆ the achievement of Strategy objectives listed under the following five priority areas
 - the creation of an enabling environment;
 - HIV/AIDS related health promotion, including disease prevention;
 - treatment, care and support;
 - research; and
 - international assistance and cooperation.
- ◆ the priority health needs of Aboriginal people and Torres Strait Islanders.

The broader communicable diseases framework

It is important to emphasise that HIV/AIDS continues to be a major cause of preventable morbidity and mortality in Australia, with serious consequences for the treatment and care of people living with HIV. The Review Panel notes that, without a well-informed and well-implemented continuing response, Australia's epidemic could

deteriorate markedly in a relatively short time and that the implications of this for the Australian health care system would be sizeable and manifold.

The evidence before the Review Panel indicated that there was broad support for placing the HIV/AIDS Strategy within a broader sexual health and communicable diseases framework but that real planning and implementation must occur if the links and synergies are to have their desired effect. There was relatively widespread concern among Review participants at the prospect of HIV/AIDS ceasing to maintain its own distinct profile.

Implementation

The fourth National HIV/AIDS Strategy was developed following widespread consultation. Key members of the HIV partnership endorsed the final document, and it was published in 2000.

Australia has had some notable successes during the term of the Strategy. HIV infection rates decreased early in the period, although they increased in 2001–02. Deaths from AIDS-related illnesses have steadily declined from the already relatively low levels and, while the spectres of side effects and resistance exist, many HIV-positive people continue to enjoy relatively good health. To this extent, it can be argued that the Strategy has been implemented to a large degree.

Opinions about aspects of the Strategy's implementation vary greatly. Some stakeholders consider that the Strategy has been an instrument of consolidation. Others feel that its implementation has been seriously undermined by various factors: for example, there was widespread complaint about the difficulty of tracking funding (at both the Commonwealth and the state and territory levels) and dissatisfaction with the role and responsibilities of ANCAHRD and the lack of support for situating hepatitis C advisory structures with those for HIV.

Many Review participants pointed to the lack of funding accountability on the part of the Commonwealth and the states and territories as a major impediment to implementation. They claimed it has become much more difficult to ascertain and track the level of Commonwealth government spending in recent years, because funds are now being disbursed among various bodies with various responsibilities—including, for instance, the Office for Aboriginal and Torres Strait Islander Health in the Department of Health and Ageing—rather than by specific program appropriations. The PHOFAs between the Commonwealth and the States and Territories were seen as very problematic for monitoring expenditure for HIV initiatives, especially State and Territory spending on health-promotion campaigns targeting gay men. This raises the question of whether adequate levels of funding have been maintained by the states and territories, a matter dealt with in more detail in Section 2.4. The Review Panel was unable to ascertain the level of funding that has underwritten the Strategy; nor was it able to make any comparisons with investment levels during previous HIV/AIDS Strategies.

Another critical concern is the state of the HIV/AIDS partnership. This is discussed in Section 2.3.2, but it should be borne in mind that the health or otherwise of the partnership is perceived to have a direct influence on the degree and effectiveness of the Strategy's implementation. The Panel considers that the current Government

places high value on the establishment and maintenance of an effective, working partnership in the HIV/AIDS area. A number of other examples of the value placed on partnership were also cited, including in connection with domestic violence and the health of Indigenous Australians.

Some participants argued that the current National HIV/AIDS Strategy does not take account of the need for effective evaluation of implementation outside a formal review process. They claimed that the Commonwealth is now less directly involved in program activities and, with the advent of the PHOFAs, the focus has shifted to the states and territories, who now undertake the majority of program activity.

Most submissions claimed that ANCAHRD's dual role—being responsible for both hepatitis C and HIV—diminishes its capacity to adequately concentrate on either.

Achievement of Strategy objectives

Creation of an enabling environment

Review participants considered that, thus far during its term, the Strategy has achieved some notable successes in relation to establishing and maintaining an enabling environment. Within this context, the Review Panel is impressed by the achievements of the ANCAHRD Legal Working Party in bringing change and awareness in areas as diverse as health privacy, human rights, anti-discrimination, public health and criminal law, and the sex industry. One example of this innovative work is the development of a Rights Analysis Instrument (measuring legislative reform) through which Australia might monitor its progress in achieving real equality for minority groups identified by the Strategy.

The issue of greatest concern to Review participants was the impact of current Commonwealth policies relating to illicit drugs and injecting drug use. The majority of submissions asserted that harm-reduction activities were being affected by a change in political emphasis and direction and that efforts were being too strongly directed at supply reduction. There was a perception that education and prevention initiatives for injecting drug users were in decline, paving the way for a potentially catastrophic change in the HIV/AIDS epidemic. It was also suggested that the culture of illicit drug use was changing—a move from heroin to amphetamine use, in the wake of a shortage in the heroin supply—but that there had been no corresponding change in HIV prevention and education campaigns. Further, it was argued that Commonwealth funding for treatment programs for illicit drug use might be better invested in the most effective programs, such as medicated withdrawal and expansion of substitution therapy, in addition to abstinence-based therapy.

All Review participants agreed that the Commonwealth should ensure that there continues to be non-partisan, whole-of-government support for the response to HIV/AIDS. The Review Panel is strongly appreciative of the enabling political environment made possible by bipartisanship in the past and considers its continuance a prerequisite for any future strategic success. Revitalisation of the Parliamentary Liaison Group was proposed by some as a useful way of stimulating and sustaining this bipartisan support.

HIV/AIDS-related health promotion, including disease prevention

This Strategy, like its predecessors, places strong emphasis on prevention and health promotion. This has meant that health-promotion programs continue to make up a large proportion of the initiatives under the Strategy. A wide range of national information resources have been produced, and various education programs have been developed—for schools, for specific community groups, for sporting clubs, and so on. This has made an important contribution to reducing HIV transmission.

But Review participants were of the view that commitment to health-promotion programs, at both federal and state and territory levels, has eroded somewhat. Most concerns stemmed from a perception that real funding for programs at the state and territory level had been reduced, particularly for community programs, but that this could not be confirmed because of the nature of the PHOFAs. Despite the lack of hard data, the Review Panel feels that significant under-resourcing is occurring in health departments at both jurisdictional levels, and it is concerned at the possible loss in the public sector of the ‘critical mass’ and knowledge needed to support the response.

Many participants also referred to the need to pay much more attention to the epidemic—both existing and potential—among people in custodial settings. Conditions in prisons were described as falling well short of good practice for prevention and health promotion, especially given the often short-term stays in custody, the movement of inmates within the prison system, and the types of behaviour (injecting drug use and forced and consensual unsafe sex between men) common in custodial institutions.

Treatment, care and support

Review participants concentrated on the changing nature of living with HIV—namely, that the virus is now a chronic illness and that infection is treated in the context of a more ‘medicalised’ environment than ever before. This situation has a number of consequences for people living with HIV and AIDS.

Prime among these is the need to consult a large number of medical professionals (and pay each one) and the need to manage increasingly complex treatment regimes and a multitude of side effects. A number of participants proposed the implementation of a ‘one stop shop’ model, where a number of medical services can be accessed at one location. The GP Enhanced Care Pilot Project in New South Wales, currently under way with Commonwealth funding, was cited as a commendable move; there were calls for it to be extended.

Most submissions also highlighted the importance of redressing the increasingly evident shortfall in the provision of mental health care for people living with HIV/AIDS. The growing complexity of living with HIV as a chronic illness means that the incidence of a broad range of mental health problems—particularly depression and dementia—among People Living with HIV/AIDS (PLWHA) is rising.

Further, on the basis of the evidence before it, the Review Panel considers that accommodation and housing support for PLWHA (of whom over 30 per cent live below the poverty line) seem to be inadequate.

Another concern raised was that a number of drug companies appear to be reluctant to make new therapies available through the Special Access Scheme and that this has potentially dire consequences for many PLWHA currently obtaining medication through the Scheme. The Review Panel did not receive detailed evidence about this.

In the Panel's view, the changing nature of treatment and care for PLWHA raises larger questions about the adequacy of current health system financing for HIV, and the subject should be examined in more detail.

Research

Research was not a primary focus of this Review because a concurrent review is focusing specifically on research related to the Strategy.

Nevertheless, broad support was expressed for HIV-related research and for the National Centres in HIV Research, and there was strong support for preserving an adequate level of resources for this purpose. The Review Panel notes the impressive reputation of Australian HIV researchers, and it reiterates the sentiments of the Strategic Research Review Team—that continued investment in a dedicated HIV research program is critical to a successful response to the epidemic.

As noted in Section 2.4, there are some major gaps in economic research, in understanding the rise of HIV in Victoria and South Australia, in surveillance, and in measuring Australia's response to HIV.

International assistance and cooperation

Internationally, Australia has been a very important and active participant in working to curb the HIV epidemic since the early 1980s. This has continued during the term of the current Strategy, with the HIV partnership working successfully on a number of fronts. For the most part, AusAID has led Australia's international efforts, although important and notable contributions have been made by other sectors, particularly Australian-based HIV/AIDS non-government organisations and the Department of Health and Ageing.

The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) took place in mid-2001, and Australia was represented by deputations from AusAID, the Department of Health and Ageing, and the Australian Federation of AIDS Organisations. Australia co-chaired the preparatory sessions and played a sizeable role in drafting the resultant declaration.

In addition, in October 2001 Melbourne hosted the International Congress on AIDS in Asia and the Pacific. As host nation, Australia was very well represented, and this was an opportunity to showcase Australia's achievements in HIV/AIDS to the rest of the region. Coinciding with the Congress was the Asia-Pacific Ministerial Forum on HIV and AIDS, which was sponsored by AusAID at the instigation of the Minister for Foreign Affairs and Trade, the Hon Alexander Downer, MP. The Forum aimed to heighten awareness of HIV among Ministers responsible for health (and other ministers) in the region and to facilitate the development of strategies for effective action against the virus in participating countries.

Many submitters to the Review felt that Australia's role in responding to the regional epidemic needs to be clarified and extended and that there has been insufficient linkage between the domestic response and the regional and international responses. This is discussed further in 2.3.4.

The priority health needs of Aboriginal and Torres Strait Islander peoples

The Review Panel received very little detailed commentary on the health needs of Aboriginal and Torres Strait Islander peoples.

Review participants noted the National HIV/AIDS Strategy's linkages with the National Indigenous Australians' Sexual Health Strategy; it was generally felt, though, that the challenges relating to Indigenous Australians' health in general were yet to be taken up. The Review Panel does not have the capacity to explore in detail the impact of the HIV/AIDS Strategy on Indigenous Australians' health and on the delivery of population health programs in Indigenous communities. Participants noted, however, that the ANCAHRD structure does include a committee with responsibility for Indigenous Australians' sexual health and recommended that this be retained. They also suggested that mainstream population health areas need to be more mindful of Indigenous concerns when planning their activities.

The strong support from the previous Health Minister, the Hon Dr Michael Woodridge, for health initiatives specific to this population group was also noted.

2.3.2 The appropriateness, strength and effectiveness of the partnership

The second term of reference requires the Review Panel to:

Assess the appropriateness, strength and effectiveness of the *partnership* in representing and progressing responses to HIV/AIDS through an analysis of the roles, responsibilities and activities of:

- ◆ the Commonwealth Government, State and Territory governments, and local government;
- ◆ the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) and the Inter-governmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD);
- ◆ research, medical, scientific and health care professionals;
- ◆ the Non-Government Organisation and community sectors.

The Commonwealth Government, state and territory governments, and local government

The submissions revealed general agreement that the Commonwealth should continue to play a leadership role in tackling the HIV/AIDS epidemic, both within Australia and regionally. Some submissions called for the Commonwealth to lead more strongly and, specifically, for any future governance structures to focus on the provision of advice as opposed to taking an active implementation role.

A number of participants argued that there was a need to retain knowledge and capacity within government at both the state and territory and the Commonwealth levels to effectively support HIV policy development and program implementation. There was concern that this fourth Strategy does not clearly define the respective roles of government at all jurisdictional levels and that information exchange and accountability between levels of government have faltered as a result. The relationship between ANCAHRD and the IGCAHRD is relevant here, and the Review Panel notes reports from some participants that the two bodies have not always interacted effectively. It was considered that an effective working relationship between ANCAHRD and IGCAHRD (or their successors) was essential to the achievement of objectives under any future Strategy.

Associated with this is the argument put forward by some in the community sector that the Commonwealth Government's focus on achieving key Strategy goals has tapered off.

ANCAHRD and IGCAHRD

Strong arguments were put forward by a majority of Review participants in relation to the effectiveness and future role of the ANCAHRD structure. At one end of the spectrum, ANCAHRD was viewed as a reasonably effective body that could be improved with modifications. At the other end, it was argued that ANCAHRD has become dysfunctional and requires radical reform.

The main criticisms concern the complexity and size of ANCAHRD's structure, a lack of clarity about the role of members, and inexplicable criteria for membership in some instances. In addition, a number of participants alluded to an element of 'territoriality' on the part of a number of stakeholders who hold positions within the ANCAHRD structure. This was seen as posing a barrier to the effective functioning and evolution of the advisory framework as individuals and various stakeholders direct their efforts at maintaining status or protecting funding. It was broadly felt that communication within ANCAHRD could be improved.

In the absence of working synergies between HIV and hepatitis C, most comments favoured separate advisory mechanisms for HIV/AIDS and hepatitis C—reporting to and advising the Minister independently—in place of the current single advisory structure (ANCAHRD). A large number of participants argued for dissolution of ANCAHRD's Clinical Trials and Research Committee and for its responsibilities to be taken up by the principal disease-focused committees. Views differed about the positioning of the Indigenous Australians' Sexual Health Committee, but most participants considered that it should sit alongside, advise and have the same status as the disease-specific committees. Small, task-oriented or time-limited working parties were generally regarded as a more efficient way of dealing with particular issues.

Overall, participants' primary theme was the lack of clarity about the role of ANCAHRD and how that body relates to the Department of Health and Ageing. This has produced tensions that need to be resolved in any future Strategy.

The Review Panel notes the submissions from a number of individuals sitting on ANCAHRD and its committees. It is surprised that ANCAHRD itself failed to present a submission.

Research, medical, scientific and health care professionals

The effectiveness of the partnership with respect to research is discussed in the report of the Strategic Research Review.

The non-government and community sector

There was universal agreement that the non-government and community sector has played an important and effective role in implementation of the fourth National HIV/AIDS Strategy. National non-government organisations such as the Australian Federation of AIDS Organisations and the National Association of People Living with HIV/AIDS have been active in the development of national policy, through representation on major Strategy committees and through political lobbying. They have also played a vital role in health-promotion and treatment and care initiatives. Any future Strategy should preserve the centrality of people living with HIV/AIDS.

However, a small number of Review participants asserted that some non-government organisations working in the sector were preoccupied with protecting their funding or position, or both, in the sector and that this was detrimental to the value of their contribution to the response, and to the partnership in general. There was also concern that some had lost their focus on their mission.

Some community sector participants claimed that people who have been part of the response since the early years are experiencing a sense of ‘exhaustion’ and that this is resulting in the disengagement of many gay men from the response. They argued that this trend needs to be reversed as a matter of urgency, to preserve gay men’s central place in the response and to keep open the communication channels with the health-promotion and prevention efforts.

2.3.3 Transferability to other chronic diseases

The third term of reference requires the Review Panel to ‘examine the transferability of approaches, partnerships, principles and services in HIV/AIDS to other chronic diseases’.

The Panel received few comments on this term of reference. The general opinion was that the HIV model had potential for applicability to other chronic diseases but that this would best happen through individual adaptation and tailoring by those with expertise in the particular area of application.

2.3.4 Australia’s role in the Asia–Pacific region

The fourth term of reference requires the Review Panel to ‘examine the impact of HIV/AIDS in the Asia–Pacific region, analysing the role Australia might play in providing assistance, and identifying which bodies might most appropriately implement Australia’s role’.

Many Review participants nominated HIV/AIDS in the Asia–Pacific region as an important emerging area of involvement for Australia.

The Review Panel acknowledges the major contributions of AusAID and the Minister for Foreign Affairs and Trade, the Hon Alexander Downer, MP, to dealing with HIV in Australia's region. In particular, the Panel considers that Minister Downer and Dr Michael Wooldridge, the then Minister for Health and Aged Care, displayed strong leadership in convening the Asia-Pacific Ministerial Forum on HIV and AIDS, bringing together for the first time 33 Ministers from 31 countries in the region.

Participants generally agreed that a significant component of AusAID's program has been devoted to HIV and that primary responsibility for Australia's international contribution rests with that agency.

There was also general agreement that Australia has enormous potential to contribute but thus far has not done enough to apply its expertise and experience to help countries in the region tackle the epidemic. Most participants viewed the apparent lack of collaboration between relevant government agencies—particularly the Department of Health and Ageing and AusAID—to bring about a whole-of-government response to HIV in the region as a central factor in need of redress. In particular, a number of participants noted the need for a strong structural link between the Ministers for Health and Foreign Affairs, in recognition of the critical role effective measures will have in assuring ongoing development in the region.

It was considered that AusAID's contractual requirements and procedures constrained access to the expertise in Australia and the deployment of that expertise in the region. The agency's contracting procedures are currently under review, with a view to developing a more flexible and accessible process.

Even though AusAID established an HIV/AIDS Taskforce in early 2002, to better coordinate regional efforts, it was argued that government agencies such as the Department of Health and Ageing and Department of Immigration and Multicultural and Indigenous Affairs are still insufficiently involved.

2.3.5 Links with other national strategies

The fifth term of reference requires the Review Panel to:

Identify and analyse strategic links with other National Strategies, including the National Hepatitis C Strategy 1999–2000 to 2003–04, the National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99 (as extended) and the National Drug Strategic Framework 1998–99 to 2003–03, having regard to the quality, strength and extent of those links.

A number of Review participants claimed that the synergies anticipated between the HIV/AIDS Strategy and Hepatitis C Strategy had not materialised to the extent originally envisaged. Almost without exception, participants considered that hepatitis C and HIV should continue to have separate strategies but that the single advisory mechanism is not working. Nevertheless, it was recognised that dialogue between the two areas has been important—particularly with regard to common risk groups—and that this should continue.

In the Review Panel's opinion, although observations about the lack of synergies were common, it is difficult to see where efforts have been made to discover and act on the

synergies between the HIV/AIDS and Hepatitis C Strategies. In the absence of such efforts, the lack of synergies is almost a foregone conclusion.

The Review Panel considers that, on balance, good opportunities still exist for collaboration between the Strategies identified by the Terms of Reference, but this observation does not extend to the permanent sharing of advisory mechanisms.

2.4 NEW PRIORITIES, NEW DIRECTIONS

The sixth term of reference requires the Review Panel to:

Identify any

- ◆ new or shifting priorities; and/or
- ◆ gaps in implementation; and/or
- ◆ barriers to achieving sustained control of HIV in Australia,

which might reshape the strategic response to HIV/AIDS and inform the next phase of Australia's public health response to the HIV/AIDS epidemic and other related communicable diseases.

In this section, seven important areas of work for Australia's future HIV/AIDS response are discussed:

- ◆ responding to the changing HIV/AIDS epidemic
- ◆ national leadership
- ◆ governance and advisory structures—principles of partnership
- ◆ measuring and understanding our response to HIV/AIDS
- ◆ research supporting the Strategy
- ◆ international and regional action
- ◆ a whole-of-government approach.

The recommendations that accompany them argue for a fifth National HIV/AIDS Strategy, with substantial changes to the current mode, level, scope and intensity of work.

2.4.1 Responding to the changing HIV/AIDS epidemic

In this section six questions are posed and discussed:

- ◆ Are our programs appropriate and sufficient?
- ◆ Do we really have an enabling environment?
- ◆ Are we doing enough in custodial settings?
- ◆ What are we doing about heterosexual transmission of HIV?
- ◆ Do our surveillance systems work well enough?
- ◆ Do we provide sufficient training and professional development?

Are our programs appropriate and sufficient?

If we look at the changing nature of the HIV/AIDS epidemic, it appears there are many areas where the breadth and intensity of Australia's efforts are insufficient. Among these areas are the following:

- ◆ Rates of unprotected anal intercourse and related STIs, such as gonorrhoea, among men who have sex with men—especially young gay men, gay men in rural and remote areas, and men who have sex with men but are not attached to the gay community—are unacceptably high.
- ◆ At the places with greatest potential for reducing transmission—such as 'sex on premises' venues, beats, other gay venues, and via online cruising—there is a need to improve prevention education, condom distribution, promotion of counselling and testing for HIV and STIs, and promotion of non-occupational post-exposure prophylaxis for men who have sex with men.
- ◆ In 'sex on premises' venues, regulation of compliance with the 'duty of care'¹ should be improved. This has been done in some states by working with venue owners, state and local governments, and AIDS Councils to develop codes of practice for these venues. However, developing support for, and enforcing, an agreed code of conduct calls for considerable work across the country. One anecdotally raised concern that needs to be investigated is the availability of illegal 'party' drugs in 'sex on premises' venues, which may be increasing the risk of transmission of HIV and STIs.
- ◆ Detection and treatment of STIs—in their own right and as important co-factors for HIV transmission—need to improve. This is confirmed in Victoria, for example, by high levels (10–15 per cent) of asymptomatic gonorrhoea and chlamydia being found in men screened at 'sex on premises' venues and in HIV-positive men screened at HIV clinics.
- ◆ Greater access to and uptake of voluntary counselling and testing for HIV and other STIs among people at highest risk are necessary. As with many other public health problems, voluntary 'screening' is a vital part of the overall approach to decreasing morbidity and mortality.

We also need to increase our understanding of, and develop a response to, the impact that the high level of use of recreational drugs (as documented in a number of studies) might be having on the levels of unsafe sex.

¹ This refers to an assumed 'duty of care' on the part of venue owners, to help their clients stay as healthy as possible.

Recommendation 29

The Review Panel recommends that a major new national education program on prevention be developed with the states and territories and key stakeholders—for the term of a fifth National HIV/AIDS Strategy and beyond—to decrease rates of unprotected anal intercourse, related STIs (gonorrhoea and chlamydia) and HIV transmission among men who have sex with men. This program should include, among other things:

- ◆ development and enforcement of agreed codes of conduct within all ‘sex on premises’ venues—including prevention education, condom distribution, promotion of HIV and STI counselling and testing, and promotion of non-occupational post-exposure prophylaxis for men
- ◆ development of new communication and community-based programs to reach young gay men, men who have sex with men but are not attached to the gay community, and gay men living in rural and remote areas
- ◆ development of a national annual sexual health check-up program for men who have sex with men, along with continuing public campaigns to increase the availability of and participation in counselling and testing
- ◆ review and updating of HIV-testing guidelines.

Do we really have an enabling environment?

Much has been done during the term of the current Strategy to ensure that the legislative, regulatory and social environment continues to support the development and maintenance of safe behaviours. The legislative frameworks for anti-discrimination, regulation of the sex industry, human rights, and health privacy have been maintained and, in some cases, strengthened.

However, as was observed in many submissions, there seems to be a diminution in the ‘enabling environment’ for injecting drug users; this is attested to by difficulties in the operation of NSPs, either because of problems with public liability insurance or as a result of community pressure, and increasing police harassment deterring users from returning used syringes.

There has also been a significant increase in the overall number of injecting drug users and an increase in the number of users who may have a limited understanding of English and little connection to mainstream supports—information, testing and counselling, for example. It has been reported that injecting drug users no longer see HIV as a priority, their concern now being directed predominantly at hepatitis C.

An erosion of political (and some community) support for harm-reduction approaches seems to be occurring. This may be a result of the increasing number of injecting drug users, their increasing visibility, and the ‘nuisance’ caused by using on the street. It may also be a result of perceptions of harm reduction as consisting only of needle and syringe distribution, rather than the broad spectrum of activities including prevention

education and referral to detoxification, substitution therapy or abstinence-based therapy.

As part of the Needle and Syringe Program Returns-On-Investment Study (undertaken by Health Outcomes International and others), a recent review assessed the effectiveness of NSPs in 103 cities and towns (67 of them without NSPs). It found that the cities and towns that had introduced NSPs had a mean annual 18.6 per cent decrease in HIV seroprevalence compared with a mean annual 8.1 per cent increase in cities and towns that had not introduced NSPs. It also found that an estimated 25 000 HIV infections have been prevented among injecting drug users since the introduction of NSPs in Australia. Further, the study report states, 'There have been significant financial savings accruing to government from the investment in NSPs to date, and ... these savings will continue to accrue into the future' (Department of Health and Ageing 2002).

There is also consensus that, because of successes to date, there is considerably less public discussion about and emphasis on the potential for an explosion of HIV among injecting drug users—as was witnessed in Vancouver.

A number of approaches to harm reduction are hotly debated, particularly the questions of supervised injecting facilities, syringes with retractable needles, and medically prescribed heroin. Given the nature of the debate, it is important that all these options be subject to rigorous scientific evaluation—as, for example, is happening with the trial of a supervised injecting facility in Sydney.

Recommendation 30

The Review Panel recommends that harm-reduction approaches, in their broadest sense, be strongly supported from the funding and policy-level perspectives. This includes:

- ◆ needle and syringe programs
 - development of best-practice models for NSPs—for example, referral systems and local community management systems involving police, traders, residents, pharmacists, local government, non-government organisations and magistrates courts
 - support for expanded hours
 - provision of sterile water
 - workforce development
- ◆ availability of medical detoxification
- ◆ a broad range of substitution therapies—methadone, buprenorphine, and so on
- ◆ availability of abstinence-based therapies
- ◆ connections to and from the prison systems—see also recommendation 32
- ◆ peer education programs
- ◆ an education program for decision makers and the general community.

Recommendation 31

The Review Panel recommends that new approaches to harm reduction—such as the use of supervised injecting facilities, syringes with retractable needles, and medically prescribed heroin—be rigorously evaluated.

Are we doing enough in custodial settings?

The current National HIV/AIDS Strategy nominates ‘people in custodial settings’ as a priority population for HIV prevention, yet, as one Review participant described it, prisons appear to be ‘prevention-free zones’. On the basis of reported levels of injecting drug use in prisons and the very high rates of hepatitis C, the Review Panel can only assume that the relatively low levels of HIV are a matter of good luck, not good management.

We need a better understanding of the realities of prison behaviours, such as injecting drug use and forced and consensual unsafe sexual activity, which, despite attempts to prevent them in virtually every country, place a great number of prisoners at risk of HIV, hepatitis C and other blood-borne and STIs. There is also tremendous mobility of prisoners through the prison system—the huge majority are in prison for less than six months and often for drug-related offences—and from prison to prison.

Evidence from countries such as Switzerland suggests that NSPs in prisons are effective for both prisoners and prison staff—they are much less likely to receive a needlestick injury from a hidden needle and syringe—but these programs are yet to be introduced in Australia.

Progress in custodial settings will probably be slow, but it is essential that prison staff and management are consulted, educated and supported in developing more effective approaches.

Recommendation 32

The Review Panel recommends that, in close collaboration with the states and territories, a national HIV prevention and care program for prisons be developed. This should include:

- ◆ increased availability and uptake of both substitution-based and abstinence-based treatments for drug users in prisons
- ◆ strong continuing engagement with prison officers and their unions to develop programs—for example, in-prison needle and syringe exchange programs—that benefit the officers as well as the prisoners.

What are we doing about heterosexual transmission of HIV?

A number of Review participants expressed concern about the emergence of new HIV infections among people reporting heterosexual sex as their only risk factor.

Although, as noted in Section 2.2.5, the number of new HIV diagnoses attributable to heterosexual contact has been relatively constant in the past 10 or so years, there appears to be a need to develop prevention education and treatment and care programs for culturally and linguistically diverse communities that are at high risk.

Recommendation 33

The Review Panel recommends that culturally and linguistically diverse communities at high risk of HIV transmission be added to the other priority groups in the current Strategy—Aboriginal and Torres Strait Islander peoples, people who inject drugs, people in custodial settings, sex workers, and the male and female partners of these people—and that a national program be developed with the states and territories to reduce transmission in these communities.

Do our surveillance systems work well enough?

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. Increased support is needed from the National Centres in HIV Research to assist state-level surveillance, which would in turn improve the quality of the national data. The increased effort would include coordination in relation to the following:

- ◆ data on individuals being tested as well as infected individuals
- ◆ the introduction of new technologies such as detuned ELISA testing, which can indicate new HIV infections, not just new diagnoses
- ◆ surveillance of viral loads
- ◆ behavioural surveillance of unprotected anal intercourse
- ◆ active surveillance for HIV, in addition to the current passive surveillance
- ◆ organised laboratory networks collaborating with researchers and clinicians.

Despite the interest in safe-sex education across the country for 15 years, we have no system of estimating the sales, distribution and availability of condoms, one of the key indicators of success. Estimates of condom use are gained from intermittent and periodic surveys such as the Gay Community Periodic Survey.

Similarly, there is no national database on the distribution and availability of needles and syringes.

Recommendation 34

The Review Panel recommends that the next-generation national program of epidemiological, behavioural and clinical surveillance be developed. This should include new testing technologies, such as the detuned ELISA test, and indicators such as HIV testing patterns, viral load, unprotected anal intercourse, condoms, and needles and syringes.

Recommendation 35

The Review Panel recommends that one of the main performance indicators for the National Centre in HIV Epidemiology and Clinical Research be the extent to which the Centre builds surveillance capacity with the states and territories.

Do we provide sufficient training and professional development?

Notwithstanding the excellent contribution of the Australasian Society for HIV Medicine, one of the symptoms of the declining interest in the response to HIV/AIDS is diminished investment of effort in the continuing training and professional development of our national workforce—be they NSP workers, primary care and specialist services, community educators, volunteers or senior decision makers. Big investments were made in this area in the early years of the epidemic in Australia; this needs to continue if we are to successfully prevent and treat HIV as well as maintain strong community and bipartisan political support.

Recommendation 36

The Review Panel recommends that a national workforce-development program be designed and implemented with the states and territories and key stakeholders.

2.4.2 National leadership

Bipartisan political support has been one of the central elements of Australia's response since the beginning of the HIV/AIDS epidemic. The Review Panel congratulates all sides of politics in Australia for this and strongly endorses its continuity.

But the price of ongoing success with HIV prevention and treatment is eternal vigilance at the national level.

Some Review participants asserted that the Commonwealth's role has diminished noticeably during the term of the current National HIV/AIDS Strategy, and the Review Panel is concerned lest the national response be allowed to continue to diminish in importance. The human and financial costs of avoidable and treatable HIV infection are too great for the Commonwealth to 'take its hand off the tiller'.

The Review Panel acknowledges that all major stakeholders strongly support a continuing and stronger central leadership role for the Commonwealth. This should be in the following areas:

- ◆ funding—particularly for national peak organisations such as the Australian Federation of AIDS Organisations, the Australasian Society for HIV Medicine and the Australian Injecting and Illicit Drug Users League
- ◆ policy—which has to be developed and agreed to at the national level
- ◆ research—through specific directed research centres and projects that respond to national priorities
- ◆ coordination and partnership development—where the Commonwealth can act as an ‘honest broker’ between the states and territories and between the many community-based, non-government and government partners
- ◆ international assistance—which can really only be effective from a national standpoint
- ◆ the whole-of-government approach. In particular, the area of care and support for people living with HIV increasingly involves other sectors and government portfolios such as those responsible for labour, welfare, housing and transport.

Recommendation 37

The Review Panel recommends that the Commonwealth revitalise its national leadership role through enhanced funding, policy development, research, overall coordination, support for the partnership, and international assistance.

2.4.3 Governance and advisory structures: principles of partnership

Governance and advisory structures must be able to provide the best possible advice to and support for government and the Minister. Many submissions to the Review evinced a lack of confidence in the leadership, functioning, membership, and the cumbersome and expensive nature of the current advisory structure. There appears to be little effective communication and cohesion between the different parts of the structure, and concern was expressed that decisions were often made outside the various committees.

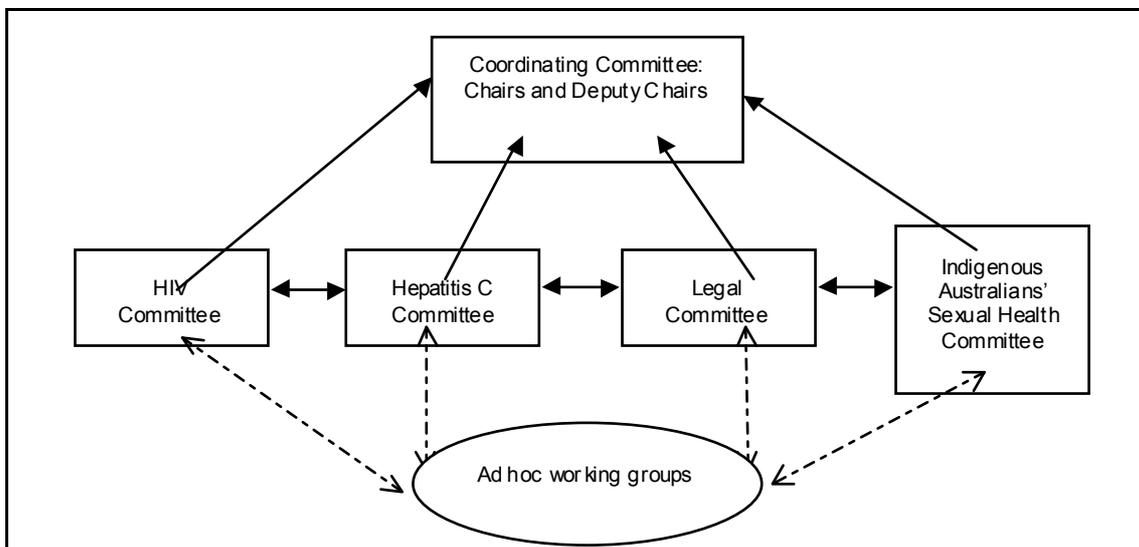
No submissions or oral presentations argued for retention of the existing structure and system of governance.

The structures and the accompanying processes should operate in such a way as to reflect the principle of partnership.

To improve the current structure, the Review Panel advocates the dissolution of ANCAHRD and its Clinical Trials and Research Committee and the establishment of four new committees—HIV, Hepatitis C, a Legal Committee, and an Indigenous Australians’ Sexual Health Committee (see Figure 2.1)—with a Coordinating

Committee consisting of the Chairs and Deputy Chairs of each Committee and reporting to the Minister.

Figure 2.1 Proposed new governance structure



The Review Panel recommends that the Minister appoint the Chairs and Deputy Chairs and have the option of appointing a rotating Chair and Deputy Chair of the Coordinating Committee or appointing an independent Chair and Deputy Chair. Membership of the advisory committees should represent a judicious balance between people with acknowledged expertise and representatives of key stakeholders: often, but not always, these two qualities are present in one person.

The setting up of time-limited, task-focused working groups at any time in order to solve problems is to be encouraged. These groups would report to the relevant committee.

In order to optimise the membership, leadership and operational functioning of the advisory structure, the Review Panel proposes the development of a Governance Charter, which will clearly define the membership criteria for and roles of the Coordinating Committee, the four advisory committees, the working groups, the Department of Health and Ageing, and other relevant departments. This would ensure that none of the advisory committees or the Coordinating Committee takes on an executive role, that they have clear processes for developing and providing advice, and that the Department of Health and Ageing retains its executive role.

The Review Panel further recommends that the Department increase its capacity to maintain the Commonwealth's leadership role, to service the advisory committees, and to implement the advice it receives.

An important mechanism that needs to be revitalised is the Parliamentary Liaison Group, at the federal level and most probably at the state and territory level, to assist with feedback to and from key parliamentary figures.

Some Review participants suggested that there was no longer a public role for the key members of the current advisory structure. Given the reduced public visibility of HIV/AIDS at present, the Review Panel disagrees and strongly supports an enhanced public role for these people.

Many participants referred to the lack of a national strategy dealing with STIs. Despite noting previous failed attempts to develop a national sexual health strategy, they strongly supported the development of a strategy more focused on prevention and treatment of STIs.

Recommendation 38

The Review Panel recommends that the current governance structure be dissolved and that four advisory committees be established—HIV, Hepatitis C, a Legal Committee, and an Indigenous Australians' Sexual Health Committee—with coordination achieved through a committee of Chairs and Deputy Chairs.

Recommendation 39

The Review Panel recommends that a Governance Charter be developed to clearly define the respective roles of the different elements of the new governance structures—for example, advisory committees, working groups and government departments.

Recommendation 40

The Review Panel recommends that the Commonwealth Parliamentary Liaison Group be revitalised and supported and be seen as a very important element of the national response.

Recommendation 41

The Review Panel recommends that consideration be given to developing a national strategy for STIs, to rekindle interest in working with Australia's young people.

2.4.4 Measuring and understanding our response to HIV/AIDS

A number of submissions commented on the difficulty of monitoring and obtaining information about the level of funding support from the states and territories and claimed that this had been much easier through the Matched Funding Program. It would appear that, given the structure and reporting requirements of the current PHOFAs and the projected Health Care Agreements—combined with the fact that in many of the states and territories, particularly the larger states, the proportion of Commonwealth funding to state funding is relatively minor—seeking reporting through these mechanisms is neither a productive nor an efficient way of finding out about the response to HIV in Australia.

One of the shortcomings of this Review is the lack of an evaluation framework and the lack of evaluation studies to guide the Review. It seems that there has been minimal follow-up on much of the excellent work done for the evaluation of the third National HIV/AIDS Strategy. There is very little information about the resources (inputs), products (outputs) and outcomes from investments in HIV/AIDS during the fourth National Strategy.

We have in Australia the capacity to understand the status of the epidemic, but we have much less capacity to identify the magnitude and effectiveness of our responses to the epidemic. An example of this is the claim that the community response has diminished through lack of funding, yet the bigger AIDS Councils in particular have very large staff components—approximately 110 in New South Wales and 55 in Victoria. It seems we just don't have the information to respond adequately to these claims.

Similarly, submissions from state governments claimed that there have been reductions in the Commonwealth contribution to the response to HIV through the PHOFAs, but the Review Panel has little or no evidence on which to judge the veracity of this claim.

Recommendation 42

The Review Panel recommends that a framework for continuing evaluation of the National HIV/AIDS Strategy be developed and implemented.

Recommendation 43

The Review Panel recommends that a biennial, comprehensive study to identify, document and track over time the responses to HIV/AIDS at the national, state and territory and local levels² be developed and carried out.

2.4.5 Research supporting the Strategy

Generally, the submissions from policy makers and practitioners expressed a high degree of satisfaction with the quality and relevance of the epidemiological, behavioural and social research supporting the Strategy. In particular, there are effective links from research to practice and from practice to research.

Despite the value of the economic research noted in Section 2.2.5, one important gap involves continuing research into the cost-effectiveness of HIV prevention and treatment programs overall and their various components and sub-components. Given Australian governments' and parliaments' increasing focus on value for money, this capacity needs considerable development—as it does in other aspects of health care.

² This would be of great use to all stakeholders: it would provide information far superior to that which could be obtained through the proposed use of the PHOFAs and Health Care Agreements as a means of reporting.

There has been much debate about the recent rises in HIV diagnoses in Victoria, yet the National Centres in HIV Research have done little to help elucidate the problem. Some Review participants suggested that the partnership should be more involved in setting the priorities of the National Centres.

Recommendation 44

The Review Panel recommends that resources be specifically dedicated to the establishment of new and continuing capacity to analyse and monitor the economic benefits and costs to government and the community of HIV programs and their components and sub-components.

Recommendation 45

The Review Panel recommends that the National Centres in HIV Research commit increased effort and resources to understanding changing trends in unprotected anal intercourse, gonorrhoea and HIV infection in Victoria and South Australia.

Recommendation 46

The Review Panel recommends that the agenda for the National Centres in HIV Research be set by means of a consultative process at three-year intervals, with provision for rapid responses to emerging problems as they arise.

2.4.6 International and regional action

The Review Panel examined only the role of the Department of Health and Ageing and its advisory structures in Australia's international HIV/AIDS work: there was neither the opportunity nor the time to adequately assess overall performance in this area.

The Review Panel does note, however, that the Australian Government, through AusAID and the Department of Health and Ageing, is showing a great deal of commitment to HIV/AIDS in our region and, to a lesser extent, in Africa. The Panel appreciates that HIV/AIDS is not only a health problem and a human rights problem; it is also a major developmental challenge and is even being seen as a matter of national security in our region. Many Asian countries are now recognising the seriousness of the situation. The Association of Southeast Asian Nations (ASEAN) has also led initiatives in this regard.

Among the problems reported is the difficulty Australian institutions and experts experience in finding out about and gaining access to initiatives supported by AusAID, and particularly the tendering process. AusAID has already taken steps to remedy this by conducting a forum in April 2002 to bring together domestic institutions, experts and representatives of AusAID and the major aid contracting firms. To be effective, this needs to become a systematic, regular mechanism for improving the deployment of human resources in Australia's international work;

examples are the Asia–Pacific Leadership Forum, assistance to the Seven Sisters, and direct country-to-country aid projects.

The Department of Health and Ageing has had an important role as a broker and facilitator (as well as a direct contributor) of the skills and experience developed in Australia and internationally in the last 20 years. Among the areas where it can make a further contribution are the following:

- ◆ development and maintenance of the human resource base to service the many AusAID- and non-government organisation-sponsored HIV/AIDS projects
- ◆ development, with AusAID, of a system that will ensure better integration of Australia's research (and project) capacity to support aid projects. The primary focus of the research would be building capacity in other countries
- ◆ monitoring and supporting Australia's role in the World Trade Organisation and in connection with the Agreement on Trade Related Aspects of Intellectual Property Rights as it affects HIV/AIDS and other relevant treatments
- ◆ monitoring and resourcing Australia's response to the UNGASS and our involvement in the UNAIDS Programme Coordination Board and firmly encouraging the other co-sponsors—especially the World Bank, UNICEF, WHO and the United Nations Development Programme—to adequately support UNAIDS and each other.

Although partnerships do exist between AusAID and the Department of Health and Ageing, the Review Panel recommends that the Department's international role be enhanced and that a formal relationship at officer level be developed. This is to ensure cross-department synergies; it should also include representation from the Department of Foreign Affairs and Trade and the Department of Immigration and Multicultural and Indigenous Affairs, and two representatives from the HIV Committee.

Recommendation 47

The Review Panel recommends that a cross-sectoral working group—with representation from the Department of Health and Ageing, AusAID, the Department of Foreign Affairs and Trade, and the Department of Immigration and Multicultural and Indigenous Affairs, plus co-opted representatives from the HIV Committee (or from elsewhere outside government)—be established to expand and coordinate Australia's international role in HIV/AIDS. The working group should report to the HIV Committee of the new governance structure.

Recommendation 48

The Review Panel recommends that the Department of Health and Ageing work with AusAID to develop a mechanism for improving the participation of Australian experts in our international response.

2.4.7 A whole-of-government approach

The Review Panel stresses the importance of further developing a whole-of-government approach to managing HIV at both the domestic and the international levels. It is, however, apparent that a whole-of-government approach does not 'just happen' and that the structures, processes, incentives and resources must be there if progress is to be made.

As discussed in Section 2.2.5, HIV has become a chronic illness rather than a terminal one, and as a result its management has become increasingly complex. A number of submissions noted the success of the recently trialled 'one stop shop' system in high-caseload general practices in New South Wales.

Review participants mentioned a number of issues that require integrated and sophisticated management across a number of government and community sectors. Among these are the effects of proposed changes to pension benefits on income support for people living with HIV/AIDS and the effects changes to the Medical Benefits Schedule and the Pharmaceutical Benefits Schedule are having on access to treatments for these people.

Other important concerns for many participants are the increasing need for (and lack of availability of) mental health services and the supported accommodation and housing needs of people living with HIV/AIDS.

All the major submissions to the Review also noted the fact that many people who are infected with HIV or at risk of infection are ineligible for Medicare entitlements. This includes (with some exceptions) people who are not permanent residents of Australia and people who are in prison. Among the reasons for providing care to HIV-infected people who are currently ineligible for Medicare entitlements are the retardation of disease progression, and the consequent reduction in hospitalisation costs, and the reduction in the potential for further transmission of HIV.

Recommendation 49

The Review Panel recommends that task-focused, time-limited working groups—reporting to the HIV Committee—develop national approaches to complex cross-government questions such as:

- ◆ income support for people living with HIV/AIDS
- ◆ access to therapies
- ◆ models of care for people living with HIV/AIDS, including evaluation of the GP Enhanced Care Pilot Project in New South Wales
- ◆ mental illness services
- ◆ supported accommodation and housing for people living with HIV/AIDS
- ◆ Medicare ineligibility.

2.4.8 The need for a fifth National HIV/AIDS Strategy

The Review Panel strongly urges that a fifth National HIV/AIDS Strategy be developed—as a means of responding to the changing epidemic and to reinvigorate the national response.

As the foregoing recommendations demonstrate, it is the Review Panel's view that the changes that are necessary are much more than simple refinements of the current Strategy. Significant improvements are needed—in the governance of the national response; in the breadth and intensity of the response at the national, state and territory, and community levels; and in our monitoring of and knowledge about the response itself and the contributions made by the key stakeholders.

Recommendation 50

The Review Panel recommends that a fifth National HIV/AIDS Strategy be developed to further develop and implement the foregoing recommendations. The Strategy should cover the three years from 2004–05 to 2006–07 and should be reviewed in mid-2006.

2.5 APPENDIX A THE REVIEW'S TERMS OF REFERENCE

The Minister for Health and Ageing approved the following Terms of Reference for the Review:

1. Assess the extent to which the current National HIV/AIDS Strategy has been effective, having particular regard to
 - ◆ the Strategy's position in a broader communicable diseases context;
 - ◆ the degree to which it has been implemented;
 - ◆ the achievement of Strategy objectives listed under the following five priority areas
 - the creation of an enabling environment;
 - HIV/AIDS related health promotion, including disease prevention;
 - treatment, care and support;
 - research; and
 - international assistance and cooperation.
 - ◆ the priority health needs of Aboriginal people and Torres Strait Islanders.
2. Assess the appropriateness, strength and effectiveness of the *partnership* in representing and progressing responses to HIV/AIDS through an analysis of the roles, responsibilities and activities of:
 - ◆ the Commonwealth Government, State and Territory governments, and local government;
 - ◆ the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) and the Inter-governmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD);
 - ◆ research, medical, scientific and health care professionals;
 - ◆ the Non-Government Organisation and community sectors.
3. Examine the transferability of approaches, partnerships, principles and services in HIV/AIDS to other chronic diseases.
4. Examine the impact of HIV/AIDS in the Asia-Pacific region, analysing the role Australia might play in providing assistance, and identifying which bodies might most appropriately implement Australia's role.
5. Identify and analyse strategic links with other National Strategies, including the *National Hepatitis C Strategy 1999–2000 to 2003–04*, the *National*

Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99 (as extended) and the National Drug Strategic Framework 1998–99 to 2003–03, having regard to the quality, strength and extent of those links.

6. Identify any

- ◆ new or shifting priorities; and/or
- ◆ gaps in implementation; and/or
- ◆ barriers to achieving sustained control of HIV in Australia,

which might reshape the strategic response to HIV/AIDS and inform the next phase of Australia's public health response to the HIV/AIDS epidemic and other related communicable diseases.

2.6 REFERENCES

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