
# Australia's Response to HIV/AIDS 1982-2005

Report Prepared for Research and Dialogue Project on Regional Responses to the Spread of HIV/AIDS in East Asia organised by the Japan Center for International Exchange and the Friends of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Japan)

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## Preface and Acknowledgments

This paper was commissioned by the Lowy Institute for International Policy in response to the invitation extended by the Japan Centre for International Exchange to participate in the seminar on Regional Responses to the Spread of HIV/AIDS in East Asia to be held in collaboration with the Friends of the Global Fund (Japan) in Tokyo in June 2005.

It outlines the major elements of Australia's response to HIV/AIDS as they developed over the nearly 25 years since the first case of AIDS was detected in Australia in 1982.

Since 1982, the many facets of Australia's response to HIV/AIDS have been recorded in a great number of monographs, reports, memoirs, theses and scholarly works, books, articles and journals.

A search of the scientific databases will quickly produce a full technical description of the Australian HIV/AIDS epidemic.

However, despite several attempts, no single comprehensive work has been written that covers the entire breadth and depth of the Australian response to HIV/AIDS, accurately records the outstanding contributions made by many individuals to the suppression of HIV/AIDS in Australia, and draws the key lessons from the Australian response that might be applied to the steadily worsening global HIV/AIDS epidemic.

Such an overarching work remains to be written.

This monograph outlines the policies and principles that Australians followed in responding to the threat posed by HIV/AIDS and that have kept Australia's HIV/AIDS infection rates so low for so long.

It was written by William Bowtell, a senior research fellow with the Lowy Institute for International Policy.

As senior political adviser to the Australian Minister for Health between 1983-87, and as senior political adviser to the Australian Prime Minister (1994-96), the author was very closely involved in the crucial early years of the Australian response to HIV/AIDS, the development of a strategic national political response to HIV/AIDS, the creation of HIV/AIDS political advisory structures, the implementation of successful preventive education campaigns and the shaping of media and communications strategies for dealing with HIV/AIDS issues.

He has also held a variety of senior positions in HIV/AIDS civil society organisations, including a term as President of the Australian Federation of AIDS Organisations.

In preparing this report, the author interviewed and consulted widely with many individuals who made crucial and invaluable contributions to the quality and depth of the Australian response to HIV/AIDS.

A list of these individuals, and the institutions they represent, is contained at **Attachment D.**

The author is very grateful for their comments and suggestions that immeasurably improved the quality of this report.

In particular, the author would like to thank Dr Alex Wodak of the Drug and Alcohol Service at St Vincent's Hospital, Sydney, Associate Professor David Plummer, of the University of New England and Mr Don Baxter, Executive Director of the Australian Federation of AIDS Organisations for their expert assistance and advice.

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The author thanks the National Centre in HIV Epidemiology and Research for permission to reproduce several of its HIV/AIDS statistical tables, Professor David Plummer and Dr Lyn Irwin for permission to reproduce their table on Australian federal government funding, and the assistance and information provided about Australia's international response to HIV/AIDS by Ms Annmaree O'Keeffe of AusAID and the Department of Foreign Affairs and Trade.

This report draws upon, but does not necessarily reflect, the views and opinions of all those consulted in its preparation.

This report does not represent the views of the Lowy Institute for International Policy.

The views and conclusions expressed in this report are solely those of the author who assumes total responsibility for this report, and the analysis and conclusions it contains.

Sydney
May 2005

## Executive Summary

The first case of acquired immune deficiency syndrome (AIDS) was diagnosed in Australia in November 1982 and the first death from AIDS occurred in July 1984.

Since then, and as at 30 September 2004, in Australia there have been 23,989 cases of human immunodeficiency virus (HIV) infection and 9,392 cases of AIDS resulting in 6,459 deaths from AIDS.

After a rapid increase in HIV/AIDS caseload in the mid-1980s, cases of new HIV infection declined significantly when the HIV epidemic did not take hold in the general heterosexually active population but was largely contained to those groups first affected by HIV.

For nearly two decades, Australia has controlled the spread of HIV/AIDS, and maintained very low rates of new HIV infection relative to comparable countries.

Consequently, many thousands of young Australians have been spared from infection and early death from HIV/AIDS; and Australian governments relieved of the financial burdens of treating a much larger HIV caseload.

Australia's relatively successful response to HIV/AIDS came about because the Australian people, civil society organisations, clinicians, researchers and provincial and national governments fashioned timely, practical and imaginative responses to the complex political, social, economic and public health challenges posed by the HIV/AIDS epidemic.

Australia built its response to HIV/AIDS from the grass roots up, not from the top down.

Public concern and mobilisation and action by communities first affected by HIV/AIDS obliged Australia's national and provincial governments to respond quickly, generously and creatively to the threat posed by HIV/AIDS.

Out of the tumultuous early years of the Australian response to HIV/AIDS, a partnership evolved between Australian national and provincial governments and political leaders, HIV/AIDS clinicians and researchers, and community groups and organisations involved with HIV/AIDS.

For nearly 25 years, this partnership has provided a solid framework for development of HIV/AIDS policies encompassing prevention, education, treatment, care and research.

This partnership developed and advocated a range of HIV/AIDS policies that were crucial in the continuing management of HIV/AIDS in Australia.

The key **policies** were:

- timely, peer-based, direct and explicit preventive education campaigns directed both at high-risk groups and the general public;
- widespread introduction of subsidised needle and syringe exchanges and rapid expansion of methadone maintenance treatment;
- access to free, anonymous and universal HIV testing;
- subsidised access to AZT and subsequent anti-retroviral treatments;
- general advocacy of the need to adopt safer sexual practices, especially the use of condoms;
- widespread availability of condoms and targeted safe sex messages;
- creation of an enabling political environment that encouraged some very socially marginalised groups (injecting drug users, sex workers) to be involved in the national response;
- removal of political and legislative barriers to enable effective preventive education and action – for example, the passage of legislation to prevent discrimination on the grounds of sexual orientation and HIV-status;
- the building of strong scientific and social research capacity and institutions.

These policies were based on several basic **principles**:

- the primacy of empirical research and evidence in making policy;
- the need to minimise risk to the general population;
- recognition of the importance of research especially epidemiology, clinical treatment, retrovirology and social science;
- respect for human rights buttressed as required by legislation
- collaboration and partnership between all stakeholders;
- long-term over short-term thinking.

Successive Australian national governments have assumed the responsibility for fashioning and funding National HIV/AIDS strategies around these core policies; and building administrative structures to develop, guide and implement detailed HIV/AIDS policies covering education, treatment, research and care.

Importantly, in the early years of the epidemic structures were created that brought together national and provincial health ministers, parliamentarians, clinicians and community groups to develop HIV/AIDS policies.

These political structures helped to build broad parliamentary and public understanding and acceptance of the need for sometimes unwelcome and controversial measures necessary to contain HIV/AIDS.

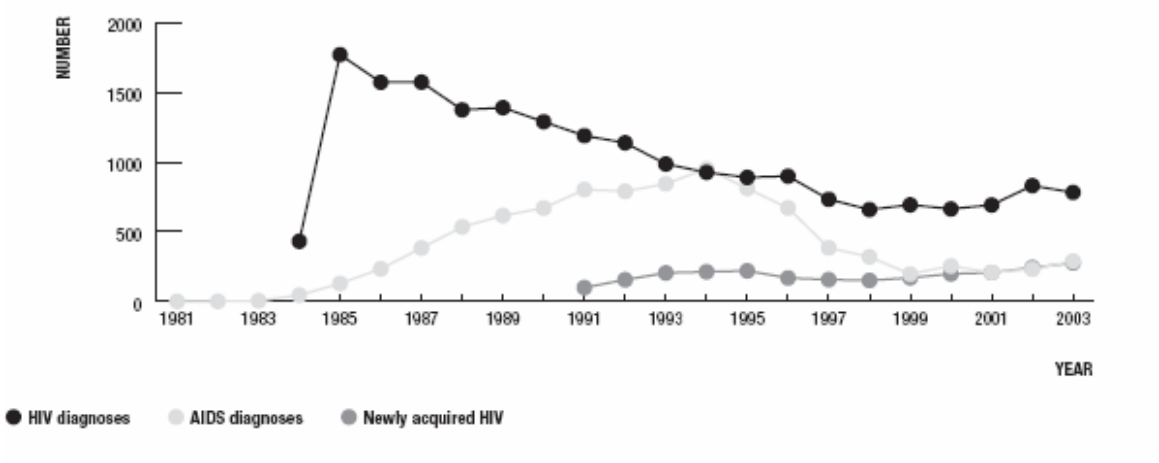
With some occasional difficulties, Australian public and political support has been sustained for these HIV/AIDS policies for over two decades.

As a result, Australia has very successfully contained HIV/AIDS infection broadly to those groups initially affected by the virus – men who have sex with men (MSM), injecting drug users(IDUs), haemophiliacs and those transfused with HIV-infected blood prior to the introduction of universal HIV testing and screening.

Largely due to the introduction of needle and syringe programs from 1986 and the rapid expansion of methadone treatment programs, the spread of HIV into the general heterosexually active community was greatly contained.

As a consequence of these policies, Australian HIV infection rates fell sharply in the mid-1980s, and have been sustained at very low levels for nearly 20 years.

**Figure 1**
**Number of diagnoses of HIV infection[1] and AIDS in Australia**
1 HIV diagnoses adjusted for multiple reporting. AIDS diagnoses adjusted for reporting delays.




Source: National Centre in HIV Epidemiology and Clinical Research, 2004 Annual Report

Over the 1990s, the HIV/AIDS epidemic in Australia settled into a “steady state”.

While the numbers of Australians living with HIV/AIDS increased from 13,737 in 1994 to 20,580 in 2003 as a result of the introduction of new and improved treatments, the numbers of annual new HIV cases stabilised around 800 cases per year, declining from 890 new cases in 1995 to 782 new cases in 2003.

In recent years, however, there has been a small but significant increase in the rate of new HIV infections.

In Australia, HIV/AIDS is still almost exclusively confined to the MSM and IDU communities in Sydney, Melbourne and the larger cities.

The recent rise in HIV infection rates seems related to a more general increase in the incidence of sexually transmitted infections amongst both homosexually and heterosexually active people as a result of a decline in condom use and higher propensity for risk taking among homosexual men as a result of less effective public education campaigns promoting safer sex practices.

The recent increase in rates of HIV and sexually transmitted infection (STI) infection among young people seems also to reflect:

- increased usage and acceptance of a range of licit and illicit drugs conducive to increased sexual activity;
- fatigue about HIV and increasing rejection of safer sex practices among older gay men;
- declining coverage of HIV issues in the Australian media;
- few recent government-funded general HIV/AIDS awareness campaigns.

In Australia, increasing HIV rates, while off a small base, are part of a larger pattern of increasing rates of sexually transmitted infections (STIs) of all kinds.

**International Comparison**

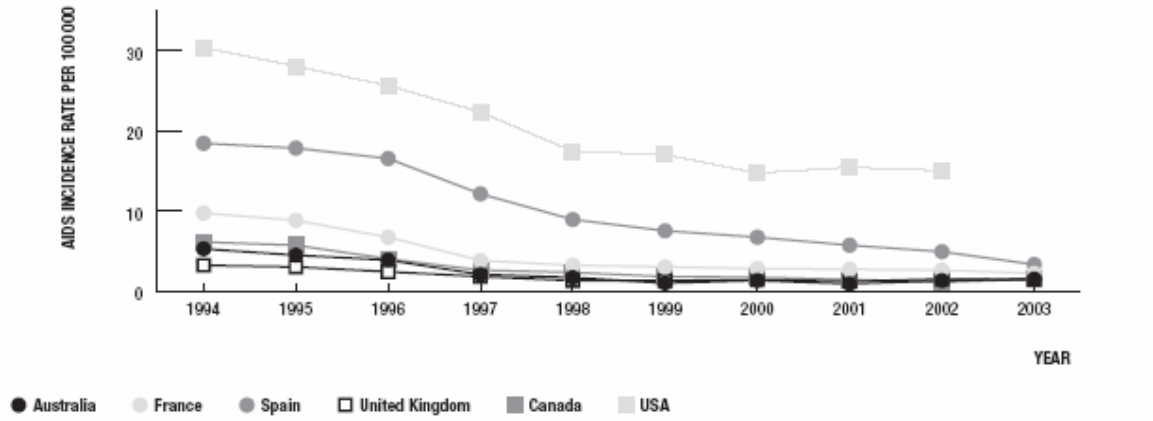
Australian rates of HIV and AIDS infection are now well below those of the United States of America, France and Spain, and comparable with those of Canada and the United Kingdom.

AIDS incidence and estimated HIV prevalence in Australia at the end of 2003 were 1.5 and 69 per 100,000 population respectively.

AIDS incidence in Australia in 2003 was similar to that recorded in the United Kingdom and Canada, and was substantially lower than in France (2.2), Spain (3.3) and the United States (15.0 in 2002).

Within the Asia-Pacific region, estimated HIV prevalence in Cambodia, Myanmar and Thailand was substantially higher than that in Australia in 2003.

**Figure 2**




Source: National Centre in HIV Epidemiology and Clinical Research, 2004 Annual Report

**The Paradox of Prevention**

Increasing HIV/AIDS and STI rates demonstrate the paradox of prevention**.**

The more successfully HIV/AIDS infection rates were kept under control, the fewer dedicated human and financial resources were directed by governments at HIV/AIDS in favour of redirecting resources to other more apparently pressing public health issues.

Over the 1990s, many Australian governments assumed that the worst of the HIV/AIDS crisis had passed.

They chose to “mainstream” HIV/AIDS funding and services within the context of general sexual health programs, the response to other related diseases including Hepatitis C and other STIs and general expenditure on medical and scientific research.

At the national level, the Australian government remained ostensibly committed to renewal of the National HIV/AIDS Strategy.

In practice, however, the national government has paid less attention to sustaining the partnership between government, clinicians, researchers and community groups that had been so successful in controlling HIV/AIDS since 1982.

As a consequence of this drift, Australian governments, clinicians, researchers and HIV community organisations have been slow to develop and implement new education campaigns targeted at both the general and at-risk communities.

In recent months, there have been encouraging signs of a renewed mobilisation of interest and resources by governments and community organisations to address the deteriorating HIV situation in Australia and regionally.

**Australia's International Response to HIV/AIDS**

Australian governments, institutions and individuals have a demonstrated record of success in managing the many complexities of the HIV/AIDS epidemic.

Their immense experience and practical knowledge is available to countries committed to limiting the spread of HIV/AIDS in their own borders, and regionally.

Internationally, Australia has been an active contributor to the World Health Organisation's efforts to contain the spread of HIV/AIDS, and the work of UNAIDS (and its predecessor the Global Program on AIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria and other specialised HIV/AIDS organisations.

Australia has also been aware of its particular responsibility to its neighbours in the Asia-Pacific region.

It has developed substantial bilateral HIV/AIDS programs with several regional countries, with particular emphasis on Pacific Island countries and territories.

In July 2004, the Australian Minister for Foreign Affairs committed the Australian government to spending $A600 million over six years to 2010 on its international HIV/AIDS initiative *Meeting the Challenge*, managed by AusAID and the Department of Foreign Affairs and Trade.

This initiative complements a wide range of projects developed over two decades between Australian universities, research institutions, government and non-government agencies, HIV/AIDS community groups, religious, charitable and welfare organisations and individuals wishing to adapt and apply Australia's experience of combating HIV/AIDS to other countries.

The relatively low rates of HIV/AIDS prevalence in most Asia-Pacific countries means that there is still an opportunity available to implement structures and programs that might cost-effectively prevent a rapid escalation of HIV infection rates in many Asia-Pacific regional countries.

**HIV/AIDS: Beliefs Based on Evidence**

Empirical and tested evidence clearly indicates which programs and policies have worked in Australia to control the spread of HIV/AIDS infection, and to best treat and care for those with HIV/AIDS infection.

The greater the number of cases of HIV/AIDS prevented, the greater the amount of finite resources that can be devoted to treating those with HIV and AIDS.

Effective HIV/AIDS prevention also spares individuals, their families and loved ones, and the community needless and avoidable suffering.

If HIV/AIDS is to be controlled, the only effective measures that have been demonstrated to work are those tried and tested over 20 years in those countries that were first exposed to HIV/AIDS.

Yet such policies can only be applied where there is strong political will and committed leadership to overcome fear, prejudice, intolerance and inertia.

## 1. Present state and future directions of the spread of HIV/AIDS in Australia

**Figure 3**

| Characteristic | Year of HIV diagnosis ≤94 | 95 | 96 | 97 | 98 | 99 | 00 | 01 | 02 | 03 | Total[2] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total cases** | **15 991** | **928** | **899** | **820** | **752** | **713** | **748** | **761** | **839** | **848** | **23 306** |
| Males (%) | 93.4 | 91.9 | 91.2 | 89.4 | 87.0 | 89.5 | 89.2 | 87.8 | 88.7 | 89.0 | 92.1 |
| **Median age (years)** | | | | | | | | | | | |
| Males | 32 | 34 | 34 | 34 | 35 | 35 | 35 | 35 | 35 | 36 | 33 |
| Females | 29 | 30 | 28 | 30 | 30 | 28 | 30 | 29 | 32 | 31 | 29 |
| **State/Territory (%)** | | | | | | | | | | | |
| ACT | 1.2 | 1.9 | 0.8 | 1.0 | 1.1 | 1.1 | 1.5 | 1.0 | 0.6 | 0.6 | 1.2 |
| NSW | 59.9 | 58.0 | 50.5 | 52.7 | 53.0 | 52.3 | 48.5 | 44.7 | 47.5 | 49.3 | 57.0 |
| NT | 0.5 | 0.2 | 0.6 | 1.3 | 1.6 | 0.7 | 0.4 | 0.5 | 1.0 | 0.6 | 0.6 |
| QLD | 9.1 | 11.9 | 16.1 | 13.8 | 13.8 | 17.3 | 15.2 | 13.8 | 15.6 | 14.9 | 10.9 |
| SA | 3.5 | 3.3 | 5.1 | 4.3 | 4.7 | 3.1 | 3.1 | 5.7 | 3.6 | 5.2 | 3.7 |
| TAS | 0.4 | 0.6 | 0.3 | 0.0 | 0.4 | 0.4 | 0.0 | 0.7 | 0.6 | 0.0 | 0.4 |
| VIC | 20.5 | 17.7 | 20.2 | 22.0 | 18.6 | 19.5 | 25.1 | 27.2 | 25.9 | 24.0 | 21.0 |
| WA | 4.9 | 6.4 | 6.3 | 4.9 | 6.8 | 5.6 | 6.2 | 6.4 | 5.2 | 5.4 | 5.2 |
| **HIV exposure category (%)[3]** | | | | | | | | | | | |
| Male homosexual contact | 81.2 | 74.0 | 75.2 | 72.9 | 65.4 | 65.4 | 68.4 | 66.5 | 71.1 | 74.0 | 77.3 |
| Male homosexual contact and injecting drug use | 3.6 | 5.3 | 4.2 | 4.8 | 4.8 | 6.3 | 3.3 | 5.1 | 4.0 | 4.2 | 4.2 |
| Injecting drug use[4] | 4.7 | 4.4 | 2.7 | 3.1 | 3.6 | 5.4 | 4.4 | 5.7 | 2.5 | 3.5 | 4.3 |
| Heterosexual contact | 6.1 | 15.1 | 16.8 | 18.1 | 25.1 | 21.9 | 23.4 | 22.1 | 22.1 | 18.0 | 11.2 |
| *Partner with/at risk of HIV infection* | *42.6* | *61.2* | *70.1* | *67.4* | *77.6* | *69.7* | *81.4* | *78.8* | *69.5* | *78.3* | *62.7* |
| *Not further specified* | *57.4* | *38.8* | *29.9* | *32.6* | *22.4* | *30.3* | *18.6* | *21.2* | *30.5* | *21.7* | *37.3* |
| Haemophilia/coagulation disorder | 2.4 | 0.1 | 0.0 | 0.0 | 0.1 | 0.5 | 0.0 | 0.1 | 0.0 | 0.0 | 1.4 |
| Receipt of blood/tissue | 1.8 | 0.3 | 0.2 | 0.1 | 0.6 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 1.2 |
| Mother with/at risk of HIV infection | 0.2 | 0.8 | 0.9 | 0.9 | 0.4 | 0.2 | 0.4 | 0.4 | 0.3 | 0.3 | 0.4 |
| Health care setting | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 | 0.1 |
| Other/undetermined | 19.6 | 7.5 | 9.5 | 9.0 | 7.8 | 9.1 | 8.2 | 7.4 | 10.0 | 9.6 | 16.4 |

1 Not adjusted for multiple reporting.

2 Total includes 7 cases for which the date of HIV diagnosis was not reported.

3 The 'Other/undetermined' category was excluded from the calculation of the percentage of cases attributed to each HIV exposure category.

4 Excludes males who also reported a history of homosexual contact.

Source: State/Territory health authorities

Source: National Centre in HIV Epidemiology and Clinical Research, 2004 Annual Report

After adjustment for reporting delay, 9,380 AIDS cases and 6,372 deaths following AIDS were notified in Australia, cumulative to 31 December 2003.

The number of HIV diagnoses, adjusted for multiple reporting, was 20,580 at the end of 2003.

An estimated 13,630 people were living with HIV/AIDS in Australia in 2003, including around 1,100 adult/adolescent women with diagnosed HIV infection.

The annual number of AIDS diagnoses in Australia has dropped from 952 cases in 1994 to 208 cases in 2001 and then increased to an estimated 290 cases in 2003.

The decline in AIDS incidence was due to a fall in HIV incidence occurring in the mid 1980s and the effectiveness since mid 1996 of combination antiretroviral therapy in delaying progression to AIDS among people whose HIV infection was diagnosed before AIDS.

The annual number of new HIV diagnoses, adjusted for multiple reporting, declined from around 930 in 1994 to 690 in 1999 and then increased to around 780 in 2003.

Reported diagnoses of newly acquired HIV infection also increased from 170 cases in 1999 to 277 cases in 2003, indicating the lower bound for the number of new HIV infections that have actually occurred in Australia over this time.

**Mode of Transmission**

Transmission of HIV infection in Australia continued to be mainly through sexual contact between men, which was reported in more than 85% of cases of newly acquired HIV infection diagnosed between 1999-2003.

HIV prevalence remained below 1% among people attending needle and syringe programs, prison entrants, and among men and women seen at sexual health clinics reporting a history of heterosexual contact and women with a history of sex work.

**Indigenous People**

Between 1994– 2003, 185 HIV diagnoses and 71 AIDS diagnoses were notified among indigenous people.

The *per capita* rate of HIV and AIDS diagnosis among indigenous people was similar to that among non-indigenous people but a higher proportion of HIV diagnoses in indigenous people was among women (33.7% as against 10.1%).

Exposure to HIV was attributed to male homosexual contact for the majority of diagnoses among non-indigenous people (67.5%) whereas an almost equal proportion of diagnoses among Indigenous people was attributed to male homosexual contact (38%) and heterosexual contact (37%).

**Overseas Born**

The rate of AIDS diagnosis among overseas born and Australian born people declined from 3.9 and 3.4 per 100,000 population, respectively, between 1994 – 1998, to 1.3 and 1.1 per 100,000 population between 1999– 2003.

**Survival After Diagnosis**

Survival following AIDS in Australia increased from 16.8 months for cases diagnosed prior to 1995 to 32 months for cases diagnosed in 2000.

**Antiretroviral Therapy**

An estimated 50% of all people living with HIV infection in Australia in 2003 were treated with antiretroviral therapy.

## 2.HIV/AIDS in Australia: 1982-2005

The first case of AIDS was diagnosed in Sydney in November 1982 and the first death from AIDS occurred in Melbourne in July 1983.

Both these cases were in gay men.

For the nearly 25 years since the HIV virus was first reported in Sydney in 1982, the HIV/AIDS epidemic has largely been confined to the two communities that were first infected – homosexually active men (men who have sex with men), and injecting drug users.

In the early years of the epidemic, several cases of HIV transmission were also recorded amongst haemophiliacs and other recipients of HIV infected blood products.

By the early 1990s however, the introduction of HIV testing, tighter controls on blood donors and more stringent treatment of blood products virtually eliminated this vector of new HIV infection.

Geographically, although HIV/AIDS cases have been reported from all Australian states and territories, the eastern, inner suburbs of Sydney remain the epicentre of the epidemic.

Between 1983 and 1985, HIV spread rapidly amongst some 4,500 MSM in the inner suburbs of Sydney, and to a lesser extent Melbourne, raising concerns that HIV would spread from MSM through IDU to infect the larger heterosexually active population.

In the event, this threatened “third wave” of HIV infection did not occur.

At the end of 2003, the cumulative number of HIV infections that had been diagnosed in Australia was estimated to have been 20,580, and an estimated 13,630 people were living with HIV infection.

Following a long-term decline, the annual number of new HIV diagnoses in Australia has gradually increased over the past five years, from around 690 cases in 1999 to around 780 in 2003.

Among these new diagnoses, an increasing number were in people who had acquired HIV infection within the previous year.

An estimated 50% of all people living with HIV infection were receiving antiretroviral treatment for HIV infection in 2003, slightly less than the 52% receiving treatment for HIV infection in 2002.

The long-term effectiveness of antiretroviral treatment in preventing progression of HIV illness remains unknown.

The annual number of AIDS diagnoses in Australia peaked at 952 diagnoses in 1994, declined to an estimated 208 diagnoses in 2001 and then increased to an estimated 290 cases in 2003.

The decrease in the number of AIDS diagnoses between 1994-2001 was due to the decline in HIV incidence that took place in the mid 1980s and to the use, since around 1996, of effective antiretroviral treatment of HIV infection.

A similar pattern of declining AIDS incidence between 1994–2001 followed by relatively stable incidence between 2002– 2003 has been reported in other industrialised countries such as the United States, Canada and in a number of European countries.

**The Politics of HIV/AIDS in Australia: Social and Cultural Environment**

The initial Australian response to HIV/AIDS was shaped by the political, social and cultural environment of the 1980s.

Since the 1960s, traditional political party structures had been displaced by emergence of political groups and movements determined to advance new social agendas.

During the 1970s and 1980s, these movements were responsible for significant recognition and improvement of the social and political status of women, homosexuals, indigenous peoples, ethnic minorities and disabled people.

By the time that HIV/AIDS first appeared in Sydney in 1982, these habits of social awareness, defence of human rights and political mobilisation were deeply ingrained in Australian life.

In particular, gay men, lesbians and their supporters had organised politically to force governments to recognise basic human rights, and to overturn legislation that criminalised gay sex and enshrined discrimination against gay men and lesbians.

Many of these activists and the structures that they created were adapted to the objectives of mobilising against HIV/AIDS.

From the very first months of the HIV/AIDS epidemic, Australian governments were therefore able to deal with organisations that broadly represented the interests of the gay community, and that could speak with the authority of many of those most closely affected by HIV/AIDS.

Similar groups quickly emerged that could speak knowledgeably and authoritatively on behalf of the other groups first affected by HIV/AIDS – injecting drug users, sex workers and haemophiliacs.

The emergence of these politically active groups occurred spontaneously and without direction from governments.

Having emerged, however, Australian governments swiftly saw the good sense of engaging these groups in HIV/AIDS policy formulation and development.

In 1989, the New South Wales government funded the establishment of the first organisation of drug users in Australia.

Subsequently, all other states and territories funded similar groups, and the federal government funded the national peak body representing drug users.

These consumer groups were therefore funded by governments to represent their communities and to provide education, care, treatment and other support services to their members and supporters.

In each state and territory, and at national level, permanent structures were established that represented at-risk communities – gay men, haemophiliacs, injecting drug users and sex workers.

Over time, many of these community activists were recruited into government departments where they became senior program administrators and policy developers.

The quality and depth of Australia's response to HIV/AIDS were greatly improved as a result.

## 3. Australian Governments' Response to HIV/AIDS

Australia has a federal system of government.

The Australian Constitution allocates functions and responsibilities between the federal government based in Canberra and six states and two self-governing territories.

The six states (with their capital cities in brackets) are: New South Wales (Sydney), Victoria (Melbourne), Queensland (Brisbane), Western Australia (Perth), South Australia (Adelaide) and Tasmania (Hobart).

The two territories are the Australian Capital Territory (Canberra) and the Northern Territory (Darwin).

Responsibility for funding and service delivery of Australia's public health system – primary care, hospital care, national health insurance, provision of subsidised pharmaceuticals, medical and scientific research – is split between the various levels of government.

It is therefore misleading to think of the Australian federal government as being solely responsible for creating and implementing Australia's response to HIV/AIDS.

While the Australian federal government accepted that it had a national responsibility to lead, coordinate and fund the Australian response to HIV/AIDS, responsibility for effective and efficient delivery of HIV/AIDS programs lay with the states and territories.

Most importantly, the initial impetus for action on HIV/AIDS in the early and mid 1980s came from community groups and individuals first affected by HIV/AIDS – gay men, injecting drug users, haemophiliacs, clinicians and researchers.

Australia's response was therefore one of "grass roots" activism pressuring governments first to acknowledge and then to fund the necessary steps to bring HIV infection under control, provide adequate care and treatment for those affected by HIV/AIDS and, over the long-term, to create administrative and bureaucratic structures that could sustain a multi-decade response to HIV.

From 1983, the Australian government, through the Minister for Health, led all Australian governments in a successful multi-sectoral effort to adopt a common national response to HIV/AIDS.

Working closely with HIV/AIDS community groups, clinicians and researchers, the Australian government determined to support radical changes in Australian public health policy to contain the threat posed by HIV/AIDS.

These measures included:

- the introduction of needle and syringe exchange programs;
- the widespread availability of free, anonymous and universal HIV/AIDS testing;
- the production of frank and imaginative HIV/AIDS education campaigns targeted at both the general community and high-risk groups – gay men, injecting drug users and sex workers;
- the promotion and greatly increased availability of condom use by all sexually active people; and
- the enactment of legislation banning discrimination towards people with HIV infection, or perceived to be infected with HIV.

As governments gained a greater understanding of the nature of HIV/AIDS, it became clear that responses to the epidemic were required across the whole of government, and not just the health portfolio.

Accordingly, governments and ministers with responsibility for social security and welfare, housing, drug law enforcement, immigration, insurance and superannuation, human rights legislation, scientific research, prisons and education became involved in developing HIV/AIDS policies in their areas of concern.

**Australian Political Parties and HIV/AIDS**

The centre-left Australian Labor Party (ALP) formed national government between 1983-1996.

Since 1996, the national government has been formed by a centre-right coalition of the Liberal and National Parties.

The coincidence of the election of the ALP government in March 1983, and the first reported cases of HIV/AIDS in November 1982, had great significance for the shaping of the Australian response to the epidemic.

The ALP was philosophically predisposed to a centralisation of political initiative at a national level, a nationally coordinated health system and a strong belief in preventive and community health programs.

Since their return to national government in 1996, the centre-right parties have endorsed and supported all major elements of the national HIV/AIDS strategy.

In particular, over the last decade the Australian government has greatly strengthened Australia’s international and regional response to HIV/AIDS.

At provincial level, over the 25 or so years of HIV/AIDS, governments have been formed comprising all shades of political opinion but all have approached HIV/AIDS with a similar spirit of pragmatism.

Furthermore, since the mid-1980s, successive national governments formed by different political parties have broadly agreed on the major elements of Australian national HIV/AIDS Strategy.

Innovative, but once-controversial, programs such as needle and syringe exchanges have been maintained and expanded, and governments have accepted the principle of frank, sustained and effective sex education targeted at young people.

Generally, governments have been unwilling to tamper with policies that have produced acceptable outcomes.

Australian public opinion accepts the need for continuing investment in effective HIV/AIDS preventive education campaigns, service delivery structures, social and medical research and needle and syringe exchange programs as the price of sustaining the lowest practically achievable level of HIV and AIDS infection.

Since 1982, Australia's major political parties have commendably not exploited HIV/AIDS for partisan political advantage, although from time to time individual politicians have attempted to do so.

Australian governments, political parties and the public can be expected to support the main pillars of the Australian response to HIV/AIDS as long as HIV/AIDS infection rates are maintained at current sustainably low levels.

However, a significant rise in new HIV infection rates would undoubtedly bring renewed focus on the key elements of HIV/AIDS policy-making.

**Medicare National Health Insurance System**

The nature of the Australian response to HIV/AIDS was greatly assisted by the fortunate coincidence of the introduction in 1984 of the Medicare system of national health insurance.

Under Medicare, all Australians are entitled to free access to medical and hospital treatment, and access to subsidised pharmaceuticals.

Medicare provided a structure of administration, funding and support that was immensely beneficial in delivering care, treatment and resources where they were most needed.

Through Medicare, those with HIV infection were able to access clinical care free of cost to them.

And through Medicare, the federal government funded the provision of HIV test kits, access to free, universal and anonymous HIV/AIDS testing and access to AZT and then subsequent antiretroviral therapies, again without cost to the patient.

In general, Australia has remarkably good health outcomes, although at 6.2% (2001) public health spending as a proportion of GDP is only about average for a developed country.

Likewise, Australia achieves remarkable health research outputs considering the size of its research investment (1.5% of GDP between 1996-2002).

**HIV/AIDS Partnership**

By the mid-1980s, a partnership had emerged that joined Australian governments, HIV-affected communities, clinicians and researchers in the fight against HIV/AIDS.

The partnership approach continues to be at the heart of Australia's response to HIV/AIDS.

The partnership is an effective, cooperative effort between all levels of government, community organisations, the medical, health care and scientific communities and people living with or affected by HIV/AIDS, all working together to control the spread of HIV and to minimise the social and personal impacts of the disease.

It is based on a commitment to consultation and joint decision-making in all aspects of the response.

While initially the involvement of many different interests, governments and civil society groups might have seemed more likely to confuse and delay an adequate response, the reverse was the case.

A wide range of organisations grew up representing those involved in prevention education, service provision, care and treatment, social and medical research, advocacy, charitable works and fund-raising.

**National HIV/AIDS Advisory Structures**

In order to coordinate advice and assistance from these groups, in November 1984 Australian Health Ministers established two national HIV/AIDS advisory structures – the National Advisory Council on AIDS (NACAIDS) and the AIDS Task Force.

The Australian government established the National Advisory Committee on AIDS (NACAIDS) as its peak advisory committee on prevention education, care and treatment of those living with HIV/AIDS and social policy for the entire Australian population and groups at high risk of acquiring HIV infection.

NACAIDS was given effective budget authority to develop and fund HIV/AIDS preventive education programs, and to negotiate with and on behalf of the Australian Department of Health, state and territory governments and civil society organisations on priorities and needs.

The AIDS Task Force was created as the peak body bringing together HIV/AIDS clinical and scientific expertise; and to recommend on the allocation of HIV/AIDS budgets for applied medical, scientific and social research.

The AIDS Task Force worked closely with two, and later three, specialised HIV/AIDS research bodies that emerged from universities and hospitals in Sydney and Melbourne in the 1980s.

Clinicians and researchers who were coping with a rapidly increasing HIV caseload also organised themselves into various groups concerned with primary care, epidemiology, drug trials and therapeutic research and social investigation and research.

The first substantive research initiatives were two ‘special units’ for AIDS research: the Virology Research Unit at Fairfield Hospital in Melbourne and the Epidemiology and Clinical Research Unit at St Vincent’s Hospital in Sydney.

These units were established in 1986 and were reconstituted as the National Centre for HIV Virology Research (NCHVR) and the National Centre for HIV Epidemiology and Clinical Research (NCHECR) respectively in 1990.

Social and behavioural research is of particular relevance to HIV prevention.

Accordingly, a third national research centre, the National Centre in HIV Social Research (NCHSR), was established in late 1990.

Federal and state governments also quickly funded these new bodies to give some order and process to establishing clear priorities in HIV/AIDS treatment, care and research.

Together, NACAIDS and the AIDS Task Force became the Australian government’s major sources of advice on HIV/AIDS policy, and worked closely with the Australian Department of Health to develop and implement these policies.

The creation of NACAIDS and the AIDS Task Force meant that innovative policy advice and ideas could be transmitted very quickly from those at the epidemic’s front line to Ministerial decision-making level.

And once decisions were taken, Ministers had confidence that policies would be implemented rapidly and effectively at the local and operational level.

With the adoption of each new HIV/AIDS strategy, the names of these advisory bodies have been changed, and some of their functions absorbed into other bodies.

However, the Australian Minister for Health is still advised by a national advisory body on HIV/AIDS and related diseases.

**Australian National HIV/AIDS Strategies**

With the establishment of NACAIDS and the AIDS Task Force, and the various state and territory based civil society organisations, the Australian government decided to draw up a comprehensive national HIV/AIDS strategy to guide future HIV/AIDS policy and priorities.

Over the 25 years of the HIV/AIDS epidemics, successive National HIV/AIDS strategies have been developed that reflect the changing nature of the Australian epidemic, deepening knowledge about the virus and assessments about the future course of the epidemic in Australia and regionally.

To date, Australian governments' commitment to a nationally coordinated response to HIV/AIDS has found expression in four successive national strategy documents.

While far from perfect, these Strategies have been exceptionally useful in establishing a shared view of HIV/AIDS amongst governments and the community, and recommending how always scarce financial and human resources should be allocated.

Australia's first National HIV/AIDS Strategy was released in 1989, following extensive consultation based on a discussion paper entitled *AIDS: a time to care, a time to act—towards a strategy for Australians.*

The first Strategy incorporated a number of concepts derived from the 1986 *Ottawa Charter for Health Promotion* that continue to guide Australia's response to the virus.

From the outset, Australia's response also had a number of distinctive features, among them the notion of partnership—between governments, affected communities, researchers, educators, and health care professionals— and the adoption of innovative education and prevention initiatives as a means of preventing the spread of the virus.

These features were retained in the second Strategy (1993-96), the third Strategy (1996-99) and the fourth Strategy (2000-04).

A fifth Strategy is currently being negotiated.

The third Strategy extended the experience gained in responding to HIV/AIDS to other diseases that are transmitted through similarly risky behaviours or affect similar target groups, or both.

The strategy document, *Partnerships in Practice*, emphasised the need to link and integrate related responses in an effort to sustain and maximise the population health benefit.

**Parliamentary Liaison Group(s) on AIDS**

The emergence of HIV/AIDS in the 1980s was a matter of great public and political interest and concern.

These concerns transcended traditional political party lines and divisions.

As the scale and nature of the epidemic became apparent, relentless and intense media coverage gave rise to interest and concern in all Australian parliaments.

In the mid 1980s, many confusing, contradictory, alarmist and often simply wrong claims were made about the threat posed by HIV/AIDS.

The decisions made by Australian governments to combat HIV/AIDS, while necessary, were radical and controversial.

In the 1980s, Australians were generally not accustomed to general media and frank public discussion of such issues as prostitution, anal sex and illicit drug use.

They were understandably resistant to government funding public education campaigns that broke social taboos and conventions.

And there was considerable public disquiet about the 1985 decision of Australian governments to commence needle and syringe exchanges with the objective of ensuring that those who used illicit drugs were not infected with HIV.

These public concerns were naturally reflected and debated in Australia's national, state and territory parliaments.

As public and political concern about HIV/AIDS rose, the Australian government responded by creating a forum in which Members of Parliament could discuss HIV/AIDS issues in a more structured and useful way.

Accordingly, in November 1985, the Australian parliament established the Parliamentary Liaison Group on AIDS (PLGAIDS).

The PLGAIDS brought together politicians of all parties with an interest in HIV/AIDS policy.

The PLGAIDS was provided with full briefings on the evolution of the epidemic and policy options likely to be considered by governments.

The PLGAIDS became a valuable conduit through which HIV/AIDS organisations could brief and lobby members of the federal parliament, and exchange views and concerns.

At times of unexpected developments that generated controversy and public debate, the work of the PLGAIDS served to create amongst parliamentarians a very high degree of awareness about HIV/AIDS that led to much better informed public debate about the key issues.

Several state and territory parliaments also established similar Parliamentary Liaison Groups that for many years performed valuable service in educating successive generations of parliamentarians and Ministers about HIV-related issues.

**Harm Minimisation/Needle and Syringe Exchange Programs**

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Perhaps the single most significant contributor to Australia's relative success in sustaining a low HIV infection rate was the adoption in 1985 of "harm minimisation" as the central principle underlying national policy on illicit drugs.

In April 1985, the Prime Minister and leaders of Australia's provincial governments met solely to decide a national approach to rising usage of illicit drugs.

This meeting became known as the Drug Summit and was the first time since the Second World War that Australia's political leaders had met to discuss non-financial matters.

This meeting approved and endorsed "harm minimisation" as the basis of Australia's response to abuse of illicit drugs.

Although not defined at the time, this term meant that reducing the adverse consequences of illicit drug use, and especially controlling HIV among injecting drug users, was an even higher priority than reducing drug consumption.

This enabled far greater policy flexibility than was available when the paramount alternative was considered to be reducing illicit drug consumption.

In November 1986, Australia's first pilot needle and syringe exchange was begun in the inner Sydney suburb of Darlinghurst, in contravention of then New South Wales law, but acting in conformity with harm minimisation principles agreed to the previous year by Australia's political leadership.

The testing of syringes returned to the Darlinghurst program detected an increase in HIV prevalence, suggesting that HIV was spreading among its clients.

The success of this scheme in detecting HIV, managing HIV-infected clients into treatment and distributing preventive education to injecting drug users led to its rapid expansion.

By 1987, community and public pressure obliged the New South Wales government to amend relevant laws so as to permit such exchanges to operate legally.

Other states and territories soon followed New South Wales in opening similar exchanges.

In 1987, Australia's health ministers endorsed and adopted needle and syringe exchange programs as a central element in the fight against HIV/AIDS, and agreed to provide continuing budgetary support for such programs.

Australian health ministers agreed that needle and syringe exchanges should be provided at public expense to encourage injecting drug users not to share equipment that might be infected with HIV and/or other blood-borne diseases.

This decision, which was adopted by all Australian governments, implicitly recognized the reality of widespread use of illicit drugs, especially by young Australians.

For nearly 20 years, needle and syringe programs have operated in all Australian states and territories, and under governments of all political persuasion.

It is abundantly clear from published research that needle and syringe exchange programs have been a crucial factor in containing HIV infection largely within the MSM and IDU communities and in preventing HIV infection from spreading into the community of heterosexually active Australians.

According to Australian National Council on AIDS, Hepatitis C and Related Diseases Report *Needle & Syringe Programs: a Review of the Evidence* (ANCHARD 2000), estimates of the cost-effectiveness of needle and syringe programs in Australia in 1991 were made using the base case (the most plausible), best case and worst case assumptions.

Needle and syringe programs were estimated to have prevented between 300 (worst case), 2900 (base case) and over 10,000 (best case) infections of HIV in 1991.

In the same year, $A10 million was spent on needle and syringe programs nationally, which produced savings of $A266 million.

The savings in treatment costs resulting from the prevention of HIV more than offset the operating costs of the programs.

Further, the analysis actually underestimated the likely cost-effectiveness of needle and syringe programs because it did not include savings from prevention of the transmission of hepatitis B and hepatitis C.

Had these additional benefits been measured, both the number of years of life saved and the net direct cost savings would have been substantially increased.

In 1999-2000, Australian governments and consumers spent some $A23 million on providing some 32 million needles and syringes to IDUs.

Almost all of these needles and syringes were returned or disposed of safely in a network of sharps boxes that has been built up around the country.

Sharps boxes are closed receptacles especially provided for the safe disposal of used needles and syringes.

Contrary to claims made before needle and syringe exchanges were introduced, no evidence has emerged in Australia or other countries to suggest a causal link between the availability of clean needles and syringes and any increase in the consumption of illicit drugs.

Compelling evidence has become available during the last two decades that needle and syringe programs are effective in reducing the spread of HIV/AIDS among injecting drug users.

When the magnitude of the threat of an HIV epidemic among and from injecting drug users was first fully recognised in Australia in 1985, there were only 2,000 heroin users in methadone maintenance treatment.

It was assumed that methadone maintenance treatment would reduce the risk of HIV and this program was therefore rapidly expanded so that by 2005, almost 40,000 Australians are receiving methadone maintenance treatment.

During this period, it has been confirmed that methadone maintenance treatment does substantially, indirectly reduce the risk of HIV infection.

**Figure 4**

**Expenditure ($A) and needles distributed by needle and syringe programs by Australian states and territories 1999/2000**

| | Government Expenditure ($'000) | Consumer Expenditure ($'000) | Total Expenditure ($'000) | Needles Distributed (000) |
|---|---|---|---|---|
| ACT | $531 | $8 | $539 | 593 |
| NSW | $9,827 | $463 | $10,290 | 11,566 |
| NT | n.a. | - | n.a. | 604[2] |
| Qld | $1,678 | - | $1,678 | 5,300 |
| SA | $787 | $43 | $830 | 3,018 |
| Tas | $484 | $138[2] | $622 | 1,381[2] |
| Vic | $4,767 | - | $4,767 | 6,177 |
| WA | $1,227 | $2,349[2] | $3,576 | 3,209 |
| **Total[1]** | **$19,673** | **$3,001** | **$22,674** | **31,848** |

[1] Data relates to government-auspiced NSPs only. Excludes expenditure on needle and syringes sold through pharmacies on a commercial basis.

[2] Includes figures imputed from data provided by State/Territory health authorities.

**HIV in Australian Prisons: A Major Concern**

Despite the demonstrable success of Australia's HIV/AIDS programs, Australian governments have failed dismally to implement the full range of effective HIV prevention measures in Australian prisons.

Additionally, the number of prison inmates has doubled during the last two decades and now approaches 30,000.

For a variety of political and industrial reasons, Australian governments have refused or been unable to provide prisoners with access to needle and syringe exchanges.

However, condoms are now provided in prisons in five jurisdictions.

The low rate of HIV prevalence amongst Australian prisoners of 0.2% percent reflects the low HIV prevalence rate in the general community, especially among injecting drug users who comprise almost half of the inmate population.

However, in common with prison systems around the world, Australian prison systems are potentially important sites for the transmission of blood-borne viruses, including HIV. (*Hellard and Aitken HIV in Prison: What are the risks and what can be done?* Burnet Institute for Medical Research Sep 2004).

Without preventive measures in place, there is a high risk of HIV infection being transmitted in Australia's prisons should general HIV infection rates rise.

However, it seems unlikely that Australian governments will move on this issue unless and until there is a significant rise in HIV rates among prisoners, especially if these infections can be traced to large numbers of people in the general community.

## 4. Civil Society Responses

### Domestic Reponses

As a robust democracy, Australia has a long history of mobilisation and organisation from the "grassroots up".

Citizens are accustomed to acting collectively to bring political pressure to bear on regional and national governments to create or change policy settings, and to fund new initiatives.

While Australians look to government to play a large part in social and political life, they generally do not wait for government to act, but move to shape and mould government's responses.

The emergence of HIV/AIDS brought forth an immediate response from individuals and then groups closest to the problem – gay men, injecting drug users, haemophiliacs, sex workers, clinicians and researchers.

Community activism, largely within the gay communities of Australia's larger cities, led to the establishment of AIDS Action Committees in key state capitals.

The first of these was in Sydney in May 1983 (the NSW AIDS Action Committee) followed by the Victorian AIDS Action Committee (VAAC) in Melbourne in July 1983.

These AIDS Action Committees were later reconstituted as AIDS Councils, which continue today as the peak state non-government HIV/AIDS organisations.

These groups responded to public and media interest and concern about HIV/AIDS.

They soon began to lobby politicians about the need to respond creatively and flexibly to the rapidly increasing rates of HIV and AIDS infection and caseload.

At the same time, HIV/AIDS community groups rapidly educated their peers about the nature of the emerging threat.

These groups rapidly acquired substantial specialised knowledge about HIV/AIDS and its impact on the interests they represented.

This knowledge was of great value in dealing with their own clients and members, and in informing government deliberations and policy formulation.

Using ad hoc funding from existing federal, state and territory governments, agencies and health institutions and community groups mobilised their members around practical HIV/AIDS education and outreach.

As the following table demonstrates, those most affected by HIV/AIDS took steps that decisively reduced new HIV infection rates, and gained valuable time until a coordinated national response could be organised and funded.

**Figure 5**

**National HIV Incidence in Australia from 1980 to 1993 calculated using back projection techniques (column 2). Federal HIV/AIDS funding earmarked for education and prevention for the financial year beginning 1 July of that year**

| Year | HIV Incidence Estimates | Australian Federal Govt Dedicated HIV/AIDS Funding ($AUDmillion) |
|---|---|---|
| 1980 | 10 | - |
| 1981 | 60 | - |
| 1982 | 540 | - |
| 1983 | 1930 | - |
| 1984 | 2890 | 1.61 |
| 1985 | 2630 | 4.29 |
| 1986 | 1960 | 7.75 |
| 1987 | 1260 | 9.545 |
| 1988 | 870 | 10.97 |
| 1989 | 740 | 12.715 |
| 1990 | 710 | 20.284 |
| 1991 | 680 | 17.586 |
| 1992 | 580 | 20.217 |
| 1993 | 450 | 16.156 |

**From: Grassroots activities, national initiatives and HIV prevention: clues to explain Australia's dramatic early successes in controlling HIV.**
**David Plummer** PhD, University of New England, Australia
**Lyn Irwin** PhD, University of New England, Australia

Community group education and action thus brought about a sharp fall in new HIV/AIDS infection rates before large-scale national government funding for prevention could be put in place.

Australian governments quickly recognized the crucial role that these civil society organisations were playing in managing the HIV/AIDS epidemic, and in ensuring that HIV/AIDS public policy was soundly based, practical and effective.

Accordingly, Australian governments decided to wholly or partly fund many of these civil society organisations to assist in their key functions – service delivery, advocacy and representation, information collection and distribution and participation in the political process.

Most of these organisations were established in the early years of the HIV/AIDS epidemic, and have now been in existence for the best part of 20 years.

In the 1990s they quickly recognised the global dimension of the epidemic and made the linkages between Australian domestic and international responses.

Together with many Australian-based NGOS and international organisations who were concerned with the impact of HIV in other countries from a humanitarian perspective, they mobilised political support, funding and helped export Australian technical expertise and programming lessons.

Many Australians currently engaged in global HIV/AIDS responses through the UN system or global networks such as the Red Cross, first gained their experience in Australia.

The key Australian civil society organisations that emerged in the 1980s to represent or respond to the needs of communities most closely affected by HIV/AIDS are listed at **Attachment A**.

## 5. Corporate and Union Responses

In general terms, the Australian corporate sector has not contributed greatly to the national response to HIV/AIDS.

Australian businesses responded to HIV/AIDS almost purely within the context of occupational health and safety concerns for its workforce and customers.

This has been particularly the case in those industries and sectors concerned with food preparation and service, hospitality, nursing and medical care.

The emergence of HIV/AIDS greatly increased corporate awareness of the risks posed by the spectrum of blood-borne viruses, and the need for greatly improved standards of care in the preparation and delivery of goods and services where transmission of such viruses was possible.

Individual companies have, of course, chosen to support HIV/AIDS causes, and to associate themselves with a progressive social approach on HIV/AIDS.

Apart from those companies with a large gay and lesbian customer base, Australian companies have been averse to associating themselves with the difficult and controversial social questions around HIV/AIDS.

Australian businesses have adapted to legislation enacted by federal and provincial governments outlawing discrimination based on disability and perceived or actual HIV/AIDS status.

Individual cases of discrimination by businesses have been handled within the civil justice system, without comment or reaction from business lobbies.

Australian unions, especially those with large memberships in the health and allied professions, hospitality and leisure sectors have generally adopted progressive and pragmatic policies on HIV/AIDS issues.

Businesses and unions have provided education and training for those workers at potential or perceived risk of HIV infection.

Since rates of new HIV infection fell in the 1990s and have stabilised at low levels, HIV/AIDS education and information has generally been absorbed within wider occupational health and safety training.

## 6. Mass Media Responses

After the first emergence of the HIV virus in Australia in 1982, the way in which issues surrounding HIV/AIDS were reported in the mass media crucially influenced the evolution of HIV/AIDS policy responses.

However, it is inaccurate to speak of a single mass media response to HIV/AIDS.

The mass media's function is to create profits and ratings by providing forums for debate, discussion and argument about the issues of the day.

In Australia, as elsewhere, the quality of reporting in the media generally reflects the quality of the information inputs – the better, more sustained and accurate the information that is put into the public domain, the better and more informed the debate will be, and the better the quality of public policy-making.

In Australia, the mass media reflects all the varied qualities of the Australian public – its fears, prejudices and concerns as well as its hopes and aspirations.

In the early days of HIV/AIDS, when there was a rapidly increasing caseload of a disease that seemed fatal and easily transmissible, it was entirely understandable that the Australian mass media would cover and report all developments in the story, and provide a forum for all shades of opinion.

From 1983 onwards, the Australian government and Minister responsible for dealing with HIV/AIDS accorded the highest priority to handling the reporting and coverage of HIV/AIDS in the mass media.

Faced with a continuing barrage of sensational reporting on HIV/AIDS, and commentary that was often based on rumour and speculation rather than evidence or fact, the Australian government and its HIV/AIDS advisory bodies established skilled media units to deal with the mass media.

The central principles of dealing with the mass media on HIV/AIDS were:

- to be always accessible to respond to breaking news developments; and
- to adhere to the highest standards of truth and honesty in conveying information to the public through the media.

Ministers believed that the greater the quantity of accurate and honest information about HIV/AIDS that appeared in the mass media, the more confidence the public would come to have in the government and its advisers on HIV/AIDS.

The greater the public's confidence in HIV/AIDS policy-making, the less likely that the public would be panicked into supporting extreme and counter-productive responses on HIV/AIDS.

Over the early years of HIV/AIDS, this careful and intelligent approach to the mass media gradually changed the nature and style of reporting about the epidemic.

Fear and irrational panic about HIV/AIDS gave way to a more thoughtful understanding of the ways in which the HIV virus could be transmitted, and a more realistic understanding of the dangers it posed and how these could be avoided.

In the mid 1980s, several cases of appalling discrimination against people with HIV/AIDS were reported fully by the Australian mass media.

These cases were thoroughly debated by the Australian community through the mass media.

The national government and its expert HIV/AIDS advisory committees fully participated in these debates by providing factual briefings, and informed opinion and commentary.

Gradually, a new public consensus about HIV/AIDS formed within the Australian community.

Initial fear and panic had led to calls for sanction, isolation and quarantine of those affected by HIV/AIDS.

Very rapidly, these responses were replaced by a reluctant acceptance of the need for frank, honest information to be supplied to those (young) people most at risk of HIV infection, and for action to be taken to provide young people with the necessary means to protect themselves from HIV infection – especially condoms and clean needles and syringes.

The mass media both reflected and led this dramatic change in community opinion about HIV/AIDS.

**Market Research and Polling**

During the 1980s, a great deal of market research and polling was undertaken into public attitudes about HIV/AIDS, and specific policy alternatives.

This polling was vitally important in shaping the look and feel of public education campaigns, and in assisting Ministers and others involved in the public debate about HIV/AIDS to communicate effectively with the Australian public.

**Mass Media Advertising and Educational Campaigns**

From 1987, the national government created and put to air a series of graphic and imaginative television and radio commercials about HIV/AIDS.

The initial campaign, built around the image of the Grim Reaper, was intentionally controversial and designed to make the maximum impact on public opinion.

These commercials were complemented by the publishing of a variety of printed materials about HIV/AIDS and what steps should be taken to prevent transmission of the virus.

This national education campaign was similarly complemented by state and territory governments and HIV/AIDS community groups actually delivering condoms, clean needles and syringes and other materials to venues where unsafe practices were most likely to occur – clubs, bars, brothels, sex-on-premises venues, beats, parks, beaches and entertainment districts in the major cities.

The mass media not only carried these advertising messages but then also reported HIV/AIDS developments editorially.

The following table demonstrates that in one of Sydney's three daily newspapers, the 1987 Grim Reaper campaign generated a 400% increase in editorial mentions about HIV/AIDS over the previous year.

**Figure 6**
**Articles on HIV/AIDS appearing in The Sydney Morning Herald 1986-2004**

| Year | Number of mentions |
|---|---|
| 1986 | 98 |
| 1987 | 439 |
| 1988 | 274 |
| 1989 | 313 |
| 1990 | 235 |
| 1991 | 226 |
| 1992 | 242 |
| 1993 | 285 |
| 1994 | 326 |
| 1995 | 333 |
| 1996 | 275 |
| 1997 | 231 |
| 1998 | 169 |
| 1999 | 172 |
| 2000 | 158 |
| 2001 | 216 |
| 2002 | 155 |
| 2003 | 218 |
| 2004 | 163 |

**Source: Factiva**

While there were many lapses in judgment, and many unfortunate stories about HIV/AIDS that gave vent to ignorance and prejudice, the Australian mass media's coverage of HIV/AIDS was a crucial factor in shaping public opinion to support enlightened and effective national HIV/AIDS policy-making.

## 7. Scientific/Research Community Responses

From a public policy perspective, Australia has placed the highest possible value on the accumulation, assessment and analysis of factual research data on HIV/AIDS.

Australian public policy-making on HIV/AIDS has been based on empirical evidence about the nature of the virus, and what works to contain and control its spread.

Over two decades, an overwhelmingly convincing body of HIV/AIDS evidence based on factual observation has been accumulated in Australia.

Australian HIV/AIDS policies have been based entirely on reasonable interpretation of the evidence accumulated by researchers.

Australia's scientists, clinicians and researchers responded immediately and imaginatively to the emergence of HIV/AIDS.

The pattern of close and active scientific study of HIV/AIDS was set from the earliest possible moment when the New South Wales health authorities funded a cohort study following the detection of the first HIV/AIDS case by Professor Ron Penny in November 1982.

Either by constituting themselves into ad hoc groups or by forming sub-committees within existing institutions, in the early 1980s the scientific and clinical communities mobilised rapidly to define and better understand the emerging epidemic.

The Australian response was notable for the very high degree of interaction between affected communities and researchers and clinicians from the earliest stages of the epidemic.

Affected communities developed great trust and confidence in HIV scientists, clinicians and researchers that allowed for very high rates of participation in clinical and epidemiological studies, as well as the highly effective delivery of treatment and care.

In Sydney, the fortunate location of St Vincent's Hospital at the geographical epicentre of the Australian HIV/AIDS epidemic led to the creation of a cluster of clinical, scientific and research organisations in and around the hospital, and the emergence of a range of experts in the various facets of the epidemic.

Similar, though smaller, clusters of expertise emerged in Melbourne around St Vincent's Hospital and the University of Melbourne.

As the epidemic progressed, Australian governments funded the establishment of three major institutions especially concerned with HIV/AIDS.

They were:

The National Centre in HIV Epidemiology and Clinical Research (NCEHCR)
The National Centre in HIV Social Research (NCHSR)
The National Centre for HIV Virology Research (NCHVR)

Of these three institutions, the NCHECR and NCHSR have maintained their autonomy and pursued vigorous research programs for nearly two decades.

The NCHVR developed within the structures of the University of Melbourne and the Melbourne scientific community to ensure that its expertise in HIV/AIDS matters is maintained.

Over time, valuable HIV/AIDS research was also undertaken within larger scientific institutions, universities, teaching hospitals and Departments of Health.

Two of these notable institutions were the Burnet Institute and the Albion Street Centre.

Australian and New Zealand HIV/AIDS clinicians formed the Australasian Society of HIV Medicine (ASHM).

ASHM played a valuable role in the dissemination of HIV/AIDS information to the health and medical workforce, both in terms of scientific research and occupational health and safety advice.

Following a succession of dedicated national HIV/AIDS conferences held over the 1980s and 90s, ASHM assumed responsibility for organizing Australia's national conference on HIV/AIDS-related issues.

Through ASHM and other institutions, Australian clinical and social scientists and researchers actively contributed to the proceedings of national, regional and international HIV/AIDS conferences and meetings, and met frequently to disseminate the findings of these meetings.

Close linkages were established between Australian HIV/AIDS researchers and international drug companies and institutions undertaking trials of new therapies and treatments.

These linkages furthered general scientific knowledge and greatly benefited those living with HIV/AIDS in Australia.

## 9. Current Assessment of and Future Prospects for Regional and International Cooperation

### Australia's International Response

The Australian government believes that the HIV/AIDS pandemic represents one of the greatest challenges facing developing countries. An estimated 38 million people are living with HIV/AIDS in developing countries. HIV/AIDS is increasing in the Asia-Pacific region with about 7.4 million people currently infected. The burden falls most heavily on those countries that have the greatest difficulty in meeting this challenge.

HIV/AIDS threatens to reverse decades of hard-won development gains. It attacks people in their most productive years, destroys communities, and disrupts food production. Heavy burdens are placed on already weak health services. The disease cuts into the fabric of society and undermines a country's stability.

Australia acted quickly in responding to HIV/AIDS at home, and has taken a prominent role in the international response to the epidemic.

### Global HIV/AIDS Initiative

In recognition of the high priority Australia places on assisting countries to combat HIV/AIDS in July 2000, the Minister for Foreign Affairs, the Hon Alexander Downer, announced a Global HIV/AIDS initiative of $200 million over six years.

At the Second Asia-Pacific Ministerial Meeting on HIV/AIDS in Bangkok, Thailand on July 11 2004, Australia's Foreign Minister, Alexander Downer, announced a significant funding boost of $350 million over six years to combat the disease - more than doubling our commitment to a total of $600 million by 2010.

Announcing the 2005-06 budget for Australia’s Overseas Aid Program in May 2005, Foreign Minister Downer announced that the government will commit a further $A50 million over three years to the Global Fund and a new $A5 million HIV/AIDS Partnership Initiative to strengthen the capacity of HIV/AIDS organisations in the Asia-Pacific through partnerships with Australian community organisations and professional associations.

The Minister said that Australia will also continue to play a leadership role in political efforts to address HIV/AIDS and has appointed a Special Representative to promote HIV/AIDS action in the region.

This significant contribution reinforces Australia's position as the leading HIV/AIDS donor in East Asia and the Pacific.

However, money alone won't solve the problem.

Australia recognises the need to tackle HIV/AIDS as more than just a health issue.

Political leadership is required to mobilise resources in a coordinated way across a broad range of fields.

Partnerships need to extend beyond government to the private sector, civil society and community-based organisations to ensure an effective response to the disease and its impact.

The continuing emphasis placed on medical responses to HIV/AIDS means a continued involvement by those with medical and other clinical experience of HIV/AIDS.

Thus Australia is active both in advocacy at the political level, and in activities designed to meet local needs and priorities.

Established in 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for worldwide action against HIV/AIDS.

Australia contributes over $2 million each year to assist UNAIDS to enable, strengthen and support an expanded response to the epidemic.

Australia works within other international forums. It played an active role in the United Nations General Assembly Special Session on HIV/AIDS in mid 2001 to develop the Declaration of Commitment on HIV/AIDS.

Australia also works with the World Trade Organization and the World Health Organization to improve the accessibility and affordability of essential HIV/AIDS drugs.

After the UN Special Session, Australia hosted a Ministerial Meeting on HIV/AIDS for Asia and the Pacific late in 2001, immediately following the 6th International Congress on AIDS in Asia and the Pacific (ICAAP).

The meeting concluded with the Ministers agreeing on a Ministerial Statement reflecting the commitment of participating countries to strengthening coordination and partnership at every level and to further action and collaboration in tackling the challenges of HIV/AIDS.

Stemming from the Ministerial Meeting, Australia worked with UNAIDS to establish the Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) to foster continued political leadership and commitment at the highest level in addressing HIV/AIDS.

**The Global Fund to Fight AIDS, Tuberculosis and Malaria**

Australia is also contributing $25 million over three years to The Global Fund to Fight AIDS, Tuberculosis and Malaria.

This announcement follows the Fund's decision to put additional resources into the Asia-Pacific region.

A full outline of Australia’s HIV/AIDS regional programs in Asia, the South Pacific and Africa and bilateral country programs is at **Attachment B**.

## 10. Issues to Be Addressed Through Regional Effort

Although regional and international cooperation to combat HIV/AIDS has developed reasonably effectively over the past decade or so, it is apparent that much still needs to be done if the Asia-Pacific region is to avert a large-scale HIV/AIDS epidemic.

The major areas of concern include:

### Upgrading Statistical Collection, Reporting and Monitoring of HIV/AIDS

HIV/AIDS statistical collection in the Asia-Pacific needs substantial improvement.

Present data sets for many countries are unreliable and understate the spread of HIV/AIDS.

However, the Australian experience demonstrates that HIV testing for the sake of testing is counter-productive.

Individuals will only come forward for testing if they do not feel threatened by it, and if there is a real prospect of a positive HIV test leading to access to treatments and therapies.

Testing without ensuring access to treatment is virtually guaranteed to lead to HIV infection rates being greatly understated, thereby depriving policy-makers of accurate information on which to base HIV/AIDS programs.

### Prisons

Globally, and regionally in the Asia-Pacific, HIV infection rates in prisons are increasing at an alarming rate.

Existing policies are generating large numbers of HIV-positive prisoners who will return to the general population at the conclusion of their sentences.

Prisoners are overwhelmingly young, sexually active heterosexual males who are exposed in prison to the widespread use of shared needles and syringes, and unprotected sex.

As is shown in the selection below, a body of research is beginning to demonstrate that the numbers of HIV-positive prisoners in many countries is becoming overwhelming for the community and prison authorities:

- In Estonia 9% of prisoners are estimated to be HIV-positive

- In the USA 2% of prisoners are estimated to be HIV-positive

- In South Africa 43% of prisoners are estimated to be HIV-positive
- In Brazil 16% of prisoners are estimated to be HIV-positive
- In Spain 17% of prisoners are estimated to be HIV-positive
- In Portugal 20% of prisoners are estimated to be HIV-positive
- In Zambia 27% of prisoners are estimated to be HIV-positive
- In Greece 11% of prisoners are estimated to be HIV-positive
- In Malaysia 6% or prisoners are estimated to be HIV-positive with the main mode of transmission (94%) being a result of sharing a contaminated needle and syringe
- In Ukraine the number of new HIV cases in prisons has risen by 26% compared to 5% in the general population
- In Russian prisons there are an estimated 34,000 HIV-positive prisoners with 95% being injecting drug users

*(Sources: Davies, Goyer, HIV Education Prison Project, Prison Health Care News, US Dept of Justice, Prisons Department of Malaysia)*

A full discussion of the threat posed by HIV infection rates in prisons is at **Attachment C.**

**Drug Prohibition/Harm Minimisation**

From the earliest days of HIV/AIDS in Australia, Australian governments and the general public came to understand that the general population was more at risk of a general HIV/AIDS epidemic from injecting drug users than from men who have sex with men.

It was also understood that the most serious threat from drug use both for individual drug users and the community was an uncontrollable epidemic of HIV/AIDS.

Australia did not abandon attempts to restrict drug trafficking but realised the importance of balancing efforts to restrict drug supply with the even more urgent need to control HIV.

Needle and syringe programs are examples of harm minimisation because they try to reduce HIV infection without trying to stem drug use.

Similarly, methadone maintenance treatment is also an example of harm minimisation because drug users continue to consume mood-altering drugs but with considerable improvements in their health and well-being including less risk of HIV infection.

The Australian experience conclusively demonstrates that the widespread availability of clean needles and syringes for those who use illicit drugs is critical to the control and suppression of HIV/AIDS, and in keeping HIV/AIDS infection rates low within the general heterosexually active community.

It is erroneous to believe that HIV/AIDS can be confined only to the MSM and IDU communities without eventually crossing over to the general heterosexually active population.

Effective harm minimisation policies in relation to IDUs implicitly oblige communities and governments to acknowledge, but not to endorse, that illicit drug use is occurring in their populations.

From 2 decades' worth of empirical evidence, it is abundantly clear that those nations that have criminalised all forms of illicit drug-taking behaviour, and have therefore repudiated the introduction of needle and syringe exchange programs and related measures, now have an HIV/AIDS caseload that is very large compared to those countries that have adopted harm minimisation principles.

It is also clear from the Australian experience that introduction of needle and syringe exchange programs did not lead to a significant increase in overall demand for illicit drugs.

Indeed, there is evidence that injecting drug users attracted to needle and syringe exchange programs can be enticed to enter drug treatment and rehabilitation with

consequent benefits to the individual and to society, including the reduction of crime rates.

On the contrary, harm minimisation programs coordinated with more effective policing aimed at the controllers of the illicit drug trade rather than end-users and effective preventive education campaigns have worked to reduce both supply and demand of heroin and other similar narcotics.

## 11. Priorities for Research and Action

Control and management of HIV/AIDS cannot be left solely to national health authorities, although they must bear the brunt of service delivery, care and treatment.

The vital intersection points for the rapid transmission of HIV/AIDS into the general community occur in social areas that often involve shame, marginalisation and criminal behaviours – female and male prostitution, consumption of illicit drugs, imprisonment, infidelity and frequent unprotected sexual encounters.

Typically, security, police and intelligence agencies have high degrees of understanding and involvement in these areas yet they are very rarely involved in directly considering policies in relation to HIV/AIDS control.

Understandably, religious, cultural and moral issues relating to the need to modify and alter at-risk behaviours must also be debated before a new social consensus can emerge about HIV/AIDS.

In many regional countries, there is a need to research social and political attitudes to HIV/AIDS to determine how best to increase knowledge and awareness about HIV/AIDS.

Such research, and the policy implications that flow from it, should be considered not just by health ministries but by agencies with responsibility for finance, national security, law enforcement, illicit drug control and national research.

The understanding and consent of religious and social leaders and groups and the involvement of the national and local media must be sought and maintained if HIV/AIDS is to be brought under management and control.

### HIV/AIDS and New Communications Technologies

The rapid expansion in new communications technologies of all kinds – internet, mobile telephones, 3G phones, broadband access, PodCasting, satellite radio and television, chat rooms and so on – has dramatically multiplied the channels by which young people receive and process information.

This is particularly so in the large cities of the Asia-Pacific.

Governments must consider strategies that use these new communications channels to reach young people at risk of HIV/AIDS infection, and in ways that will appeal to them and bring about sustained behaviour change.

The communications strategies that must be adopted for the larger cities are very different from those required amongst rural and regional populations.

The tools that can be used for communicating with young people in the larger cities are much different than those used in rural and remote areas.

However, the consequences of a large-scale HIV/AIDS epidemic in the larger cities are likely to be far more severe and rapidly felt than the spread of HIV/AIDS in rural areas.

The rapidly multiplying communications options available to many young people requires a thorough review of accepted marketing techniques, and much closer research, development and interaction with artists and those whose businesses is the development of new content and communications systems.

As with all successful marketing and communications campaigns, there must be comprehensive and insightful market research and opinion polling undertaken that will reflect the nature of community concerns and knowledge about HIV/AIDS; and suggest how to communicate most effectively with younger people at risk of HIV infection.

While communications campaigns must be adapted to local sensitivities, the core messages about how to prevent HIV infection and to control the epidemic must be those derived from empirical observation and research.

The challenge is not to deny the facts and existence of HIV and how it is transmitted, but how to shape and send the message so that young people can take effective action to moderate and sustain behaviour change.

**The Crucial Role of Women**

In their many roles as mothers, partners, wives, teachers and carers, women must play a crucial role in educating their families and societies about the facts of HIV transmission, and how it may be prevented.

The Australian experience was that women were most easily able to be engaged and convinced about HIV/AIDS issues if they were spoken to by other women acknowledged and respected as communicators.

It is primarily through women that men will be persuaded and cajoled to take the necessary steps to protect themselves from HIV/AIDS.

HIV/AIDS projects and communications must therefore involve women at all stages from inception to delivery.

**Engagement with Religious Leaders, Groups and Organisations**

It seems likely that the introduction of policies that have been incontrovertibly demonstrated to suppress and control the spread of HIV/AIDS will continue to be questioned, if not opposed, by some of those who speak for religious faiths and beliefs.

HIV/AIDS policy-making is just one area in which the clash between the values of science and religion are being contested in the modern world.

Religious faith and belief play central roles in the lives of the great majority of the world's peoples.

If HIV/AIDS policies that have been shown to work are to be introduced successfully in countries where religious beliefs are strong, then ways must be found to engage religious leaders in constructive dialogue about the need for these policies and the evidence that supports their implementation.

In countries as diverse as Iran and China, Australian institutions and groups have successfully engaged local religious leaders in very productive dialogue about HIV/AIDS.

Despite the ferocity of the debate, every attempt must be made to respectfully address the concerns and views of religious leaders in developing pragmatic and life-enhancing outcomes for those at risk of HIV infection.

## Attachment A

**Major Australian civil society organizations involved in HIV/AIDS treatment, care, research and preventive education**

**The Australian Federation of AIDS Organisations (AFAO) (www.afao.org.au)**

AFAO represents the AIDS Councils of the six states and two territories:

- the AIDS Council of New South Wales (www.acon.org.au)
- The Victorian AIDS Council (www.vicaids.asn.au)
- Queensland AIDS Council (www.quac.org.au)
- Western Australian AIDS Council (www.waaids.com)
- AIDS Council of South Australia (www.acsa.org.au)
- Tasmanian Council on AIDS, Hepatitis and Related Diseases (www.tascahrd.org.au)
- Northern Territory AIDS and Hepatitis Council (www.ntahc.org.au)
- AIDS Action Council of the ACT (www.aidsaction.org.au)

**National Association of People Living with HIV/AIDS (NAPWA) and AIDS Treatment Project Australia (ATPA) (www.napwa.org.au)**

NAPWA and ATPA comprise organizations representing people living with HIV/AIDS as follows:

People Living With HIV/AIDS (PLWHA) ACT

People Living With HIV/AIDS (PLWH/A NSW)

Queensland Positive People

Positive Women Victoria

People Living With HIV/AIDS (PLWHA SA)

People Living With HIV/AIDS (PLWHA Vic)

Straight Arrows

Straight Arrows is a group providing information and support for HIV positive heterosexual men and women and their families.

**Scarlet Alliance (www.scarletalliance.org.au)**

Representing sex workers generally, and with a particular interest in HIV/AIDS and STI issues

**AIVL - Australian Injecting and Illicit Drug Users League Inc. (www.aivl.org.au)**

Representing organizations of injecting drug users and with a particular interest in HIV/AIDS prevention programs, treatment and IDU policy

In the early years of the epidemic, several organisations that represented people with blood borne diseases, or which were responsible for the blood supply, also became involved in HIV/AIDS policy development

These organisations were:

**Australian Red Cross (www.redcross.org.au)**

Australian Red Cross ARC has been responsible for the collection, processing and distribution of blood and blood products to the Australian community since 1929.

In the 1980s Australian Red Cross contributed to blood collection policy development and technical review in the face of emerging evidence about HIV transmission.

In the 1990s Australian Red Cross also developed an international HIV assistance program, working directly with partners in the Asia/Pacific region to address HIV prevention, care and support.

The program began in the Mekong sub-region and by 2004 had expanded to over 11 countries in the Asia/Pacific region.

Additionally, through the Geneva-based International Federation of Red Cross and Red Crescent Societies, ARC has made significant contribution to global HIV programs through technical and policy input.

It has also managed HIV programs in Asia/Pacific on behalf of the International Federation.

Australian Red Cross currently promotes International Federation global policies and campaigns in relation to volunteer blood donation, reduction of discrimination to PLWHA, drug treatments access and harm reduction.

**Haemophilia Foundation of Australia (www.haemophilia.org.au)**

Representing people with haemophilia, their carers and families

**HIV/AIDS Clinical and Scientific Institutions**

In relation to the clinical and scientific aspects of HIV/AIDS, several institutions were founded or adapted to respond to the epidemic.

They include:

**National Centre in HIV Epidemiology and Clinical Research (www.med.unsw.edu.au/nchecr)**

The NCHECR was founded in 1986 and is one of Australia's leading medical research institutes with particular expertise in the fields of HIV/AIDS and viral hepatitis.

NCHECR's primary functions relate to the coordination of national surveillance programs and clinical trials.

While its original focus was exclusively on HIV/AIDS, NCHECR's work has expanded to encompass hepatitis B and C, and sexually transmissible infections.

NCHECR also conducts research into the transmission, prevention and natural history of these infections.

NCHECR's research program has increasingly taken on a regional focus, with major collaborative programs in Thailand and Cambodia.

Other functions of NCHECR include the training of health professionals, and input into the development and implementation of health policy and programs.

**Australasian Society for HIV/AIDS Medicine (ASHM) (www.ashm.org.au)**

ASHM was incorporated in 1990 to represent medical practitioners working in the HIV sector. Over time ASHM has broadened its membership to include health care workers and other graduates working in the HIV sector.

The Society is a key partner in the Australian response to HIV, hepatitis and related diseases.

It works closely with government, advisory bodies, community agencies and other professional organizations.

The Society conducts a broad education program in HIV and viral hepatitis for medical practitioners, health care providers and allied health workers and manages a program of continuing medical education in HIV and viral hepatitis.

**National Centre in HIV Social Research (www.nchsr.arts.nsw.edu.au)**

The National Centre in HIV Social Research (NCHSR) was established in 1990 with funding from the Commonwealth government and is located within the Faculty of Arts and Social Sciences at The University of New South Wales, Sydney.

The National Centre in HIV Social Research conducts research which describes and analyses the social understandings, meanings and practices of peoples, institutions and communities in relation to HIV, Hepatitis C and other communicable diseases.

**Australian Research Centre in Sex, Health and Society (www.latrobe.edu.au/arcshs)**

The Australian Research Centre in Sex, Health and Society (ARCSHS) was established as the Centre for the Study of Sexually Transmissible Diseases in1992 as an independent research unit within the Faculty of Health Sciences.

ARCSHS has a multi-disciplinary team of staff with qualifications and expertise in psychology, anthropology, sociology, public health, health promotion, methodology, epidemiology, education, women's health, consumer advocacy and health policy

**Australian Centre for HIV and Hepatitis Virology Research** (**www.hiv.edu.au**)

Formerly the National Centre for HIV Virology Research, the National Centre for HIV Virology Research is in the process of being re-organised into the new Australian Centre for HIV and Hepatitis Virology Research (ACH2), which is to be a broadly inclusive, collaborative national virology research organization focused on HIV and Hepatitis C.

**Albion Street Centre (www.sesahs.nsw.gov.au/albionstcentre)**

The Albion Street Centre is a community based multidisciplinary centre dealing exclusively with HIV/AIDS and Hepatitis C clinical management, counselling, research, prevention and education.

The Centre has over 60 professional staff and more than 200 volunteers who provide care, support and education.

The staff has significant experience in HIV/AIDS, hepatitis, infection control, sexual health, and health care worker education and training both in Australia and overseas.

**Alcohol and Drug Service St Vincent's Hospital, Sydney (wwwsvh.stvincents.com.au/drugandalc.htm)**

By virtue of its geographical location at the centre of the Australian HIV/AIDS epidemic, and its functional role within St Vincent's Hospital, the Alcohol and Drug Service has played a major role in HIV/AIDS policy-making for over 20 years, as well as providing specialized service delivery for those with alcohol and drug-related problems, including those with HIV/AIDS.

The Centre has taken practiced "harm minimisation" approaches to HIV/AIDS, and was a pioneer and advocate of needle and syringe exchanges as an efficient and relatively cost-effective method of reducing HIV/AIDS infection rates amongst IDUs.

**Burnet Institute (www.burnet.edu.au)**

The Burnet Institute was founded in 1986 and is Australia's largest communicable diseases research institute, investigating some of today's most serious viral infections such as HIV/AIDS, hepatitis and measles.

The Institute integrates basic and applied laboratory research in virology and other communicable diseases with field research and the design, implementation and evaluation of public health programs.

The Burnet Institute is the only medical research institute to be accredited for funding by AusAID, an Australian Federal Government overseas funding agency.

In 1988, the Burnet Institute was accorded Collaborating Centre status by the United Nations Program on AIDS (UNAIDS) - one of just 12 such centres in the world.

**HIV/AIDS Charitable Groups**

Over two decades, many groups emerged to deal with fund-raising for HIV/AIDS-related causes, and to support those living with HIV/AIDS.

As the emergency phase of the epidemic passed, and HIV/AIDS caseload stabilized, many of these groups disbanded.

However, several HIV/AIDS charitable organizations have continued to raise funds from Australians wishing to support those living with HIV/AIDS, and those at risk of acquiring the disease.

The largest of these groups are The AIDS Trust of Australia and the Bobby Goldsmith Foundation.

**AIDS Trust of Australia (www.aidstrust.com.au)**

The AIDS Trust of Australia was founded in 1987.

The AIDS Trust of Australia is the only national body raising and dispersing funds for HIV/AIDS research, education, care and support provided by community based organisations.

The Trust does not receive nor seek government funding, preferring to rely on corporations, quality events and the generosity of individuals for its income.

The AIDS Trust raises funds and disburses them to community based organisations that provide education, care, support and research in a way that fulfils the trust placed in them by donors, supports and those living with HIV/AIDS.

**The Bobby Goldsmith Foundation (www.bgf.org.au)**

The Bobby Goldsmith Foundation Inc. (BGF) is a community based charity providing direct welfare assistance to people who are financially disadvantaged as a direct result of HIV/AIDS in New South Wales.

BGF also provides financial counselling and supported housing to those with HIV/AIDS.

## Attachment B

### Australia's International Response to HIV/AIDS

The Australian government believes that the HIV/AIDS pandemic represents one of the greatest challenges facing developing countries. An estimated 38 million people are living with HIV/AIDS in developing countries. HIV/AIDS is increasing in the Asia-Pacific region with about 7.4 million people currently infected. The burden falls most heavily on those countries that have the greatest difficulty in meeting this challenge.

HIV/AIDS threatens to reverse decades of hard-won development gains. It attacks people in their most productive years, destroys communities, and disrupts food production. Heavy burdens are placed on already weak health services. The disease cuts into the fabric of society and undermines a country's stability.

Australia acted quickly in responding to HIV/AIDS at home, and has taken a prominent role in the international response to the epidemic.

In announcing the 2005-06 budget for Australia’s Overseas Aid Program in May 2005, Foreign Minister Downer announced that the government will commit a further $A50 million over three years to the Global Fund and a new $A5 million HIV/AIDS Partnership Initiative to strengthen the capacity of HIV/AIDS organisations in the Asia-Pacific through partnerships with Australian community organisations and professional associations.

The Minister said that Australia will also continue to play a leadership role in political efforts to address HIV/AIDS and has appointed a Special Representative to promote HIV/AIDS action in the region.

### Global HIV/AIDS Initiative

In recognition of the high priority Australia places on assisting countries to combat HIV/AIDS in July 2000, the Minister for Foreign Affairs, the Hon Alexander Downer, announced a Global HIV/AIDS initiative of $A200 million over six years.

At the Second Asia-Pacific Ministerial Meeting on HIV/AIDS in Bangkok, Thailand on July 11 2004, Foreign Minister Downer announced a significant funding boost of $350 million over six years to combat the disease - more than doubling our commitment to a total of $A600 million by 2010.

However money alone won't solve the problem.

Australia recognises the need to tackle HIV/AIDS as more than just a health issue.

Political leadership is required to mobilise resources in a coordinated way across a broad range of fields. Partnerships need to extend beyond government to the private sector, civil

society and community-based organisations to ensure an effective response to the disease and its impact. Thus Australia is active both in advocacy at the political level, and in activities designed to meet local needs and priorities.

Established in 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for worldwide action against HIV/AIDS. Australia contributes over $2 million each year to assist UNAIDS to enable, strengthen and support an expanded response to the epidemic.

Australia works within other international forums. It played an active role in the United Nations General Assembly Special Session on HIV/AIDS in mid 2001 to develop the Declaration of Commitment on HIV/AIDS. Australia also works with the World Trade Organisation and the World Health Organisation to improve the accessibility and affordability of essential HIV/AIDS drugs.

After the UN Special Session, Australia hosted a Ministerial Meeting on HIV/AIDS for Asia and the Pacific late in 2001, immediately following the 6th International Congress on AIDS in Asia and the Pacific (ICAAP). The meeting concluded with the Ministers agreeing on a Ministerial Statement reflecting the commitment of participating countries to strengthening coordination and partnership at every level and to further action and collaboration in tackling the challenges of HIV/AIDS.

Stemming from the Ministerial Meeting, Australia worked with UNAIDS to establish the Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) to foster continued political leadership and commitment at the highest level in addressing HIV/AIDS.

**The Global Fund to Fight AIDS, Tuberculosis and Malaria**

Australia is also contributing $A25 million over three years to The Global Fund to Fight AIDS, Tuberculosis and Malaria. This announcement follows the Fund's decision to put additional resources into the Asia-Pacific region.

Almost 40 per cent of funding disbursed by the Fund in the Asia-Pacific region is used to purchase much-needed commodities such as pharmaceuticals, mosquito bed nets and other medical supplies.

The Fund is also working to improve diagnosis and treatment facilities in the region and providing additional training for health professionals. Australia's work with The Global Fund is an excellent example of the partnership needed to tackle HIV/AIDS.

**Regional Programs**

The four-year, $A9 million Asia Regional HIV/AIDS Project plays a key role in developing a regional response to the epidemic of HIV among drug users in South East and East Asia.

Australia has committed to a new Pacific Regional HIV/AIDS project which will provide support for the development and implementation of a regional HIV/AIDS strategy, while continuing support for the implementation of national HIV/AIDS strategies, and Non Government Organisation (NGO) activities in the region.

A number of HIV/AIDS activities operate in South East Asia under the South East Asia Regional Program. These include HIV/AIDS care and support capacity building, and harm reduction activities reducing vulnerability in mobile populations.

In addition, $A1.2 million funding is being provided for UNICEF's HIV/AIDS program which aims to reduce both HIV transmission and the impact of the epidemic on children, young people and families.

## The SE Asia Regional Program

Almost 1 million people in the Asia-Pacific acquired HIV in 2002, bringing to an estimated 7.5 million the number of people now living with the virus - a 10% increase since 2001. With the exception of Cambodia, Burma and Thailand, national HIV prevalence levels remain comparatively low in most countries in the Asia-Pacific.

*The Asia Regional HIV/AIDS Project*

The project focusses on four sites in China, Burma and Vietnam. It commenced in July 2002 and will expend $A9 million dollars over 4 years. The project will play a key role in developing a regional response to the epidemic of HIV amongst drug users, aiming to strengthen the capacity of both the health and public security sectors of governments and key stakeholders to reduce transmission of HIV among and from injecting drug users. The project is employing tools and guidelines for Rapid assessment and Response (RAR) developed by WHO for use in the region under AusAID International Health Program funding.

*Factory Workers Reproductive Health Awareness Project - CARE*

This $A350,000 project is one of a number of HIV/AIDS activities operating in South East Asia under the Asia Regional Program. This regional model is being implemented by CARE in ten factories in Vientiane. The project commenced in May 2002 and is addressing issues of low levels of reproductive health awareness and problems with sustaining adequate levels of service in factory clinics. The project will be focusing on this latter issue in their upcoming mid-term review. The training of peer educators is proving a most effective aspect of the project's strategies.

*HIV in Migrating Populations - World Vision*

This $A350,000 project is being implemented with mobile populations, particularly seafarers, in Burma and Thailand by World Vision. The aim is to strengthen networks between primary and clinical health care services, train health volunteers and peer

trainers as well as the social marketing of condoms. Materials developed under other AusAID funded work will be utilised in carrying out the activities.

After initial delays and the relocation of some activities, the project has established its baseline surveys and networks for implementation, which was completed in 2004.

*STD/HIV/AIDS Prevention Between Vietnam (Nghe An) and Laos (Xiang Khoang)*

This $A170,000 project is one of two cross-border projects being implemented by the Hanoi based STD/HIV/AIDS Prevention Centre (SHAPC). This project is working through peer educators, collaborative government workshops and training of health staff to promote harm reduction approaches for mobile and itinerant populations

*Strengthening Bilateral Cooperation between Vietnam (Quang Ninh) and China (Gaingxi)*

The second of the cross border projects, is aiming to promote peer education approaches with authorities as well as surveying mobile populations with respect to awareness and risk behaviours.

## The Pacific Regional Program

The HIV epidemic has spread slowly in the Pacific to a total of 5281 recorded HIV positive and 1635 AIDS cases as at 31 December 2002 with estimates being much higher. It should be noted that, for administrative reasons, some Pacific Island Countries and Territories (PICT) have not reported HIV/AIDS data for a couple of years, not all reporting and surveillance systems operate properly, and AIDS is not always recorded as the cause of death.

The rates of infection vary between PICT. Papua New Guinea (PNG), French Polynesia, Guam and New Caledonia have significant epidemics. Fiji, Kiribati, Tuvalu have recently reported increases in HIV rates, whilst other countries still have low infection levels. There is significant concern that the Pacific is vulnerable to the HIV epidemic due to high rates of STI, a known precursor to HIV in other developing countries.

*Pacific Regional HIV/AIDS Project*

The goal of the Pacific Regional HIV/AIDS Project is to reduce the vulnerability to, and impact of, HIV/AIDS in Pacific Island Countries and Territories by strengthening the capacity of Pacific Island governments, NGOs and communities for an effective and sustainable multi-sectoral response to HIV/AIDS. Australia has committed $A12.5 million over five years for this project.

The project consists of a Regional Strategy component, which will be managed by the Secretariat of the Pacific Community (SPC) and a component of national level support

including a Grant Facility, which will be undertaken by an AusAID representative based in Suva.

The key outcomes of the project will be the development and implementation of:

- A Pacific Regional HIV/AIDS Strategy (22 Pacific Countries and Territories)
- Behaviour change communication (BCC) strategies and materials. SPC will also provide training in BCC methods to governments, NGO and other community groups in the Pacific region.
- Support for the 14 independent Pacific island countries through a grant scheme to developing and implementing National HIV/AIDS Strategies.

*The Joint Australia-France HIV and STI initiative for Pacific Islands*

This initiative forms one Component of the Pacific Regional HIV/AIDS Project, contributing to the first two outcomes with the Secretariat of the Pacific Community (SPC) being the implementing partner. The outcomes of the Joint Australia-France HIV and STI initiative are:

- The development and coordination of HIV/AIDS/STI surveillance capacity in the region
- To expansion of participation in surveillance, training and prevention activities to include all SPC members, particularly those territories (the French Territories of French Polynesia, New Caledonia, Wallis and Futuna; American Samoa, Guam, Marshall Islands, Nauru, Northern Marianas, Pitcairn and Tokelau) that are not covered by the Australian funded regional initiative.

*UNAIDS coordinator position in Suva*

In addition, Australia is co-funding (with NZAID) a UNAIDS program coordinator position in Suva worth $A241,000 over three-years to assist South Pacific countries to develop regional responses to the epidemic. This position will be important for coordinating the UN funded activities in the Pacific that will complement the various bilateral and regional activities.

**Country Programs**

Australia is the largest bilateral donor working on HIV/AIDS programs in the Pacific and South East Asia. The majority of the $200 million initiative is spent through our bilateral programs.

## Indonesia

HIV transmission in Indonesia has escalated sharply since 1995. This is reflected in the increase in the number of blood donors testing positive for HIV: rising from 3 per 100,000 in 1994 to 4 per 100,000 in 1998/99 to 16 percent in 2000. Blood donor data shows that there has been at least an eightfold increase in HIV levels in the last 10 years.

Recently, changes in the patterns of the epidemic in Indonesia have also become discernable. A significant increase in HIV levels was detected among sex workers, and also a trend toward increasing variations in levels from one region to another. The highest prevalence among sex workers was found in Merauke, Papua where levels were as high as 26.5%. The province of second highest prevalence was West Java (5.5%) followed by Jakarta (3.36%). In the same year Indonesia's classification in regard to HIV prevalence shifted from "low prevalence" to concentrated due to the fact that while HIV prevalence among the general population remained low, there were certain sub-populations where prevalence exceeded 5%.

Another new phenomenon in HIV/AIDS transmission that has appeared recently is the emergence of HIV prevalence among injecting drug users (IDUs). Recent social and economic upheavals in Indonesia appear to be fuelling a sharp rise in injecting drug use (IDU). While 10 years ago, IDU was virtually unknown in Indonesia, the country is now thought to have as many as 200,000 IDUs. The practice of sharing needles among IDUs allows HIV to be spread very rapidly. In 1999, 18% of IDUs being treated at the Drug Dependency Hospital were infected with HIV. In 2000 this increased to 40% and in 2001, 48%. By 2002 IDU was a much more significant causal factor in relation to HIV prevalence (associated with 20% of cases) than it had been in 1996 (associated with 2.5% of cases).

In recognition of the seriousness of the situation in Indonesia, Australia directs a large share of its HIV/AIDS resources to the archipelago. In 2002/03, Indonesia received one seventh of Australia's HIV/AIDS expenditure.

*The HIV/AIDS Prevention and Care Project - Phase 2*

Phase 1 of the project provided $A28 million over five years (1995-2000). It worked with the national and provincial Aids Commissions and local non-government organisations to prevent HIV and mitigate its effects on Indonesian society. Its target provinces were Bali, East Nusa Tenggara and South Sulawesi. A second phase of the project was mobilised in September 2002 and will seek to consolidate and strengthen the achievements of Phase 1.

Phase 2 of the project will provide $A34 million to be spent over five years.

The aim of Phase 2 is to provide capacity building support for AIDS commissions at the national, provincial and district level in addition to providing targeted assistance for

vulnerable groups such as Ides and commercial sex workers. Activities will also focus on issues of treatment, care and support for People living with HIV/AIDS. The project is operating in Jakarta, West Java, Bali, South Sulawesi, Papua and East Nusa Tenggara.

## Vietnam

As of December 2000, over 32,000 people had been reported as being infected with HIV in Vietnam, however UNAIDS estimates the number to be around 107,000. The epidemic has rapidly evolved since the first reported case in Ho Chi Minh City in 1990; the major evolution has been the rapid spread between IDU's. Almost two-thirds (65%) of all reported HIV infection to date in Vietnam has been between Ides.

In certain cities of Vietnam, infection levels are rising quickly and in some cases exponentially. In Ho Chi Minh City, HIV infection rates among sex workers and their clients increased from virtually nil in 1996 to more than 20% in 2000

*UNDP HIV/AIDS Capacity Building project:*

This project will expend $A1.6 million over three years. The aim is to strengthen the capacity of the National AIDS Standing Bureau, Ministry of Health and selected provincial AIDS committees.

*UNDP HIV/AIDS Youth Awareness Project*

This project will expend $A1.4 million over three years and aims to increase the capacity of the Vietnam Youth Union to implement HIV/AIDS education and awareness activities.

*NOVA*

There are currently also three HIV/AIDS awareness raising and harm reduction projects funded through the NGO Vietnam - Australia program (NOVA), with a total value of about $A1.5 million over three years.

## Cambodia

The Asian country with the highest adult HIV prevalence - Cambodia - has reported stabilising levels of infection, along with continued decreasing levels of high-risk behaviour.

Recent surveillance data has shown a decline in HIV prevalence in pregnant women from 3.2% in 1996 to 2.8% in 2002 and in sex workers, prevalence has decreased from 42% in 1998 to 29% in 2002. Because the majority of sex workers are usually engaged in sex work for less than two years, this steady decline suggests that prevention efforts focused on sex workers are yielding positive results among the succession of new entrants into sex work. Consistent condom use by sex workers appears to be most important

behavioural change achieved. Condom usage rates in sex workers rose from 37% in 1997 to 90% in 2001.

The Cambodia program has recently received approval to support a study by the National Centre in HIV Epidemiology and Clinical Research (NCHECR) of UNSW. Under the proposal to start in January 2004, the NCHECR will help the Cambodian Ministry of Health undertake trials to determine the most effective means of providing treatment for HIV/AIDS in a resource poor setting. It is proposed that the project will be implemented over a 3 year period.

## Lao PDR

Located between the higher prevalence countries of Cambodia and Thailand, HIV prevalence has remained low in the Lao People's Democratic Republic until the present time. However the likely route of transmission into Lao appears to be migrant workers temporarily working in Thailand who may visit sex workers and become infected, thus returning home with the virus. Already some of the early cases of HIV detected in Lao PDR are among migrant workers returning from work in Thailand.

The Lao bilateral program funds two NGOs to undertake HIV/AIDS activities.

*The Macfarlane Burnet Institute for Medical Research and Public Health/Lao Youth Union Lao Youth HIV/ AIDS & Sexually Transmitted Infections Response, Phase II*

This project aims to support the effective implementation of the Lao Youth Union's national HIV/AIDS/STI strategic plan, and to enhance the ability of young Lao people to respond to the risk of HV/AIDS and STIs through increased access to a locally appropriate prevention and care program.

*The Lao-Australia Red Cross Capacity Building for HIV/AIDS Prevention and Care project 2001-2005 $A1.4 million*

With the technical assistance of Australian Red Cross, this project (Phase 4) is being implemented in 8 provinces with a core focus on HIV prevention through peer education.

By end of December 2004 the project had implemented 625 youth peer education workshops and developed care/support programs for PLWHA in another 2 provinces.

Increasingly the program is addressing discrimination, particularly in the health service area.

The HIV program is augmented by capacity-building of the Lao Red Cross, principally its health division.

Australia Red Cross began working in Laos in 1992 and has recently assisted Lao Red Cross to obtain funding from a number of other sources so that the current program is now one of the two largest in the country.

Recent initiatives include establishment of a Lao positive people's network.

## Burma

The HIV epidemic in Burma is rapidly expanding. Surveillance figures show the virus has spread across the general population with a 2.2% infection rate in pregnant women. Overall, 30% of HIV cases occur in Injecting Drug Users (IDU's), who were the first group heavily affected by the epidemic. Within a year of the first HIV infection being detected in Burma, it was found that the infection rates among Ides were the highest in the world, where they have remained.

Australia supports a coordinated approach to HIV/AIDS control in Burma as a member of the UN Expanded Theme Group that oversees Burma's UN Joint Program on HIV/AIDS 2003-05. Besides the Asia Regional HIV/AIDS Project, which encompasses Burma, Australia is supporting five NGO projects which are consistent with the UN Joint Plan of Action 2003-05 on HIV/AIDS (Myanmar). Each of the projects will be delivered through implementing partners in Burma and is three years in duration beginning early 2003 and due for completion in 2006. These projects will cover the four priority areas of the Joint Plan of Action:

1. Targeted condom promotion and STI prevention and care;
2. Injecting drug user (IDU) interventions;
3. Awareness raising for the general population with a focus on young people;
4. Care, compassion and support for people living with HIV/AIDS (PLWHA)

## East Timor

Based on available data, the prevalence of HIV infection in East Timor is probably low. Only seven ambulatory blood donors, a handful of other individuals, and about nine United Nations (UN) personnel have tested positive to HIV since 1999.

There is a small but growing sex industry in East Timor, and other behavioural and cultural risk factors are consistent with vulnerability within society to HIV transmission.

Between March 2001 and August 2002, AusAID provided technical assistance to support the Ministry of Health (MoH) to address East Timor's most urgent HIV/AIDS prevention needs and to support the MoH and the East Timor Working Group on HIV/AIDS to develop medium to longer term HIV/AIDS programs. Australian assistance culminated in a National conference on HIV/AIDS and the development of a National Strategy for the prevention of HIV/AIDS. This catalytic work attracted the attention of other Donors and has enabled Australia to plan to move to other essential areas of health need.

## Papua New Guinea

PNG has the highest incidence of HIV/AIDS in the Pacific region and the fifth highest percentage of 15 to 24 year olds living with HIV/AIDS in South-East Asia and the Pacific. Since the 1990's, HIV prevalence amongst women attending antenatal clinics, blood donors and tuberculosis patients has grown sharply. Heterosexual transmission is the predominant means of infection, with approximately equal numbers of men and women affected, except in the 15 to 29 year old age group where women outnumber men.

Parent to child transmission is the second most common means of infection. Significant prevalence rates are found not only in large urban areas (for example the national capital Port Moresby), but also in rural pockets typically around primary industry sites. The similarity of sexual behaviour patterns in PNG and Sub-Saharan Africa suggest that PNG's epidemic has the potential to reach Sub-Saharan African levels. The resulting impact on PNG's economy and societal structures could be devastating.

In 2002/03 Australia committed over one quarter of its international HIV/AIDS resources to PNG; the most significant component within Australia's aid program HIV/AIDS allocation.

*PNG National HIV/AIDS Support Project*

This project commenced in October 2000 and will expend $60 million over five years. This project will support the work of the PNG government in implementing the PNG National HIV/AIDS Medium Term Plan. It provides a multi-sectoral response to the epidemic and focuses on raising awareness through education and information; improved counselling and community care and support; monitoring the spread of HIV/AIDS; improving clinical services and medical care; addressing policy, legal and ethical issues and supporting the National AIDS Council secretariat.

*The Collaboration for Health in Papua New Guinea (courtesy of Ms Elizabeth Reid)*

The Collaboration for Health in Papua New Guinea (CHPNG) was established by a number of Australian pharmaceutical companies as a philanthropic contribution towards improving the health and well-being of the people of PNG and towards increased political and social stability of Australia’s nearest neighbour.

Collaborative and philanthropic action was a new instrumentality for the participating companies[1] and the initiative was originally known as the Informal Consortium on HIV. The Informal Consortium was to serve as a demonstration of the Australian industry’s

[1] Merck Sharp and Dohme, Boehringer-Ingelheim, Pfizer, Bristol Myers Squibb, Glaxo Smith Kline, Abbot, and Roche with the Australian Pharmaceutical Manufacturers Association providing the secretariat.

commitment to corporate social responsibility, and to provide leadership for the development of an Australian-PNG public-private partnership to enhance the well-being of people in PNG living with HIV.[2]

Within the framework of a public-private partnership for health, the companies sought to establish new sets of relationships with their traditional associates, both in government and in the HIV NGO community, working in partnership with interested parties within which each contributed according to their mandates, interests and areas of expertise.

The first major activity of the consortium was the organisation of an International Roundtable on Increasing Access to HIV Care, Support and Treatment, which was held at the Australian National University in September 2002. Multidisciplinary teams from 13 countries in the Asia and Pacific regions drew lessons from case studies of successful approaches to HIV care and support in resource poor settings and developed a strategic framework for moving forward. The main funding for the Roundtable came from the Informal Consortium members, who were joined by a diverse range of funding partners: AusAID, UN agencies, and international NGOs[3].

The Roundtable was timely, as the morbidity and mortality of the epidemic were just beginning to be felt in the region. Its impact was significant. It galvanised commitment to concrete action across the region, impressed on its participants that action was often best begun on a small scale, building on the efforts of those committed to HIV care and support, and reinforced the importance of involving those infected and affected by the epidemic. It also provided an opportunity for the PNG participants to discuss and identify HIV care and support capacity building needs in PNG with the consortium members.

At the successful completion of the Roundtable, it was decided in February 2003 to formalise the consortium and form the Collaboration for Health in PNG (CHPNG). Some of the original members withdrew and others joined[4]. This new body adopted a broader charter (CHPNG Statement of Purpose 2003), formalised its governance arrangements, and reinstated its commitment to work in close consultation and partnership with other actors.

A number of critical challenges faced the CHPNG: the need to find means of strengthening coordination and collaboration within a competitive industry, the need to protect and clarify the philanthropic nature of the work in a sceptical environment, and the need to use CHPNG limited resources in ways which ensured good development practice.

To address the first challenge, the Collaboration determined that all philanthropic activities of participating companies in PNG will be part of the CHPNG, whilst

[2] Steve Haynes 2002. Report of the Informal Consortium Familiarisation Visit to PNG, February 2002.
[3] http://www.hivroundtable2002.virtual-asia.com/index.htm
[4] Its continuing members were Merck Sharp and Dohme, Boehringer-Ingelheim, Pfizer, Bristol Myers Squibb, and Glaxo Smith Kline, and they were joined by Aventis.

remaining initiatives of the particular company or companies. Further, companies undertaking such initiatives will keep other Collaboration members informed (CHPNG Statement of Purpose 2003). This required the establishment of structures for consultation and joint planning.

The second and third challenges were addressed by the appointment of a Senior Adviser with extensive development and HIV expertise to manage the philanthropic funds and to establish and manage the CHPNG partnerships. The member companies continued their established HIV funding activities, including the sponsorship of HIV conferences, the provision of conference scholarships, and the funding of HIV training courses and similar activities, but the partnership mode of the CHPNG established a new set of relationships with the recipient organisations.

After extensive consultations, three collaborative ventures were identified and initiated in 2003-2004[5]:

- Strengthening the role of day care and drop in centres, and of people living with HIV, in the national response to the epidemic; this was undertaken together with NAPWA and a range of PNG partners,

- The development of new approaches to strengthening the capacity of health care teams for HIV care and their piloting across the country; this was undertaken together with the Australasian Society for HIV Medicine (ASHM) and a range of PNG partners, and

- Material support to Port Moresby General Hospital, a gift programme.

The CHPNG represents a significant development in the types of activities pharmaceutical companies in Australia are willing to support. The feedback on the value of these activities to PNG has been very positive, with PNG partners particularly appreciating the consultative and capacity building approach.

As these initiatives draw to a close, a number of important lessons have been learnt. Firstly, the non-recurrent nature of Collaboration funding and the high public profile of the HIV epidemic require the careful management of expectations and meticulous project design and monitoring.

The partnership modality has enabled the skills, resources and commitment of significant numbers of Australian individuals and organisation to be brought to bear on the work and has enabled similar partnerships to be built among a wide range of PNG actors.

The consultative approach has strengthened the trust required for a complex intercultural endeavour and the capacity building approach has ensured that the human and intellectual resources of PNG have been capitalised.

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[5] CHPNG members by 2004 were Merck Sharp and Dohme, Boerhinger-Ingelheim, Pfizer, Bristol Myers Squibb and Aventis. Bristol Myers Squibb and Aventis later withdrew and in 2005 Gilead joined.

However, the time required to build trust, partnerships and create initiatives that meet development best practice requirements is lengthier than that of commercial ventures. This has placed accommodation demands on the participating companies.

The Collaboration has shown that cooperation within a competitive industry can be achieved. However, the tensions between the practices of philanthropy and those of the market have created discomfort and led some to a questioning of the value of philanthropic activities.

In the confluence of these factors, there has been a fairly high turnover of member companies.

Philanthropy based public private partnerships are not only new to the Australian pharmaceutical industry but are also new to its partners. No longer is the industry a provider of financial resources to the work of others. Rather each is a working partner in a collaborative undertaking, in which decision making is a cooperative activity and intellectual property rights accrue to the partners jointly.

This new modality has had to be developed in the context of discussion and trial and error. It has not succeeded where cynicism or disparagement of industry motivation have been dominant styles. Where trust, or at least suspended distrust, has been created or offered this new mode of association has proved highly productive.

The work undertaken under the aegis of the CHPNG has been greatly beneficial in its contribution not only to the health and well being of the people of PNG, but to a sense that the nation itself is shaping its distinctive response to its distinctive HIV epidemic in a context of collaboration.

**South Asia**

## Bangladesh

All of the known HIV-risk behaviours and factors - Floating Sex Workers (FSW), Men who have sex with men (MSM), Intravenous Drug Users (IDU's) and "high" rates of STI are acknowledged to be present in Bangladesh. As a result, there is increasing concern that a marked epidemic spread of HIV might occur in a manner similar to that documented in neighbouring countries of India, Myanmar and Thailand.

Australia currently has three HIV/AIDS activities (two of which are research studies) being implemented in Bangladesh by the **Centre for Population Health (ICDDR**). Funding of A$600,000 for three years starting in 2001/2 was provided. A further A$ 900,000 in core funding was provided to the Centre for the same period.

*Investigating the Risk Factors for HIV and Hepatitis infections in Ides in Dhaka*

This study aims to describe the incidence of HIV, hepatitis & syphilis infections in Ides attending a needle/syringe exchange program in Khilgaon and Moulavibazar. High-risk behaviour in IDU's attending the program will also be considered. The study is expected to increase understanding of the dynamics of HIV infection in this demographic.

*Male Sexuality and Masculinity: Implications for STI/HIV and Sexual Health Interventions in Bangladesh*

This project will explore and describe Bangladeshi males' sexuality construction in the framework of gender and masculinity. The study will analyse the overall significance and consequence of these constructions in terms of engaging in and maintaining behaviours contributing to the transmission, prevention and control of STI/HIV and sexual health promotion in Bangladesh. The study aims to achieve maximum diversity in terms of socio-cultural, economic, educational and occupational backgrounds.

*Establishment of Facilities for Monitoring Disease Progression in HIV infected Individuals*

This project has three objectives:

- Establish facilities for measuring CD4 counts using a Fluorescence Activated Cell Sorter (FACS) in HIV positive persons
- Form part of an "HIV referral network" for the Voluntary Counselling & Testing Centre for HIV at ICDDR
- Provide services to other research projects & other clinical conditions where phenotyping of cells is required.

## India

India's national adult HIV prevalence rate of less than 1% offers little indication of the serious situation it faces. An estimated 4.58 million people were living with HIV at the end of 2002 - the world's second highest figure, after South Africa. The virus has been found to be more prevalent (higher than 1%) in women attending antenatal clinics in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu.

*India-Australia HIV/AIDS Prevention and Care Project*

AusAID is awaiting final approval from the Government of India (GOI) of the redesigned PDD in order to proceed with tendering the implementation of the proposed five-year $19.2 million project. The aim is to provide integrated responses in three Northeast states and New Delhi, addressing the priorities identified by each of those states. The project will focus on reducing the risk of HIV transmission among vulnerable populations through a program of targeted interventions specific to these groups.

## Nepal

HIV infection rates in Nepal are linked to migrant worker flows to neighbouring India. A substantial proportion of the adolescent and adult male population in Nepal seeks temporary, and sometimes permanent, work in several states in India. A recent survey among returning migrants and non-migrants in Nepal shows some of the first evidence of what could become a major epidemic in Nepal. Preliminary research conducted in Doti district shows high HIV prevalence (10%) in returning migrants from Mumbai India.

Behavioural surveys conducted on sex workers in Terai, Nepal show the association of HIV with sex work and the trafficking of women to India. However, striking prevalence differences were found according to whether the women had done sex work in India.

Data has shown an overall HIV prevalence among Nepali sex workers (located in Terai) of 4%. Striking differences were found according to whether the women had done sex work in India. Women who worked in commercial sex in Mumbai registered the highest HIV prevalence (50 percent), followed by those who worked in other areas of India (7.4 percent). Women who never worked in India had far lower prevalence (1.2 percent) than those who had worked in India.

*HIV/AIDS and STI Prevention and Awareness Project*

Australia funded a local project on HIV/AIDS under the South Asia Community Assistance Scheme (SACAS). This project aims to raise awareness amongst migrant workers and commercial sex workers of Baitatdi district in regard to prevention of HIV/AIDS transmission.

## China

The epidemic in China shows no signs of abating. Official estimates of people living with HIV in China are 1 million in mid-2002. UNAIDS estimate that unless effective responses rapidly take hold, 10 million Chinese will have acquired HIV by 2010.

*HIV/AIDS Prevention and Care Project*

In the Xinjiang Autonomous Region, a five-year, $A14.7 million commenced in March 2002. It seeks to improve the capacity of the Xinjiang provincial government to reduce the incidence of HIV/AIDS through a multi-sectoral response focusing on policy development, health promotion, strengthening the indirect care environment (diagnosis, testing and infection control); and providing a better environment for care in hospitals and homes for people with AIDS.

*Tibet Health Sector Support Program*

This $A17.3 million program will commence in 2004 and includes a component to raise knowledge and awareness about HIV/AIDS and help reduce risk behaviours amongst vulnerable groups. Safer blood supply practices will also be supported.

*World Bank Health IX HIV/AIDS/STD Prevention and Control Project*

Australia has made a $A2 million contribution to this project which will work in four areas: policy development and institutional strengthening; HIV/AIDS intervention; HIV/AIDS surveillance and blood management at both the national level and across four provinces (Fujian, Guangxi, Shanxi, Xinjiang).

**Africa**

By far the worst affected region, 29.4 million people living with HIV/AIDS live in sub-Saharan Africa. There were approximately 3.5 million new infections in 2002, an estimated 2.4 million AIDS deaths in the past year. In Botswana, Lesotho, Swaziland and Zimbabwe, HIV prevalence ranges from 30-39%.

The AusAID Africa program provides HIV/AIDS assistance primarily through Australian NGOs, who work with partners in the recipient countries to conduct the projects. Under the NGO HIV/AIDS program $A10 million is being provided over three years to NGOs working in Kenya, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia, Swaziland and Zimbabwe.

Priority for HIV/AIDS funding in Africa is given to activities in the following areas: awareness raising education and prevention efforts; voluntary, confidential and relevant counseling; community/family-based care and support programs for people affected by HIV/AIDS; community-based orphan care programs; economic and social development activities which are HIV/AIDS focused; institutional building activities; and ethical, political, legal and civil liberty efforts to protect the rights of people living with HIV/AIDS.

Australia will provide $A11.5 million over four years to assist African members of the Commonwealth to reduce infection rates and the impact of HIV/AIDS, by using Australian expertise in this field. Of this, $A10 million will go to community-based projects identified by Australian Non Government Organisations. $A1.5 million will go towards a scholarships program to train African health workers to develop and implement strategies for reducing HIV/AIDS. Australia is also providing $A250,000 per year to research the impact of AIDS in South Africa.

## Attachment C

### Impact of HIV Infection Rates on IDU in Prisons

## Diagram: 1

### At Risk HIV Exposures Model of IDU in Prisons

*Based on a Model Developed by Dr Wiwat Rojanapithayakorn, UNAIDS SEAPICT*

| | A | B | C |
|---|---|---|---|
| Number of IDU in Prison | 1,000 | 1,000 | 1,000 |
| HIV +ve (%) | 1% | 10% | 40% |
| Unsafe injecting episodes per week | 5 | 5 | 5 |
| No. of people sharing injecting equipment | 1-5-10 | 1-5-10 | 1-5-10 |

Scenario A

10 HIV+ve people X 5 episodes X 1 sharer = 50 (HIV risk exposures per week)
10 HIV+ve people X 5 episodes X 5 sharers = 250 (HIV risk exposures per week)
10 HIV+ve people X 5 episodes X 10 sharers = 500 (HIV risk exposures per week)

Scenario B

100 HIV+ve people X 5 episodes X 1 sharer = 500 (HIV risk exposures per week)
100 HIV+ve people X 5 episodes X 5 sharers = 2,500 (HIV risk exposures per week)
100 HIV+ve people X 5 episodes X 10 sharers = 5,000 (HIV risk exposures per week)

Scenario C

400 HIV+ve people X 5 episodes X 1 sharer = 2,000 (HIV risk exposures per week)
400 HIV+ve people X 5 episodes X 5 sharers = 10,000 (HIV risk exposures per week)
400 HIV+ve people X 5 episodes X 10 sharers = 20,000 (HIV risk exposures per week)

Diagram 1 demonstrates that as the number of injecting drug users who are HIV positive in prison increases from 1% to 40% the potential number of HIV risk exposures for prisoners injecting drugs increases from 250 to 10,000 each week for every 1,000 prisoners (based on 5 prisoners sharing a needle and syringe at each of 5 drug injecting episodes each week).

As a result, the opportunity for HIV negative injecting drug users to remain HIV negative is substantially reduced, particularly given they are in an environment where there is often insufficient access to education, drug treatment and sterile injecting equipment.

These figures are even more alarming given it does not take into account the many prisoners that actually commence injecting drug use for the first time whilst in prison, or the anecdotal evidence that large numbers of prisoners often share a single needle and syringe repeatedly, or the higher risk of HIV infection from other potential risk exposures such as unsafe sexual activity or unsafe tattooing practices.

The model has been developed to underline how risky injecting drugs in prisons are likely to be. It should be noted this model could also be used to describe the risk for hepatitis C which already affects a higher number of prisoners and is therefore a greater risk for transmission in the prison environment.

**Diagram: 2**

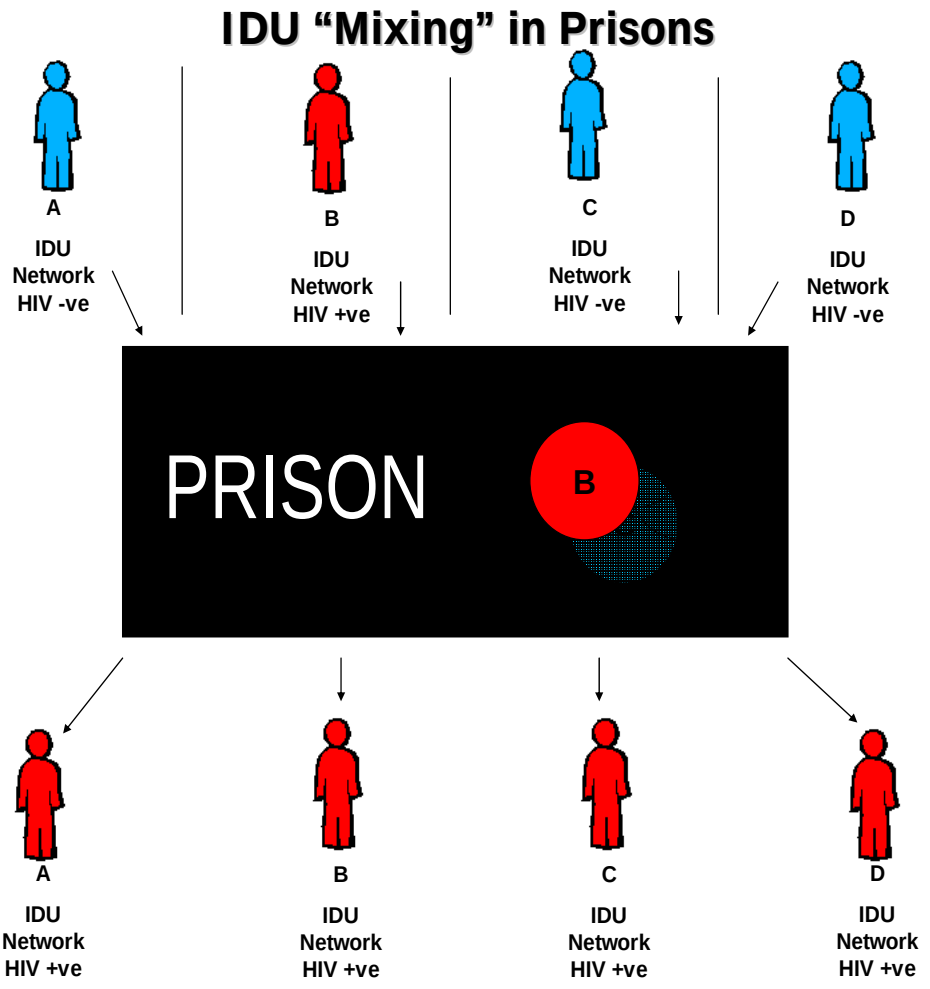

Diagram 2 demonstrates how natural geographic or socioeconomic barriers within a country, where different networks of injecting drug users can co-exist with little opportunity for contact and thus HIV transmission from one group to another, can be broken down.

In this hypothetical model, members of 4 different injecting drug using groups (A, B, C & D) are imprisoned and as a result of continuing their injecting drug use in prison eventually use and share drugs with each other.

Upon returning to their usual and quite separate injecting groups these members by sharing injecting equipment also share any infections they acquired whilst in prison. The potential for transmission to friends and family members of these injecting drug using groups also now increases.

So, given this wealth of data and evidence available it would seem reasonable to expect some dramatic changes in prison based HIV/AIDS and drug treatment policies and programs over the past few years.

At the least the establishment of prison programs that equivalent to those that exist in the community would be expected. Yet the response to date, as can be seen below remains inexplicably inadequate:

- Number of countries with prison based needle & syringe programs 5
- Number of countries with prison based substitution (eg methadone) programs 10+
- Number of countries with prison based bleach programs 14
- Number of countries with prison based condom programs 18

*(Source: Rutter et al 2001, EMCDDA etc)*

So despite the evidence of rampant HIV infection in many prisons around the world and a growing recognition that the community based efforts to reduce HIV infection and provide treatment for drug use will be undermined by a prison system which actually increases the risks and consequences of drug use for these same people; there remains a real lethargy amongst politicians and prison authorities to support the efforts being made in the community.

Whilst it is logical to assume that there would be a multitude of localised and regional reasons to explain this growing gap between evidence and practice, there is also some consistency in the reasons.

In short, it is the pressure on governments to ensure prisons are strictly controlled environments.

As a result, there is a growing community and political view to see prisons as institutions of punishment for criminal activity rather than opportunities for change. From this base it becomes very difficult for more affluent countries to introduce and maintain prison based services that are equitable to those in the community, whilst for less affluent countries the

allocation of resources to prisons to reduce the gap between community and prison service levels is made even more difficult.

This article and the models used to describe the level of risk in prisons challenge as both idealistic and somewhat dangerous any response that focuses solely on eradicating the supply of drugs in prisons.

Whilst achieving a completely drug free prison may be an admirable goal, it is highly unlikely.

Indeed, there would be very few, if any prisons around the world that could claim such a status, notwithstanding the community and political pressure to attest to one's prisons being drug free.

What is required in response to this risk in prisons is a number of concurrent goals:

- make the trafficking of drugs into prisons difficult;
- provide clear and appropriate HIV/AIDS and drug prevention education for all staff and prisoners;
- make a range of drug treatment regimes widely available;
- make HIV and hepatitis treatments available for all affected prisoners;
- ensure a continuum of treatment and care into the community for prisoners upon release.

It may appear a simple task to introduce these measures, but until prison authorities embrace the pragmatic effectiveness of a Risk Management Strategy to their work (something that most businesses, health and other organisations have done for some time now) there is little chance of reducing the level of potential HIV risk and other harms that can occur in prisons and improving safety for the workplace, the prisoners and the community.

## Appendix D

## Individuals Consulted in the Preparation of this Report

| | |
|---|---|
| Mr Don Baxter | Executive Director, Australian Federation of AIDS Organisations |
| Ms Stevie Clayton | Executive Officer AIDS Council of NSW |
| Ms Levinia Crooks | Executive Officer, Australian Society of HIV/AIDS Medicine |
| Professor David Cooper | Director, National Centre in HIV Epidemiology and Clinical Research |
| Dr Rob Finlayson | Sydney general practitioner specialising in HIV/AIDS |
| A/Professor Julian Gold | Director, Albion Street Clinic, Sydney |
| Professor John Kaldor | Deputy Director, National Centre in HIV Epidemiology and Clinical Research |
| Ms Annmaree O'Keeffe | Australian government's HIV/AIDS Coordinator, AusAID, Department of Foreign Affairs and Trade |
| Mr Shane Martin | Melbourne University Private |
| Prof Ron Penny | former Chair, AIDS Task Force and Professor of Immunology, St Vincent's Hospital |
| A/Prof David Plummer | University of New England, former President, Australian Federation of AIDS Organisations |
| Mr Chris Puplick | Albion St Clinic, Sydney, former Australian Senator and Chair, Australian National Council on HIV and Related Diseases |
| Mr Nathan Rabe | Manager, International Programs, Australian Red Cross |
| Ms Elizabeth Reid | Senior Consultant on HIV/AIDS |
| Mr Gino Vumbaca | Executive Officer Australian National Council on Drugs |
| Mr Bill Whittaker | President, Australian Federation of AIDS Organisations |
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