



DRAFT HIV & STI Strategy and Hepatitis C Strategy Comments on the Consultation Drafts Australasian Society for HIV Medicine October 2004

This response is prepared on behalf of ASHM. It contains a number of sections.

1. General Comments about the scope of the strategies and the relationships between the HIV/STI and Hepatitis C Strategies
2. Recommendations for the continuing process of the consultation and the nature and scope of the strategies
3. Specific observations about the HIV and STI Strategy (following the sequence as presented in the consultation draft)
4. Specific observations about the STI Strategy
5. Specific observations about the Hepatitis C Strategy (following the sequence as presented in the consultation draft)

Section 1: General Comments about the Scope of the Strategies and the Relationships between the HIV/STI and Hepatitis C Strategies

The Review of the National HIV and HCV Strategies and Review of National Research Centres commenced roughly three years ago, initially as a mid-term review of the 4th HIV strategy and 2nd HCV strategy. The reviews resulted in a response document from the Australian Government, and change of procedure for planning for subsequent strategies.

During this time there have been many upheavals, changes of health Ministers, abolition of Committees, extensions of Committees and strategies which had essentially been made redundant (therefore making them impotent or at best "caretakers"), changes in department personnel and structures and, when the consultation strategies were released, the announcement of a Federal election, which in turn has pushed out the timelines as well as the nature of the consultation on the strategies. Suffice to say the process has been drawn out, unsettling and confusing. It has in fact jeopardised the future of there being meaningful strategic approaches to the issues under consideration.

ASHM believes that a strategic approach to HIV, viral hepatitis and sexual health is beneficial and essential to maximise useful outcomes. ASHM also believes that the manner in which the strategy is derived is of great importance.

The 1st National HIV/AIDS Strategy was developed following a considerable process of consultation, resulting in an options or green paper (A Time to ACT). This options paper put forward possible courses of action and the resultant Strategy, derived from these options, was one which was broadly agreed upon and appropriately resourced. It laid a foundation for work at all levels of government, in the medical, scientific and community sectors. It encouraged and supported the participation of affected communities and consumers. It reflected the partnership approach that had arisen to managing HIV and that spanned prevention, education, research, treatment, care and management and international cooperation.

It is this developmental step, and the broad sign-on, which is missing in the current process particularly in regard to the inclusion of a sexually transmitted infections strategy as an addendum to the HIV strategy. This is reminiscent of the development of the hepatitis C strategy. ASHM strongly supports the development of a national STI strategy as well as the inclusion of STI issues and a sexual health context within the 5th National HIV Strategy.

The HIV strategy and STI strategy has been developed in relative isolation, yet it is meant to be a guiding document to which people and organisations can commit. This may have been achievable with appropriate subsequent consultation, had it remained an HIV Strategy. There is, however, a fundamental change brought about by the inclusion of STI. Decision making about the STI area should be subject to appropriate priority setting. The commonalities and differences between HIV and STI should be explored. Without this there remains a confusing marriage of the issues, much like there was in the adding of Hepatitis C as a 'related disease' to HIV. Ultimately this addendum approach was abandoned in hepatitis C, but considerable time had been lost in appropriately responding to hepatitis C, while procedural debate consumed much energy.

There may be considerable overlap between our HIV and STI and viral hepatitis strategies, but there is fear that appearing to 'just tack STI on' could result in disharmony between the disciplines, areas and issues. This was seen in hepatitis C and it has resulted in on-going problems in the sector. These problems continue to haunt those working in both areas. An unnecessary adversarial environment has developed as the various stakeholders have been forced to compete for resources and access to policy and advisory influence.

It is indisputable that HIV is an STI, but the implications of an HIV epidemic out strip any other STI epidemic ever experienced. It can also be transmitted by other means and some epidemics are driven by these means. There needs to be greater discussion about why the two areas should be combined and the implications of this. There also needs to be consideration of the cost implications of combining the strategies, and probably there needs to be an injection of funds to resource and support any new strategy development. Where this is not done, further pressure is placed upon existing funded programs, again resulting in claims of disparity and partiality and undermining gains made in HIV management.

The Reviews have identified a need to prioritize HIV and STI prevention activities for gay men. This is one of the clear areas of overlap and commonality between a strategic HIV and STI response. Similarly the position of HIV as a priority in relation to indigenous Australian's sexual health is also central.

In its current form, the STI strategy is not a strategy. It is at best a briefing document that explicitly calls for the development of an STI strategy. To be broadly supported, an STI strategy would require greater consultation in its development and priority setting. ASHM strongly endorses the development of a national STI strategy and the inclusion of a sexual health context and STI related activities in the HIV strategy. The current proposed STI strategy may be too restrictive and may unnecessarily limit the development of a broad based STI strategy, if it were adopted in its current form.

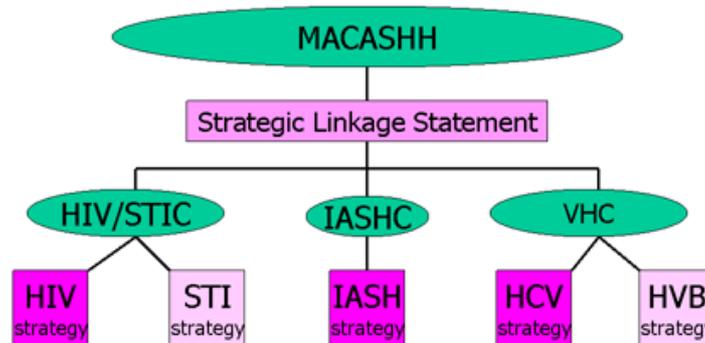
ASHM is directly aware of the areas of overlap in regard to HIV and the so-called related diseases, but we do not see the need for omnibus strategies. Far better would be the layering and combining of individual strategies, which relate to each other. This would allow users of the various strategies to focus on those issues central to them. It also allows for the inclusion of other related conditions and for flexibility to reflect local or organisation specific priorities and needs. For example, a remote public health service may give prominence to the Indigenous Australians Sexual Health Strategy, while an inner city gay men's health facility may focus on a sexual health strategy and HIV strategy. At the same time, a Hepatitis C organisation may focus on and draw guidance from a Hepatitis C strategy and Drug and Alcohol strategy.

Section 2: Recommendations for the continuing process of the consultation process and the nature and scope of the strategies

The MACASHH framework covers HIV, viral hepatitis and sexual health; it also embraces indigenous Australian's sexual health. The creation of separate strategies gathered together via a Strategic Linkage Statement could provide a strategic response to each of these areas with clearly stated commonalities. Many aspects of HIV prevention are embedded in sexual health practice and as such, areas of overlap should be included in both the HIV and STI strategies. (Examples include STI

screening for gay men and HBV vaccine for PLWHA) The HIV, Hepatitis C and Indigenous Australians Sexual Health Strategies are significantly progressed, while the STI and HBV strategies need to be developed. The Strategic Linkage Statement could be drafted relatively quickly and, along with elaborating on the MACASHH strategies and committees, should also indicate broader linkages to other strategies, advisory structures and committees, such as the IGCAHRD, CDNA, Drugs Strategy and NPHP etc.

Suggested policy and committee structure
(Lighter colours reflect documents in development or to be developed)



ASHM recommends:

- That the HIV and STI Strategies be separated. The HIV strategy needs considerable work but has been progressed quite significantly.
- That areas of commonality between the HIV and STI strategies and the National Indigenous Australians Sexual Health Strategy be included in each strategy.
- That the STI strategy be mentioned in the strategic linkage statement and that the current draft be translated to a briefing/background document and be subject to broad consultation.
- That the Hepatitis C Strategy is well developed and could progress quite quickly through to finalisation (see our comments later in this document).
- Consideration should be given to the development of a Hepatitis B strategy, which would form part of this stable of strategies but would take some time to develop and should not delay the release of the Hepatitis C strategy.
- It may be possible to combine a Hepatitis C and Hepatitis B strategy as a viral hepatitis strategy, but this decision would need to be taken by the MACASHH Hepatitis Committee and should not impact on the development of a separate HBV strategy in the first instance.
- The Indigenous Australian's Sexual Health Strategy should also be linked to this stable of strategies.

Development of the strategies in this manner would reflect the MACASHH areas of interest, provide for autonomy as well as communality. If the MACASHH can share these responsibilities then it should transpire that strategically these are intrinsically linked. Further it would allow for the development of a brief introductory document (Strategic Linkage Statement) that could stand alone reflecting Australia's response priorities, the partnerships and shared goals. Such a document would also need to relate to other strategies and policies and describe the various members of the partnership.

Section 3: Specific observations about the HIV and STI Strategy (following the sequence as presented in the consultation draft)

Numbers in this section relate to numbering in the Draft Strategy

2.3 Current HIV/AIDS infection rates in Australia

Currently the data being referred to in this section are out of date, yet reference is made throughout the document to recent changes in notification. It is impossible to comment on the veracity of this section until the data are updated.

We make the general observation, however, that enhanced and timely surveillance is an absolute necessity to planning and monitoring intervention, responding to emerging trends and addressing community level concerns.

Recommendation:

- That an updated section 2.3 be disseminated prior to the consultations on 16/17 November

4.2 The HIV/AIDS Partnership

This section gives lip-service to the notion of partnership. However this has not been sufficiently translated into action recently. The role of the medical and scientific sector in the Australian response to HIV/AIDS is considerable and growing. Yet the medical scientific community is not represented at an organisational level in this strategy.

This poses significant difficulties when the public medical response to HIV/AIDS is seen in many respects as a state and territory responsibility. Yet even with increasing numbers of people living with HIV/AIDS, and therefore making use of medical services, it is time consuming and costly to develop repetitive strategies at a state and territory level. Coordination across jurisdictions and the sharing of ideas and resources is of central importance and needs to be further supported by the Australian government and embodied in this strategy.

The role of the Community Sector, particularly the contribution made by affected communities also needs to be supported and reinforced. Strong commitment to the partnership has served Australia well in the past. The non-government sector (professional and community) needs to be supported to fully contribute to policy development as well as to provide service delivery in the areas of education, prevention and care.

Recommendations:

- That the Australasian Society for HIV Medicine be represented on the HIV/STI Committee and IGCAHRD (see 7.2)
- That the Sexual Health Chapter of the Royal Australian College of Physicians (AChSHM) be represented on the HIV/STI Committee
- That the role and contribution of the community sector in the partnership needs to be recognised and supported
- Non-government organisations may require financial support to fully participate in policy development processes and providing this support is a feature of the partnership approach

5.1 A program of targeted prevention education

ASHM supports the development of targeted prevention education, at the same time it would support the reinstatement of broad based media campaigns raising awareness of HIV and supporting prevention activities at an individual and population level.

Recent data suggest that gay men remain the highest priority for prevention education. Concomitant rises in STIs, other than HIV, in gay men over time (most recently syphilis, but also previously gonorrhoea and hepatitis A) suggest that HIV prevention should be positioned within a broader STI education and prevention strategy. Further, an appropriate testing and treatment strategy would be beneficial and should be seen as a priority.

While targeted campaigns reaching gay men have been seen to be most beneficial, there is a clear relationship between elaboration of this priority need and initiatives of a broader STI strategy and indigenous Australians STI strategy. The symbiotic relationship between HIV and STI prevention and management necessitates the inclusion of sexual health based initiatives in the HIV strategy and STI embedded initiatives in the HIV strategy (eg sexual health screening including HIV testing in some at risk groups including, but not limited to gay men).

Previous national mass media campaigns such as the 'beds' campaign have provided a broad community backdrop to the development of targeted prevention campaigns. It would be timely to reinvigorate the national prevention response by investment in broad based campaigns that can also support more targeted initiatives. Such campaigns also allow for the engagement of the health workforce and others (such as school based educators and the media generally) in a dialogue of prevention.

There remains a lack of coordination of activities targeted to people in custodial settings. Custodial settings can act as incubators for viral infection. This is particularly the case in relation to viral hepatitis, but remains a potential for HIV and one that has manifested in other developed country settings. National initiatives in relation to BBV in custodial settings are therefore needed and any initiatives undertaken in relation to HCV should also incorporate initiatives in relation to HIV and HBV.

Recent data suggest that there is a persistent increase in risk associated with travel and as such travel related prevention campaigns should be reinvigorated.

Recommendations:

- That education targeted to gay men be a stated, supported and resourced priority in relation to prevention
- That additional priorities reflect emerging trends in HIV transmission including but not restricted to ATSI, young people and people at risk
- That the Australian Government support and resource a program of broad media campaigns. It must invigorate initiatives to engage community leaders, media and other government jurisdictions in prevention
- That there be a coordinated, supported and resourced response to BBV in custodial settings. It should incorporate information and education for the workforce, information and materials for in-mates and information referral and support for releasees and the communities and services to which they are returning
- That the positioning of HIV prevention in a broader STI education and prevention strategy as well as an appropriate testing and treatment strategy would be beneficial and should be seen as a priority
- That campaigns and initiatives aimed at travellers be reinvigorated

5.2 Maximising the effectiveness of new treatments

ASHM is particularly concerned about this section. The confusion of terms and lack of understanding of issues, data and evidence needs to be rectified.

5.2.1 Managing the side effects of antiretroviral treatment

Effective side effects management is one of the central features of successful long-term treatment of HIV. It is not, however, the only issue. Minimising resistance and maximising compliance, correct selection of first and subsequent therapies and facilitating access to treatment are also important. They are particularly important, as HIV therapy is currently a life long commitment.

In relation to the development of national policy, there appears to be confusion between the HIV Model of Care and the Antiretroviral Guidelines and the term 'model of care' is used generically throughout the documents. ASHM has been vigilant in requesting Australian Government support for reviewing and updating the Models of Care and Antiretroviral Guidelines to facilitate these activities. It has recently received modest support to initiate and facilitate these activities.

However, the areas identified in the strategy for priority action are far too narrow and do not reflect the complexity of long-term antiretroviral therapy. The abolition of CTARC and the structure of the current HIV/STI committee of MACASHH, without specialised secretariat support or budget, does not allow for these activities to be included in the HIV/STI Committee workplan.

Notwithstanding the above, innovative care delivery strategies will need to be developed locally to respond to presenting needs.

Recommendation:

- That ASHM, which has been modestly resourced by the Australian Government be appropriately resourced to facilitate these activities
- That innovative models of care delivery be explored to facilitate, maximise and sustain effective HIV treatment
- That an annual consensus conference be held to discuss treatment policy, guidelines and models.

5.2.2 Assistance to High Caseload GPs (see also section 5.3)

ASHM strongly supports the need for better support of high HIV caseload general practitioners, but this issue is much more complex than merely adding support. It requires greater consideration and the development of more sophisticated actions than those identified as priorities in this section, particularly the exploration of innovative strategies to support low caseload GPs, shared care arrangements and the delivery of multidisciplinary care.

The suggestion that “the responsibility for HIV management has increasingly shifted to GPs” is flawed. The number of people living with HIV has increased as a function of the reduction of deaths from AIDS, an increase in the number of people infected with HIV and an increase of length of life following HIV diagnosis. This has changed the duration and type of care required by these individuals.

Given the above, there is an increase in the length of time a person with HIV remains in the care of their GP. In 1995 a person with an AIDS diagnosis lived on average 16.8 months, by 2000 this had almost doubled to 32 months. At the same time, AIDS diagnoses dropped from 952 in 1994 to 208 in 2001. Even excluding new infections, this translates into more than 4 times as many people living with HIV and not progressing to AIDS, but ostensibly continuing to use their GP as a primary care provider. Not all of this care is provided by high caseload GPs and lower caseload GPs need to be encouraged into the field.

The ARCSHS Futures studies 1 – 4 covering the period from 1998 to 2004 indicate an increase in the percentage of PLWHA seeking care from their GP. However, this is generally a small increase building on a relatively high base. In short, PLWHA remain eager to be managed by their general practitioners. PLWHA report a high desire to access their GP for HIV related care as well as for non-HIV related care.

It has also been suggested (based on comments coming from one surgery in Darlinghurst) that GPs cannot take on positive patients due to lack of staffing. This lack of GP care is not restricted to HIV and similar difficulties have been reported in both country and city areas where many GPs books are full, irrespective of their HIV caseload.

Recommendation:

- That HIV, sexual health and Hepatitis C medicine should be seen as a priorities by the general practice branch and divisions of general practice
- That creative solutions be explored to make remaining in or joining HIV general practice more attractive, including the possibility to do sessional placements or work part-time in some state-funded clinics, shared care facilities and hospital arrangements

The priority areas identified include “*strengthening of training programs and opportunities for GPs with interest in or High caseloads of HIV*”. This fails to:

1) recognise appropriately the spread of HIV across Australia, 2) acknowledge the role played by GPs with a less-than high caseload, 3) suggests that training opportunities need to be strengthened, 4) neglects the difficulties of attracting practitioners to HIV care so that they can learn this type of care, and 5) ignores the development of strategies appropriate to maintain their skills and interests.

Recommendation:

- That all states and territories meet with HIV education training groups annually to discuss GP training and support initiatives, particularly those aimed at supporting practitioners to join the HIV area

Enhanced Primary Care (EPC) is also identified in the strategy as a priority area and support for those doctors using EPC be supported. While EPC may work in some situations, this is likely to be the case when the patient has complex multidisciplinary needs. Further, a patient must be seeing at least 2 other health care providers, to be eligible to have a case plan written. There has been some praise for the EPC program in place in Darlinghurst, but this has been resourced intensively and as such may not be sustainable in that environment, nor generalised to more dispersed populations, where enrichment of local services and alternative models of service delivery may be more suitable. New and innovative models of care need to be explored which respond to local area needs. Models of monitoring, case conferencing, shared care, visiting specialists, supporting high case load practitioners and encouraging and providing work force development to mainstream agencies should also be explored, including the roles of nursing and allied health staff.

Recommendation:

- That greater consideration be given to the development of EPC, Medicare initiatives and innovative service delivery strategies which may be appropriately applied to some patients with complex needs
- That a range of innovative services delivery strategies be considered to respond to patient and local needs

5.2.3 Improving the monitoring of therapies

In relation to policy and therapy, the Australian Government has supported the development of a National Clinical Sub-Committee. One of the activities of this group is to establish a panel with responsibility for ensuring the updating of an Antiretroviral Guideline; it will include the monitoring of therapy.

Another responsibility of this Committee is to provide advice to MACASHH and the HIV committee, IGCAHRD and HSDWP on management issues and determine the most appropriate way to deliver an updateable model of care.

In relation to direct care, barriers to pathology based monitoring should be reduced and MBS coning restrictions reviewed, particularly in regard to GPs accredited to prescribe S100 drugs.

5.2.4 Strengthening clinical and other research related to treatment

This section of the document appears lame given the number of people relying on treatment for management of their HIV. Prior to the review of the 4th HIV and 2nd HCV strategies the CTARC had responsibility to provide advice in this regard. It also drew together the existing research centres.

No current structure has replaced the CTARC, each of the HIV/STI, HCV and IASH committees have some responsibility for research, but in their current forms the Committees can not devote sufficient time to these activities. These committees need to be able to access or commission research as required.

The Annual ASHM Conference, ACH² research meeting and National Centre Working Group meetings could perform some of these activities, but this would require greater participation by the relevant stakeholders.

Recommendation:

- That a national meeting of research stakeholders be held to determine policy in this area. It must include issues of development, collaboration, review and reporting, as well as dissemination of findings
- Collaborative networks like ACH² should be encouraged and supported.

5.2.5 Specific treatment needs of particular groups**Custodial settings**

ASHM strongly supports the proposed summit to review treatment and care of BBV in custodial settings.

People co-infected with HIV and HBV and/or HCV

ASHM supports the statements made in this section but includes the following

Recommendations:

- People with HIV should be vaccinated against HAV and HBV
- Treatment of HBV or HCV in co-infection should be conducted in line with the guidelines for management of HIV Co-infection published by ASHM. (*Coinfection HIV & Viral Hepatitis a guide for clinical management*)
- That these guidelines should be updated regularly as required, based on changes in agreed treatment standards.

5.3 Responding to changing care and support needs (see also section 5.2)

We again question the assertion of a significant shift to general practitioners in favour of stating that there has been a consistently high reliance on general practitioners for many years, as borne out by four successive reports from the ARCSHS Futures national studies covering the last 8 years. The increase in GP participation is more closely related to an increase in the overall number of people with HIV seeking treatment, and that as a result of more effective therapy they are seeking this for longer periods of time.

The reliance on EPC strategies to reduce GP burden is not sufficiently evaluated to be the primary strategy proposed in this section. EPC may have a particular place for some patients, particularly those with complex and multidisciplinary needs, but the risk of promoting EPC over other strategies is one that relies on there being a network of other services able to contribute to the care plan and in many instances these other services would need to be established. No costing or consideration of this is given in the document. Ancillary care is thought to be lacking in many of the areas where HIV GP care is also at a premium.

Reference is made to the new Medicare items, but again this presupposes that these additional services can be accessed locally for people living with HIV.

Recommendations:

- New initiatives aimed at increasing GP participation in HIV management need to be explored, tried and supported. To date, GP participation has been evaluated purely on the basis of capacity to prescribe subsidised antiretroviral therapy via section 100. Increased participation in HIV management and the capacity to share care with hospital based specialists or GP s100 prescribers should also be developed. Such strategies would have a number of benefits including forming greater linkages between specialist and generalist services.
- New models of on the job training and/or GP practices within funded clinics, such as sexual health clinics and specialist facilities should also be explored. The cost implications for such strategies will need to be considered by state and territories as well as with the Australian government.
- Training alone is not the answer. Many GPs are already over stretched and just providing more training initiatives or placing more coordination onto GPs only increases this burden.
- The capacity to increase nursing support in high caseload general practice, via the initiatives in the General Practice Branch and/or Divisions of General Practice should be explored.

NEW ITEM

Specialist services – [This section should be added]

Much emphasis has been placed on the further development and support of GP services. Yet little thought has been given to increasing the skills of hospital based specialists, outside designated HIV services, to respond to the treatment care and management of people living with HIV.

Recommendation:

- Existing GP training programs should be enhanced to include existing HIV training programs or produce dedicated programs for registrars and practicing physicians in non-designated units.

Equitable access and making mainstream services more accessible

ASHM supports the initiatives outlined in this provision and refers also to the above point.

It should be noted that specialist services for people living with HIV might not be available in all localities. It is therefore important that existing schemes such as IPTAS are called upon to facilitate visits to specialist services when they are unavailable locally.

5.4 HIV Testing

ASHM supports a review of the HIV testing guidelines and suggests that HIV testing should attract an MBS item number. Current arrangements do not appear to reduce delayed testing and, as a consequence, it is not thought that the introduction of MBS funded testing would discourage people from seeking testing. However, this should be done in conjunction with provision of arrangements for free, anonymous testing via public clinics, such as sexual health clinics. Medicare ineligibility should not be used as a barrier to HIV testing.

Reference is made to the former ASHM publication *Could it be HIV?* This publication was replaced by *HIV/Viral Hepatitis a guide for primary care*, released in 2001, which has been updated and re-released in 2004. The former publication concentrated on the identification of advanced HIV at a time where much HIV infection was un-noticed. A national publication with that scope is not warranted in the context of current HIV infections.

Instead, ASHM proposes a review of the testing guidelines, the production of simple and straight forward guidelines for HIV testing and the broad promulgation of this material to all general practitioners. Such a strategy would support and give impetus to a broad based HIV education and prevention campaign, and could be supported by targeted campaigns reaching communities at higher risk of infection, particularly gay men and their health care providers. The existing publication, *HIV/Viral Hepatitis a guide for primary care*, could also be made available as a component of this strategy.

Recommendations:

- HIV testing be included as a rebate-able item excluded from coning provisions.
- State governments be encouraged to redirect funds currently allocated to HIV testing, to supporting general practitioner and other medical practitioner education and a campaign to promote HIV testing. This should include the promotion of anonymous tests for individuals who may be discouraged from testing if a Medicare record is created.
- That specific campaigns be developed targeting the gay community and ATSI populations that incorporate a generalised STI testing strategy.

5.6 Enhanced Surveillance and Notifications of HIV/AIDS

ASHM supports the recommendations associated with this section but would add the following:

Recommendations:

- That all HIV testing laboratories performing confirmatory tests be required, when conducting enhanced notification, to provide medical practitioners requesting the HIV test which is found to be positive with:
 - information about where they can gain information for themselves about HIV and
 - information for their patients about HIV, including how to locate information in languages other than English
- Where local GP education programs are in existence the doctor should be referred to this organisation for information. Where a dedicated education program is not in existence they should be referred to the local health department and/or ASHM.
- New technologies in relation to testing should be subject to scrutiny and quality assurance and the National Serum Reference Laboratory should be resourced to provide this service.

5.7 Research

ASHM encourages continued support of research including basic science research as well as strategic research and believes that more emphasis should be placed on encouraging new researchers to join the HIV, viral hepatitis and sexual health sectors.

6. Linkages with related strategies

ASHM has proposed a strategy for relating the HIV, STI (including the Indigenous Australian Sexual Health Strategy) and viral hepatitis strategies (see our recommendations in section 2)

The Strategic Linkage Statement proposed should also make reference to the related strategies listed in item 6 and the various advisory structures that guide Australia's responses. Specific reference should be made to *Meeting the Challenge: Australia's International HIV/AIDS Strategy*.

At several points in the current document general reference is made to the importance of international HIV/AIDS efforts, Australia's international responsibilities and the scale and impacts of regional epidemics. The strategy does not however articulate particular responses to these points. The strategy would be enhanced by describing the roles and connections that should be established and/or strengthened by the Commonwealth Department of Health and Ageing in order to better address the international agenda, notwithstanding the existence of AusAID's International HIV/AIDS strategy.

7. Roles and responsibilities

MACASHH membership should be expanded to include representatives of the key medical scientific organisations on each of the committees and on MACASHH.

- ASHM should join the HIV/STI Committee
- The Sexual Health Chapter of the RACP should join the HIV/STI Committee
- The ALA should join the Viral Hepatitis Committee
- AusAID should join the HIV/STI Committee and MACASHH

7.2 The IGCAHRD

Membership of the IGCAHRD needs to be re-examined. It is currently somewhere between a government committee and a partnership committee. ASHM recognises that there is a need for government partners to meet together and supports a government only committee with representatives from states, territories, NZ and the Commonwealth. The Committee may wish to consider occasional participation from the Papua New Guinean Department of Health (perhaps in an observer status).

ASHM also recognises the considerable need for a partnership committee that allows for participation of all members of the partnership. Such a committee could meet adjacent to the IGCAHRD meeting, as this would reduce cost burdens and duplications for national organisations talking with states and territories.

Recommendations:

- The IGCAHRD be reconstituted to comprise government members only
- The ICGAHRD Partnership Committee be formed with the following membership, in addition to the current state and territory IGCAHRD membership:
 - AFAO
 - NAPWA
 - AHC
 - AIVL
 - Scarlet Alliance
 - ALA
 - ASHM
 - AChSHM

7.6 Professional Organisations (new section to be added)

A new paragraph should be included indicating the significant contribution to the partnership of professional organisations. This is particularly the case in relation to the significant role played by ASHM, ALA and AChSHM. The role of medical care is identified as central to the partnership and the strategy and yet it is omitted here.

Section 4: Part B STI Strategy

ASHM is committed to a national STI strategy with full consideration of areas of overlap with HIV, as well as issues and priorities that are not related to HIV.

In its current form, the STI Strategy is not a strategy. ASHM welcomes the development of an STI strategy and suggests that this section of the consultation draft be used as a briefing document to inform the development of an STI Strategy.

Action on the development of this strategy should be referred to in the overarching Strategic Linkages Statement we have proposed to preface the individual strategies.

Section 5: Specific observations about the Hepatitis C Strategy

ASHM was represented on the writing committee for the hepatitis C strategy and as such, has had continuous opportunity to feed into the process of the development of the consultation draft. ASHM is generally very satisfied with the draft.

ASHM believes that mention should be made to HBV in the STI strategy and this should be cross-referenced with the HBV strategy we propose should be developed, as well as with HBV as a co-infection in HIV and HCV.

We have made considerable comment about how the strategies should proceed in section 2 of this response.

Recommendations:

- That the Hepatitis C Strategy is well developed and could progress quite quickly through to finalisation (see our comments later in this document).
- Consideration should be given to the development of a Hepatitis B strategy, which would form part of this stable of strategies but would take some time to develop and should not delay the release of the Hepatitis C strategy.

1.3 Guiding principles

ASHM does not believe that it is useful to include the statement “while also encouraging addicts to kick the habit” and accordingly recommends strongly that it be removed. Harm reduction strategies

appropriately embrace diversionary strategies. Suggesting that the strategy is restricted to people who have a drug addiction narrows the scope of the document, which should be relevant to all people who inject drugs whether this is done once only or on a controlled recreational basis. ASHM endorses all forms of harm minimisation.

2.9 Partnership

ASHM welcomes the recognition of partnership in the strategy but believes that steps should be taken to strengthen this, including support for partners to participate fully in policy development as well as service provision. This relates particularly to NGO such as consumer, community and professional organisations that will require ongoing support.

3.2 Research

The Hepatitis Committee of MACASHH should have the capacity to commission research to help inform its strategic activities.

Effort needs to be made to facilitate collaboration and the entry of new researchers into the field. Work in this regard, particularly that of ACH² should be encouraged, especially commonalities with HBV and HIV in basic research.

3.4 Treatment

ASHM believes that there needs to be greater awareness in the community of the availability of treatment.

Recommendation:

- Greater emphasis should be given to improvements in treatment and this should be a key feature of the proposed awareness campaign, as well as being targeted to people diagnosing HCV
- Models of care to provide HCV treatment in prisons should be expanded.

3.5 Health maintenance, care and support

There is considerable need for up skilling the medical workforce in relation HCV. While a number of small pilots are in progress to expand access to prescribing to general practitioners, GP participation should not be evaluated on prescribing behaviour alone. Also, there should be an expansion in the number of models being tried so that GPs can be supported to play an appropriate role in patient management. This may include but is not limited to expanding the participation of general practitioners in the delivery of care within liver clinics and exploring the feasibility of nurse practitioner roles. Over time the role of GPs should be continuously reviewed with the aim of maximising their participation in the provision of care to people seeking treatment for HCV.

HCV is a huge current and potential problem confronting the GP workforce. This should be reflected in the national health priorities for general practice.

Recommendations:

- Expand the number and type of models of GP and nursing care being considered
- Explore the opportunities to appropriately resource these strategies through GP funding initiatives, the GP Branch and Divisions of General Practice
- Include HCV as a national health priority

4. Supporting Structures

4.2 MACASHH

MACASHH membership should be expanded to include representatives of the key medical scientific organisations on each of the committees and on MACASHH.

- The ALA should join the Viral Hepatitis Committee
- ASHM should join the HIV/STI Committee
- The Sexual Health Chapter of the RACP should join the HIV/STI Committee

We have proposed earlier in this response that a HBV strategy be developed. The MACASHH Hepatitis Committee could oversee this. Progress on this strategy should not delay finalisation, publication and distribution of this strategy. ASHM envisages the strategy documents being introduced by a Strategic Linkage Statement, which reflects the make-up and roles and responsibilities of MACASHH (see diagram).

4.6 The IGCAHRD

Membership of the IGCAHRD needs to be re-examined. It is currently somewhere between a government committee and a partnership committee. ASHM recognises that there is a need for government partners to meet together and supports a government only committee with representatives from states, territories, NZ and the Commonwealth. The Committee may wish to consider occasional participation from the Papua New Guinean Department of Health (perhaps in an observer status).

ASHM also recognises the considerable need for a partnership committee that allows for participation of all members of the partnership. Such a committee could meet adjacent to the IGCAHRD meeting, as this would reduce cost burdens and duplications for national organisations talking with states and territories.

Recommendations:

- The IGCAHRD be reconstituted to comprise government members only
- The IGCAHRD Partnership Committee be formed with the following membership, in addition to the current state and territory IGCAHRD membership:
 - AFAO
 - NAPWA
 - AHC
 - AIVL
 - Scarlet Alliance
 - ALA
 - ASHM
 - AChSHM

5.2 Annual Strategic Issues Workshop

ASHM welcomes the inclusion of an annual strategic issues workshop and looks forward to participating in this forum.

The Australian Government has supported the Australian Hepatitis C Conference. Ongoing support of this conference should be featured and this could be achieved by suggesting that the SIW be held adjacent to the Conference when it is held biennially.