

UNGASS COUNTRY PROGRESS REPORT

AUSTRALIA

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II. Status at a glance

a) The inclusiveness of stakeholders in the report writing process

A central tenet of Australia's *National HIV/AIDS Strategy 2005 – 2008* is the participation of people living with HIV/AIDS in policy and program development, implementation, monitoring and evaluation. This involvement ensures policies and programs are informed by the experiences of people living with HIV/AIDS, are responsive to need, and take adequate account of the full range of personal and community effects of policy.

The development of Australia's *Country Progress Report 2006 – 07* continued this partnership approach. Key non-government, community-based organisations, including the Australian Federation of AIDS Organisations, the National Association of People Living with HIV/AIDS, the Australian Injecting and Illicit Drug Users' League and the Scarlet Alliance (representing Australian sex workers) were invited to contribute to the report.

Statistical and other information was provided by four national research centres funded by the Commonwealth Government of Australia to provide epidemiological data and undertake HIV clinical and social research, HIV and hepatitis virology research, and research focusing on sex, health and society.

b) The status of the epidemic

Australia continues to have one of the lowest population rates of new HIV diagnoses among similarly developed countries.

By 31 December 2006, there were 26,267 diagnoses of HIV infection in Australia. There were 10,125 diagnoses of AIDS and 6,723 deaths following AIDS had occurred. Following a long-term decline, the annual number of new HIV diagnoses has gradually increased, from 763 cases in 2000 to 998 in 2006.

Over the past ten years, combination antiretroviral treatment of HIV infection has been effective in delaying the progression of those who have been infected with HIV to AIDS and for improving survival following AIDS. The annual number of AIDS diagnoses in Australia declined from 395 in 1997 to 213 diagnoses in 2001 and has remained relatively stable over the past 5 years at around 240 diagnoses per year.

c) The policy and programmatic response

Australia has recognised the need for a national response to HIV/AIDS since the first person with AIDS was diagnosed in the country in 1982. This response has included a series of national strategies for HIV/AIDS, the creation of community-based organisations to deliver education, prevention and support services, the establishment of national research centres to conduct strategic research on the disease and national participation in World AIDS Day.

The Commonwealth Department of Health and Ageing is responsible for the coordination of Australia's national response to HIV/AIDS, hepatitis, sexually transmissible infections and Aboriginal and Torres Strait Islander sexual health and blood borne viruses. It has primary carriage of four strategies: the *National HIV/AIDS Strategy*, the *National Sexually Transmissible Infections Strategy*, the *National Hepatitis C Strategy* and the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy* aimed at reducing the incidence of infections. The strategies focus on health promotion, prevention education, improved awareness

of transmission and improved access to health services. Each current strategy covers the period 2005 – 2008.

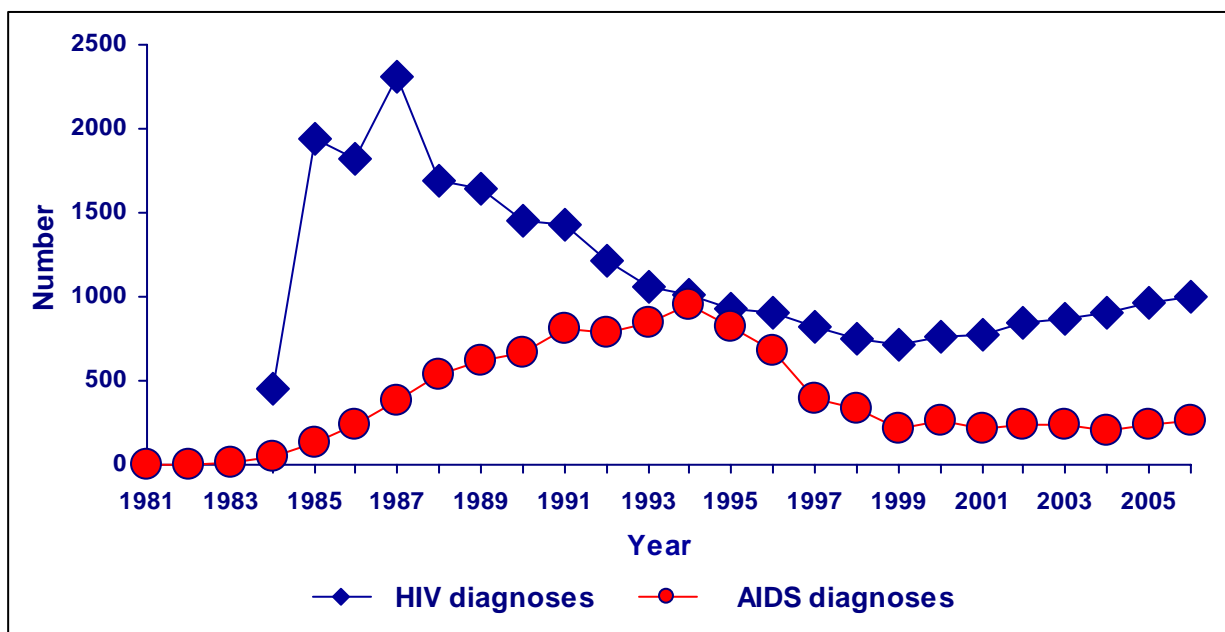
III. Overview of the HIV/AIDS epidemic¹

In contrast to comparable countries, Australia has low HIV/AIDS prevalence in all populations, including among homosexually active men, injecting drug users and sex workers. In terms of risk and those living with HIV, the Australian epidemic remains as it began: overwhelmingly an epidemic among homosexually active men.

In other aspects, the Australian HIV epidemic continues to evolve. With effective treatments and the consequent improvement in survival after HIV infection, Australia is now faced with an increasing prevalence of HIV among homosexually active men.

Following a long-term decline, the annual number of new HIV diagnoses in Australia has gradually increased, from 763 cases in 2000 to 998 in 2006 (Figure 1). Among cases of newly diagnosed HIV infection, an increasing number were in people who had acquired HIV infection within the previous year.

Figure 1: Number of HIV and AIDS diagnoses in Australia, 1981 to 2006.



Source: National Centre in HIV Epidemiology and Clinical Research: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2007.

HIV in Australia continues to be transmitted primarily through sexual contact between men. Among cases of newly acquired HIV infection in 2006, male homosexual contact was reported in 84%, male homosexual contact and injecting drug use in 4%, heterosexual contact only in 8%, and injecting drug use only in 1% of cases. In 3% of cases, exposure to HIV remained undetermined. There was a similar rate of HIV diagnosis *per capita* in the Aboriginal and Torres

¹ Note: At the time of writing, confirmed data on HIV and AIDS in Australia are available only to the end of 2006. This report confines itself to the reporting of confirmed data.

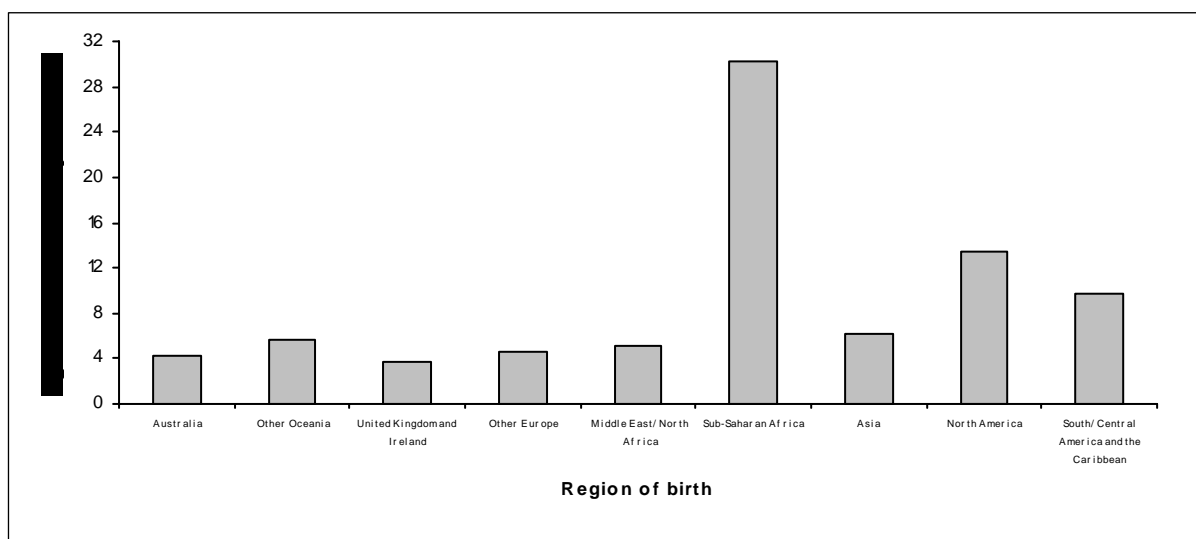
Strait Islander (4.9 per 100,000) and non-Indigenous (5.1 per 100,000) populations. Higher proportions of cases were attributed to heterosexual contact and injecting drug use in the Indigenous population.

People born in Australia accounted for 67% and 65% of AIDS diagnoses in Australia in 1997 – 2001 and in 2002 – 2006 respectively. The highest AIDS incidence in both five year intervals was among people born in countries in sub-Saharan Africa.

Around 60% of new HIV diagnoses in 2002 – 2006 were in people who were born in Australia. Countries in sub-Saharan Africa were associated with the highest population rate of HIV diagnosis in Australia in 2002 – 2006 (Figure 2).

The annual number of AIDS diagnoses in Australia declined from 395 in 1997 to 213 diagnoses in 2001 and has remained relatively stable over the past 5 years at around 240 diagnoses per year.

Figure 2: HIV diagnoses in Australia, 2002 – 2006, by year and region of birth.



Source: National Centre in HIV Epidemiology and Clinical Research: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2007.

HIV infections in selected populations

Population groups regarded as priorities for prevention and health promotion activities under the *National HIV/AIDS Strategy 2005 – 2008* include gay and other homosexually active men, Aboriginal and Torres Strait Islander people and people who have injected drugs. These populations are identified as priority groups because they are recognised as either experiencing ongoing HIV transmission or having the potential for increases in transmission.

Gay and other homosexually active men

Men with a history of homosexual contact continue to make up the majority of people diagnosed with HIV infection and AIDS in Australia. The overall number of new HIV diagnoses in this population was 3,154, including 1,200 diagnoses of newly acquired HIV infection, in the period 2002 – 2006. Sexual transmission between men accounted for a higher proportion of diagnoses of newly acquired HIV infection (85%) than total HIV diagnoses (67%) in 2006.

Among gay men seen at metropolitan sexual health clinics, the percentage with newly acquired HIV infection has increased both in those aged less than 25 years, from 0.8% in 2003 to 1.1% in 2006, and in those aged 25 years or older, from 0.5% in 2003 to 1.4% in 2006.

Aboriginal and Torres Strait Islander people

The rate of HIV diagnosis in the non-Indigenous population gradually increased from 4.1 in 2002 to 5.1 per 100,000 population in 2006. This compares to a rate of 4.9 in Aboriginal and Torres Strait Islander people in 2006, which has declined from a peak of 7.5 in 2002. The rate of AIDS diagnosis in the Aboriginal and Torres Strait Islander population declined from a peak of 4.2 in 2004 to 1.3 in 2006. The rate of AIDS diagnosis in the non-Indigenous population also declined from 1.3 in 2002 to 1.0 in 2006.

Among new HIV diagnoses in 2002 – 2006, the most frequently reported route of HIV transmission was male homosexual contact in the non-Indigenous population (65%). In the Aboriginal and Torres Strait Islander population exposure to HIV was attributed to male homosexual contact in 37% of cases and in 34%, heterosexual contact was the reported source of exposure. Aboriginal and Torres Strait Islander cases also differed from non-Indigenous cases in that a higher proportion of infections were attributed to injecting drug use (18% among Aboriginal and Torres Strait Islander cases versus 3% for non-Indigenous cases), and a higher proportion of infections were among women (30% among Aboriginal and Torres Strait Islander cases versus 11% for non-Indigenous cases).

People who have injected drugs

In 1997 – 2006, approximately 8% of HIV diagnoses in Australia were in people with a history of injecting drug use, of whom more than half were men who also reported a history of homosexual contact.

HIV prevalence among people attending needle and syringe programs however has remained low (around 1% in 2002 – 2006), but in the subgroup of men who identified as homosexual it was 32.2% in 2006. Of 820 men and 380 women with a history of injecting drug use who were tested for HIV antibody at metropolitan sexual health centres in 2005 – 2006, 6 cases of HIV infection (0.73%) were diagnosed in men and none were diagnosed in women.

Heterosexual transmission of HIV infection

The number of new HIV diagnoses for which exposure to HIV was attributed to heterosexual contact has increased from 775 in 1997 – 2001 to 914 in 2002 – 2006, accounting for 20% of total diagnoses in both periods.

Men and women who came from a country with high HIV prevalence accounted for 36% and 38% of HIV diagnoses attributed to heterosexual contact in 1997 – 2001 and 2002 – 2006 respectively. In both five year intervals, the majority of cases came from high prevalence countries in sub-Saharan Africa (57% and 61%) and South East Asia (36% and 29%). The proportion of cases from high prevalence countries that were among women increased from 54% in 1997 – 2001 to 63% in 2002 – 2006.

Excluding cases from a high prevalence country, there was a small annual increase (about 3% per year) in 1997 – 2006 in the number of new HIV diagnoses associated with heterosexual contact among men but not among women.

HIV prevalence has remained less than 0.5% among heterosexually active men and women seen through metropolitan sexual health clinics. In 2002 – 2006, HIV prevalence was less than 0.5%

among men and women who reported a history of heterosexual contact overseas and among men and women who reported a history of heterosexual contact in Australia only.

HIV prevalence has also remained low among women self-identifying as sex workers, with or without a history of injecting drug use.

Levels of HIV infection in blood donors who undergo a screening interview to exclude those with recognised risk factors for HIV infection have been below 1 per 100,000 donations since 1985, with some evidence of a decline during this period, possibly reflecting increasingly effective deferral procedures.

IV. National response to the AIDS epidemic

The history of the Australian response to HIV and AIDS bears testament to the importance of both an evidence-based policy platform and an effective partnership between government, community, researchers, clinicians and people living with HIV/AIDS. These features have enhanced Australia's ability to modify behaviours that put people at risk of HIV infection and enabled containment of the disease.

Australia's commitment to HIV/AIDS prevention, treatment, care and support, knowledge building and behaviour change is described in the fifth *National HIV/AIDS Strategy 2005 – 2008*. The health needs of people at higher risk of infection, infected with HIV, and living with AIDS remain the focus of Australia's response.

a) Prevention

Prevention education and health promotion is delivered nationally on behalf of the Commonwealth Government by community-based organisations and state and territory government health services. Community-based organisations are funded by both the Commonwealth and state and territory governments and contribute to the development and implementation of programs linked to the HIV/AIDS strategy. State and territory health services also receive funding through Public Health Outcome Funding Agreements to provide public health education, prevention, treatment and counselling services.

At the beginning of Australia's epidemic, unprotected anal intercourse was an almost universal practice among gay and homosexually active men. Prevention programs aimed at informing gay and other homosexually active men of the risks of this behaviour and influencing behaviour change have had mixed results. Survey data in New South Wales (NSW) indicate the proportion of gay and other homosexually active men engaging in unprotected anal intercourse with casual partners has declined from 25.7% in 2001 to 20.8% in 2006. The same surveys carried out in the capital cities of other Australian states indicated either a stable or increasing rate. In Adelaide, Brisbane and Melbourne the level of reported unsafe sexual behaviour had stabilised at around 16%, 22% and 20%, respectively, whereas in Perth, the level of reported unsafe sexual behaviour had increased from 18.5% in 2002 to 20.7% in 2006.

NSW is the only place in the world with available data where HIV risk behaviour is decreasing among homosexual men². Strengths of the NSW prevention efforts are worth noting.

There exists:

² NSW Health, A Think Tank: Why are HIV Notifications Flat in NSW 1998-2006? Consensus Statement. NSW Health, April 2007.

- an effective partnership between government, clinicians, researchers and the community. There are clear, well-supported mechanisms for liaison and priority-setting, frankness of debate, the sharing of evidence, the absence of blame and the respect of different roles among partners;
- a comparatively high *per capita* investment in HIV prevention programs targeting homosexually active men;
- maintenance of a skilled workforce in HIV health promotion and policy, with key personnel working across different settings, including community-based organisations, area health services, the national research centres (based in Sydney) and the NSW Department of Health. The maintenance of a skilled workforce within the NSW Department of Health has enabled the department to maintain a leadership and coordination role in the response;
- effective social marketing initiatives that have targeted both broad and specific audiences of gay men, including HIV positive men. The NSW material is comprehensive in terms of both the diversity and volume of education material and in the range of different homosexually active men to whom it speaks. It is also integrated with other interventions (e.g. a comprehensive range of community development and group support programs, sexual health testing and treatment, mental health and self-esteem and drug harm initiatives); and
- a health promotion response that prioritises and integrates issues of service access, clinician support and education. The evidence is that health promotion social marketing works best when reinforcing well thought through clinical and service responses. That is, linking social marketing to a health promotion message and investment in the development of more appropriate sexual health services in high prevalence areas.

Nationally, achievements in prevention activities include the establishment of successful partnerships between jurisdictional and community-based organisations and affected individuals for the development and delivery of targeted prevention education and other health promotion activities.

b) Care, treatment and support

Initiatives in treatment and care are aimed at improving access to systems that promote the health and quality of life for people living with HIV/AIDS.

Treatment and care embrace a range of services, including testing, early access to health maintenance programs, antiretroviral therapy, counselling, treatment adherence programs and management of HIV-associated conditions. Initiatives have been tailored to the identified needs of priority groups under the strategy. For example, there are care, treatment and support initiatives for:

- the development of health promotion programs to increase the awareness of HIV/AIDS risk among Aboriginal and Torres Strait Islander people in both remote and urban settings, including specific programs focused on gay and other homosexually active men, women and people who inject drugs within Indigenous communities. A *Sexually Transmissible Infections and Blood Borne Infections Manual* has been developed by the Aboriginal Health and Medical Research Council of NSW to improve access to early detection and treatment programs for Indigenous people and communities in NSW;
- workforce development for health care workers, with the aim of maintaining high quality expert knowledge and skills in relation to HIV/AIDS in both government and non-government health and community services. Partner organisations continue to develop and deliver high quality training and education to health care professionals and focus attention on

the need for resources for culturally and linguistically diverse communities. A website publication *Models of Care for HIV Management in Adults* has been developed and updated by the Australasian Society of HIV Medicine to provide clinicians (especially those without a high HIV caseload) with access to locally relevant, up-to-date and easy to use information to guide and support patient care. National *HIV Testing Guidelines* have also been reviewed and updated;

- ensuring that people living with HIV/AIDS can access appropriate treatment, care and support, including appropriate income support, disability support and carer allowances.

c) Antiretroviral therapy

The rate of AIDS diagnoses and death in Australia has continued to decline, predominantly due to the widespread uptake of antiretroviral therapy. An estimated 9,463 people were prescribed antiretroviral treatment for HIV infection (up from 6,440 in 2002) at an estimated cost of AUD\$118 million dollars in the 2006-2007 financial year. In addition, via government funded HIV/AIDS programs, people living with HIV/AIDS have been assisted to participate in trials of new treatments, special treatment access schemes and studies that intend to address the social and physical impacts of antiretroviral therapy.

The proportion of HIV-positive men who reported that they were taking antiretroviral treatment in recent years has risen. In the *Positive Health* cohort, the proportion of men on therapy has increased from 69% in 2002 – 2003 to around 75% in 2006. The *Australian HIV Observational Database* indicated that 72% of 1,802 people under follow-up in 2006 were receiving triple combination antiretroviral treatment for HIV infection. Use of combination antiretroviral therapy by gay and other homosexually active men participating in the *Gay Community Periodic Surveys* is at around 66% in Sydney, 60% or less in Melbourne, and 65% in Brisbane.

d) Knowledge and behaviour change

The development of knowledge, behaviour change and maintenance of behaviour change are priority areas for action under the HIV/AIDS strategy. The promotion of safe sex practices, in particular, among homosexually active men and sex workers, and the avoidance of contaminated drug injecting equipment among intravenous drug users, have been important prevention education messages. There is emerging evidence of an awareness and avoidance of risky sexual and drug injecting practices having an impact on HIV notification rates in some communities.

Awareness of safe sex practices

NSW stands out among comparable jurisdictions both within Australia and overseas as a jurisdiction with both a stable rate of HIV notifications among homosexually active men and *decreasing* rates of unprotected anal intercourse with casual partners among homosexually active men, including among HIV positive men, from 2001 to 2006. Other trends in behaviour having a positive impact on notification rates include:

- decreases in factors that increase risk, for example: a reduction in the proportion of homosexually active men since 2003 reporting high numbers of sexual partners; an increase in the proportion of NSW men, since 2003, reporting no current sexual partners or only having sex with one partner; a reduction in the proportion of men who do not know their HIV status; a reduction in the proportion of HIV positive men, who practice unprotected anal intercourse with casual partners, who have never disclosed their HIV status to casual partners; and a stabilisation of usage rates of a group of illicit drugs associated with parties, which are also associated with risk behaviours and with HIV infection;

- increases in factors that decrease risk, for example: an increase in the proportion of HIV positive men reporting undetectable viral load, irrespective of the proportion on treatment, indicative of improved treatment efficacy and effective clinical practice; an increase in the proportion of men reporting recent HIV testing and testing for other sexually transmissible infections; and an increase in the frequency of testing among sexually active men; and
- changes in sexual practices and culture – regular relationships, for example: a decline in the proportion of relationships between partners where one man is HIV positive and one is HIV negative (serodiscordant); and an increase in seroconcordant relationships in which the partners are both HIV negative.

Awareness of HIV testing

There appears to be a high level of awareness of testing among homosexually active men in the gay community with around 80% reporting having ever been tested for HIV³. This high rate of testing has remained stable since 2000.

Needle and syringe programs

One of the most dramatic factors contributing to Australia's success in HIV/AIDS prevention has been the success of needle and syringe programs in keeping HIV/AIDS rates low among injecting drug users.

Negotiation of high levels of condom use amongst sex workers

Due to the work of community-based sex worker organisations and projects conducted in partnership with state and territory governments there is presently a low prevalence of HIV/AIDS among Australian sex workers. Sex workers are able to negotiate high levels of condom use in their work and voluntary testing has also been an effective component.

V. Best practices

The Australian response to HIV/AIDS has undoubtedly contributed to the comparatively low rates of the disease in Australia.

a) Partnership approach and national HIV/AIDS strategies

Australia's partnership approach has placed its response at the forefront of international responses. This viewpoint is supported by data that show that Australia has one of the lowest population rates of new HIV diagnoses among similar countries.

The HIV/AIDS response has included a series of national strategies, the creation of community-based organisations to deliver education, prevention and support services, the establishment of national centres to conduct strategic research, national participation in World AIDS Day and the involvement of people living with HIV/AIDS in program development and implementation.

The maintenance of the response to the disease has also been important. The first national HIV/AIDS strategy was released in 1989, and four strategies have since followed, each one extending and building on the one before it. Despite a sharp decrease in the incidence of HIV and a change in the nature of the disease from a terminal illness to a largely chronic one, Australia has not become complacent but continues to refine its response.

³ Imrie, J. & Frankland, A. (Eds.). HIV/AIDS, hepatitis and sexually transmissible infections in Australia: Annual report of trends in behaviour 2007 (Monograph 1/2007). Sydney: National Centre in HIV Social Research, The University of New South Wales.

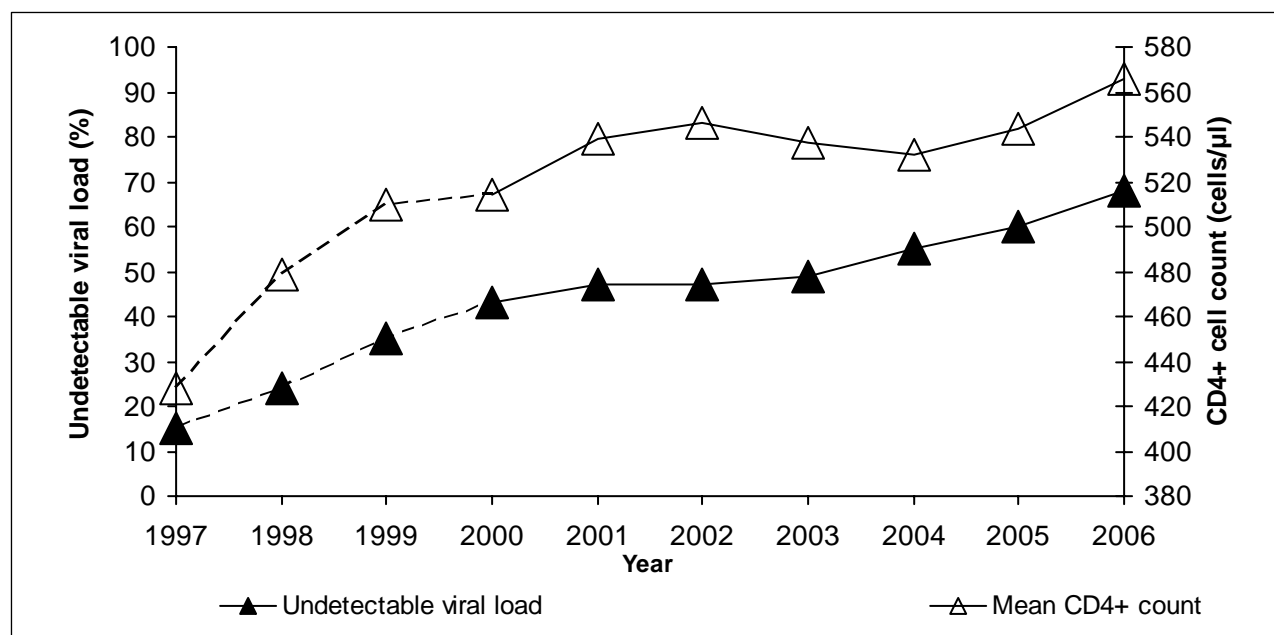
b) Centrality of people living with HIV/AIDS

The *National HIV/AIDS Strategy* recognises the overriding importance of the participation of people living with HIV/AIDS in policy and program development, implementation, monitoring and evaluation. The National Association of People Living with HIV/AIDS, Australia is the peak body and is funded by the Commonwealth Government to, among other things, ensure the engagement and representation of people living with HIV/AIDS on treatment, legal, women's, Indigenous, international, and care, support and education issues. The value of involving people living with HIV/AIDS in the national response has been demonstrated by the effective strategies and messages that have been developed with the benefit of personal knowledge and experience.

c) Antiretroviral treatment and viral load

There has been significant success in the use of antiretroviral therapies in reducing viral load (and thereby reducing infectivity) in some communities. In the *Positive Health* cohort, the proportion of men on therapy increased from 69% in 2002 to around 75% in 2006. In 2006, 85% of *Positive Health* respondents on antiretroviral therapy had an undetectable viral load, which was a significant increase over time. Since 2004, more than 50% of people being followed through the *Australian HIV Observational Database* had undetectable viral load. CD4+ cell counts have also increased in this population (Figure 3).

Figure 3: HIV viral load and CD4+ cell count among people enrolled on the Australian HIV Observational Database*



* Dashed lines indicate the years of retrospective data collection.

Source: National Centre in HIV Epidemiology and Clinical Research: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2007.

VI. Major challenges and remedial actions

Challenges to Australia's ongoing HIV/AIDS response were highlighted at a forum in February 2007 attended by over 80 representatives of government, community-based, clinical and research organisations. The forum discussed progress on implementation of the *National HIV/AIDS Strategy* and prioritised activities to address the identified challenges.

a) Partnerships and implementation of the National HIV/AIDS Strategy

A strength of Australia's response to HIV/AIDS is the partnership approach adopted for the coordination and implementation of activities under the *National HIV/AIDS Strategy*. This is also one of the enduring challenges. In addition to the Commonwealth Department of Health and Ageing, each state and territory has its own government department responsible for health services. Each jurisdiction also has its own AIDS council. Improved coordination of the activities of all levels of government and community and research organisations to ensure that services are not unnecessarily duplicated and to eliminate instances of overlapping research will improve the efficiency and effectiveness of the response.

b) Increasing incidence of STIs

Rates of sexually transmissible infections (STIs) among gay and other homosexually active men and in the Aboriginal and Torres Strait Islander population in Australia have increased in recent years. These rises are of concern because of the epidemiological association between STIs and HIV transmission, with the presence of certain STIs increasing the risk of HIV transmission.

In 2006, chlamydia was the most frequently reported infection notified in Australia (47,030 notifications at a population rate of 232 per 100,000 population). The population rate of gonorrhoea increased by 29% over the period 2002 – 2006 (population rate of 42.2 per 100,000 population in 2006), and the population rate of diagnosis of infectious syphilis increased from 3.1 per 100,000 population in 2004 to 4.0 in 2006.

In recognition of the increasing rates of STIs a separate *National Sexually Transmissible Infections Strategy* was developed and implemented in 2005. Its aim is to address the increases in STIs in Australia in three main priority areas: namely, in gay and other homosexually active men, in Aboriginal and Torres Strait Islander communities, and chlamydia control and prevention generally.

c) Late HIV diagnosis in people from culturally and linguistically diverse backgrounds

The proportion of AIDS cases having undiagnosed HIV infection until around the time of AIDS diagnosis has increased from 31% in 1997, to 37% in 2002 to around 56% in 2006. Late HIV presentation has disproportionately affected men and women with a history of heterosexual contact and those with an undetermined exposure history. Late HIV presentation is also associated with region of birth, with a substantially higher percentage of cases of late presentation among people born in countries in Asia, sub-Saharan Africa and European countries other than the United Kingdom and Ireland, compared to Australian born cases.

To increase awareness, the Commonwealth Government provided funds for the development of a resource in HIV/AIDS for culturally and linguistically diverse communities. Developed by the Multicultural HIV/AIDS and Hepatitis C Service, the audiovisual resource package provides information in English, Indonesian, Khmer, Somali, Thai, Arabic, Spanish, Chinese (Mandarin) and Vietnamese on how HIV is transmitted, how to prevent the spread of HIV, how to get tested and make use of the Australian health system, and issues faced by people who have HIV.

d) Rises in notification rates in gay and other homosexually active men

Unprotected anal intercourse remains the most important behavioural factor in HIV transmission in Australia. Of homosexually active men surveyed in 2006 in Australian gay communities, 40% - 50% of respondents reported having had any unprotected anal intercourse. In New South Wales there is both a stable rate of HIV notifications among homosexually active men and decreasing rates of unprotected anal intercourse with casual partners. The challenge is to reverse increasing rates of notifications among gay and other homosexually active men in all Australian jurisdictions.

e) Barriers to services

People living with HIV who reported to be heterosexual have identified barriers to HIV community services and support groups. Some HIV services were viewed as alienating and did not meet the needs of, or provide support for heterosexuals, catering more for gay, lesbian and transgender communities.

Alienation and stigma remain significant problems for all people living with HIV/AIDS. HIV-positive heterosexual men, people from culturally and linguistically diverse communities, sex workers and Aboriginal and Torres Strait Islanders have been identified as requiring better access to HIV medical and support services.

VII. Support from the country's development partners

This criterion is not applicable as Australia does not have development partners that contribute to the achievement of UNGASS targets in Australia.

VIII. Monitoring and evaluation environment

The surveillance and monitoring systems for HIV and AIDS in Australia are extensive and well developed.

a) Overview of HIV/AIDS surveillance

National surveillance for HIV and AIDS is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR) in collaboration with state and territory health authorities, the Commonwealth Government Department of Health and Ageing, the Australian Institute of Health and Welfare and other collaborating networks in surveillance for HIV/AIDS.

Newly diagnosed HIV infections and AIDS are notifiable conditions in each state and territory health jurisdiction in Australia. Under national HIV/AIDS surveillance procedures, AIDS notifications are forwarded to the *National AIDS Registry* and newly diagnosed HIV infections are reported to the *National HIV Registry* for national collation and analysis. A range of information is sought at notification, including state/territory of diagnosis, name code, sex, date of birth, country of birth, Aboriginal and Torres Strait Islander status, date of diagnosis, CD4+ cell count at diagnosis, source of HIV exposure and AIDS defining illness.

Diagnoses of specific sexually transmissible infections are notified by state and territory health authorities to the *National Notifiable Disease Surveillance System*, maintained by the Commonwealth Government Department of Health and Ageing. Chlamydia has been a notifiable

condition in all Australian states and territories since 1984, gonorrhoea and syphilis since at least 2004. In most health jurisdictions, diagnoses of sexually transmissible infections are notified by the diagnosing laboratory, the medical practitioner, hospital or a combination of these sources.

Information on sexual behaviour in a cross section of gay men is collected annually via *Gay Community Periodic Surveys* conducted in six state and territory capitals. HIV incidence and incidence of specific sexually transmissible infections among gay and other homosexually active men is determined from longitudinal studies, such as the *Health in Men* study of HIV-negative men, and the *Positive Health* study of HIV-positive men, both based in New South Wales.

HIV seroprevalence among people who have injected drugs is determined via a blood test and self-administered questionnaire of people attending needle and syringe program sites during one week each year. HIV seroprevalence among people seen at sexual health clinics is determined through a network of selected metropolitan sexual health clinics that quarterly and annually provide tabulations of the number of people seen, the number tested for HIV antibody and the number newly diagnosed with HIV infection.

The *Australian HIV Observational Database* (AHOD) is a collaborative study that records observational data on the natural history of HIV infection and its treatment. The primary objective is to monitor the pattern of antiretroviral and prophylactic treatment use by demographic factors and markers of HIV infection stage. Other objectives are to monitor how often people with HIV infection change antiretroviral treatments and the reasons for treatment change.

All blood donations in Australia have been screened for HIV-1 antibodies since 1985 and HIV-2 antibodies since 1992. Prior to donation, all blood donors are required to sign a declaration that they do not have a history of any specified factors associated with a higher risk of HIV infection and other blood borne infections.

b) Monitoring of Australia's response

The implementation and effectiveness of the *National HIV/AIDS Strategy 2005 – 2008* and the status of the HIV/AIDS epidemic in Australia are monitored through mechanisms that include:

- regular meetings of the Ministerial Advisory Committee on HIV/AIDS, Sexual Health and Hepatitis (MACASHH) to consider ongoing and emerging issues and provide advice to the Commonwealth Government Minister for Health and Ageing;
- publication of an annual surveillance report on HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), and an annual report of HIV/AIDS, hepatitis and sexually transmissible infections in Australia trends in behaviour by the National Centre in HIV Social Research in collaboration with the NCHECR and the Australian Research Centre in Sex, Health and Society;
- an independent review of the status of HIV and AIDS in Australia, commissioned by the Australian Health Protection Committee. The review has primarily an epidemiological and virological focus and, in part, seeks to identify whether any changes in either the virus or the behaviour of infected individuals have impacted on HIV infection rates over the last three years. This review is expected to be finalised by the end of 2007;
- monitoring and evaluation activities of national community-based organisations concerned with HIV/AIDS;

- monitoring and surveillance activities of state and territory health authorities and AIDS councils, including activities undertaken in support of the *National HIV/AIDS Strategy*;
- state and territory government reporting of performance in the use of funding provided for public health education, prevention, treatment and counselling services by the Commonwealth Government under Public Health Outcome Funding Agreements;
- a mid-term review of the effectiveness of the *National HIV/AIDS Strategy*; and
- a full evaluation of the *National HIV/AIDS Strategy* to be undertaken towards the end of its term. The evaluation will provide a detailed assessment of the strategy's continuing appropriateness, effectiveness and efficiency, and recommendations supported by evidence, on ways to improve the national response.

c) Specific challenges for improvement

The Commonwealth Government Department of Health and Ageing commissioned an evaluation of funding for HIV/AIDS, hepatitis C and STI research and HIV/AIDS and STI education in April 2007. Among other things, the evaluation found that processes for funding activities were largely appropriate, effective and efficient and met community needs. Processes that allowed greater funding flexibility, reduced the potential for the funding of activities already funded by other programs, and gave clearer operational objectives for research were some of the measures identified to improve research and education performance in Australia.

Surveillance of HIV genotypes, new HIV infections and movement of people living with HIV/AIDS between states and territories after diagnosis have been identified as other areas for improvement in the ongoing monitoring of the epidemic in Australia.

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ANNEXES

- Annex 1. Consultation/preparation process for the report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS
- Annex 2. National Composite Policy Index questionnaire, including:
 - Part A: a section to be administered to government officials; and
 - Part B: a section to be administered to representatives from non-government organisations.

Annex 1

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

- 1) Which institutions/entities were responsible for filling out the indicator forms?
- | | |
|---|-----|
| a) NAC or equivalent | Yes |
| b) NAP | Yes |
| c) Others (please specify) | |
| Australian Federation of AIDS Organisations | Yes |
| National Association of People Living with HIV/AIDS | Yes |
| AIDS Council of NSW | Yes |
- 2) With inputs from:
- | | |
|---|-----|
| Ministries: | |
| Education | Yes |
| Health | Yes |
| Labour | No |
| Foreign Affairs | No |
| Others (please specify) | |
| Australian Agency for International Development | Yes |
| Australian Federal Police | Yes |
| Department of Defence | Yes |
| Attorney General's Department | Yes |
| Civil society organizations | Yes |
| People living with HIV | Yes |
| Private sector | No |
| United Nations organisations | No |
| International NGOs | No |
- 3) Was the report discussed in a large forum? No
- 4) Are the survey results stored centrally? Yes
- 5) Are data available for public consultation? Yes
- 6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?
- Name/Title: **Ms Karen Fox**
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Department of Health and Ageing
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