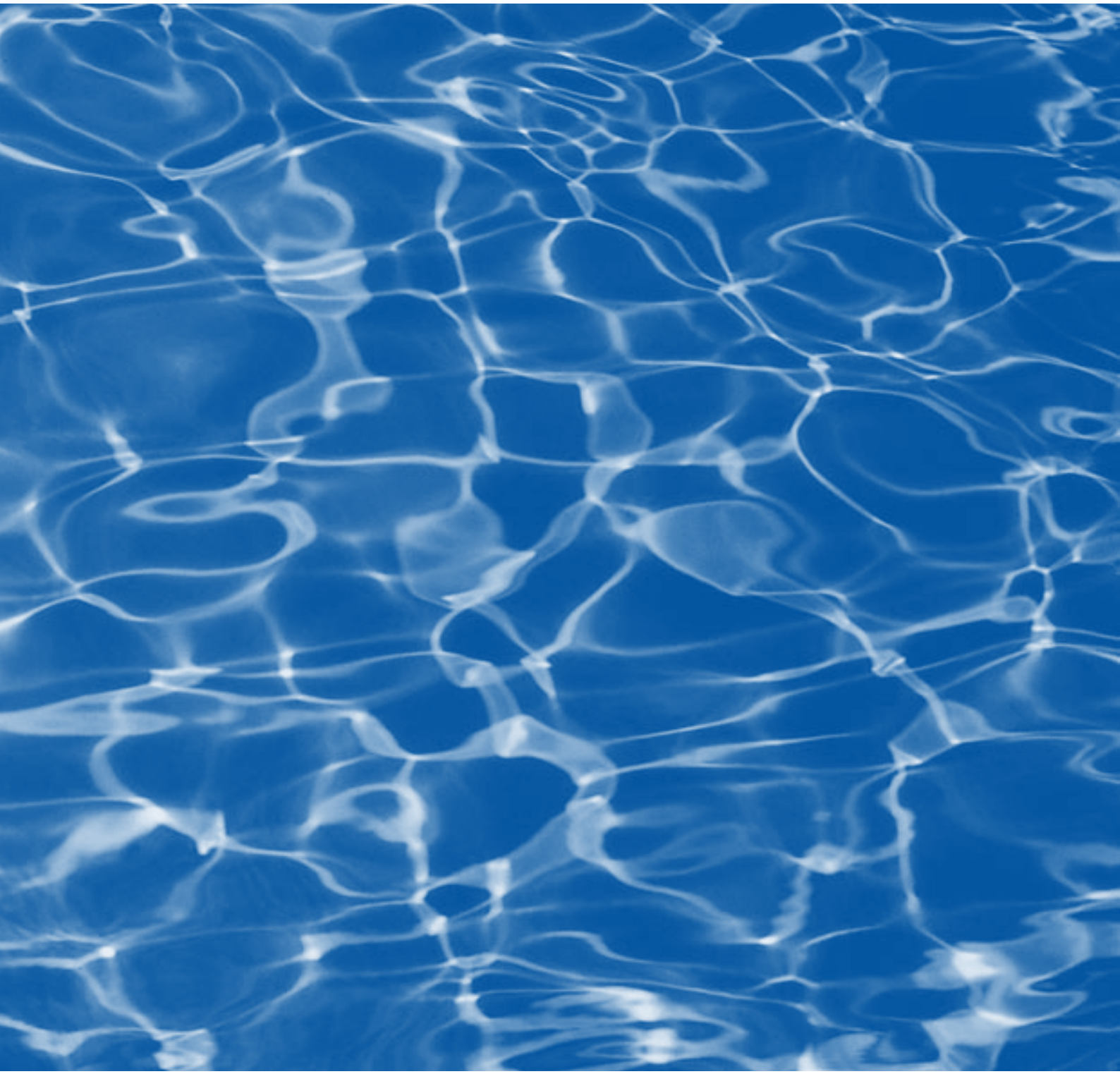
Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009



Victoria
The Place To Be

Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009

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Disclaimer

This strategy was prepared following consultation with the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases and its HIV Subcommittee, other experts in the field, government and the wider community. The addendum was prepared following consultation with the Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections and its HIV subcommittee.

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Contents

Addendum 2005–2009

The first *Victorian HIV/AIDS Strategy (2002–2004)* was formulated within the framework of the fourth *National HIV/AIDS Strategy (1999–2000 to 2003–2004)* and was endorsed as a whole of Victorian government document. It guided the public health and acute care responses and was the basis of the community and service providers' partnership in relation to HIV/AIDS during 2002–2004. The key outcomes of that strategy are discussed in "*An overview of the Victorian HIV/AIDS Strategy (2002–2004)*", in the following pages.

With the end of the term of the strategy on 31 December 2004, the Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections advised that the priority activities identified in the strategy remained current and that the document did not need to be rewritten. However, the committee identified a number of new and emerging issues to be addressed by government and the funded sector.

As such, the *Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009* is comprised of the text of the *Victorian HIV/AIDS Strategy (2002–2004)* and the following additional priority issues:

- **Improve the recording of Indigenous status in blood-borne virus (BBV) and sexually transmissible infection (STI) notifications;**
- **Refocus HIV/AIDS health promotion efforts to encourage testing and treatment for HIV and STIs;**
- **Ensure the direct involvement of HIV positive people in HIV prevention and education strategies;**
- **Focus on the needs of and issues faced by an ageing population of people living with HIV/AIDS;**
- **Focus on the BBV/STI needs of Indigenous people in custodial settings;**
- **Increase the capacity of culturally and linguistically diverse communities most affected by HIV/AIDS to contribute to policy and program development and implementation;**
- **Improve HIV/AIDS monitoring, treatment, education and support for people in custodial settings;**
- **Provide education and access to appropriate health services for Indigenous and culturally and linguistically diverse youth; and**
- **Develop comprehensive service delivery pathways spanning urban, regional and rural areas.**

Implementation of the extended strategy will be documented and prioritised in a new implementation plan, which will be developed in consultation with the committee.

An overview of key outcomes under the Victorian HIV/AIDS Strategy (2002–2004)

The first Victorian HIV/AIDS Strategy (2002–2004) was developed in the context of the challenges of reported increases in HIV diagnosis in the early 2000s, changes in the epidemiology of the epidemic, new treatments, emerging complications to treatments and changes within the communities most affected by the disease.

During the term of the first strategy HIV diagnoses remained high. In 2003, 2004 and 2005 there were 225, 222 and 286 new diagnoses of HIV in Victoria, respectively. In 2005, 72.4 per cent of these diagnoses were reported among men who have sex with men and a further 4.5 per cent among men who have sex with men (MSM) who also reported injecting drug use, 5.9 per cent were among males reporting heterosexual contact, 9.4 per cent among females reporting heterosexual contact, 3.5 per cent among individuals reporting injecting drug use and 4.2 per cent in unidentified/other exposure categories. In 2006, new diagnoses of HIV have continued to increase with 174 diagnoses reported between January and June 2006; 54 more cases than the same time period in 2005. This increase highlights the need to continue and extend initiatives under the strategy.

Notifications of sexually transmissible infections (STIs) continue to increase, especially amongst men who have sex with men who remain at particular risk of symptomatic and asymptomatic chlamydia, gonorrhoea and syphilis infection. Each of these STIs increases the risk of both transmitting and acquiring HIV infection.

Minority populations remain over-represented in the HIV epidemiology in Victoria, particularly amongst infections acquired through heterosexual contact and injecting drug use. Between 2000 and 2005 among individuals reporting heterosexual contact, 32.0 per cent were born in Africa and 14.1 per cent were born in South East Asia. Among individuals reporting injecting drug use as their primary exposure 17 per cent were born in South East Asia. These culturally and linguistically diverse groups are also more likely to present with AIDS illness at the time of their HIV diagnosis compared with other groups identified by surveillance.

The number of new HIV diagnoses among females in Victoria has also increased, with 32 females notified compared to 25 in 2003, and 12 in 1999. This increase was largely attributable to a greater number of diagnoses from women from high prevalence countries

During the period 2002 to 2005 the benefits of antiretroviral therapies continued to be experienced by HIV positive people in Victoria. However, these survival benefits were balanced by increased metabolic and cardiovascular toxicities, resistance to antiretroviral drugs, co-infections with hepatitis viruses and neuropsychiatric and neurocognitive problems, which have decreased the quality of life and increased the health service needs of positive people.

Furthermore, the population prevalence of HIV together with Victorian models of predicted prevalence indicate that now and in the future there will be further increases in numbers and complexity of health needs of people living with HIV/AIDS. This challenges and will continue to challenge the responses of Victoria's health care services.

The first *Victorian HIV/AIDS Strategy* resulted in a number of substantial cross-sectorial responses. In particular it should be acknowledged that substantial progress has been made in all areas of the strategy. Key outcomes include:

Surveillance and epidemiology

- Strengthening of the Victorian surveillance system.
- The development of a sentinel surveillance system for HIV, hepatitis C and chlamydia.
- Funding for a number of research activities to better understand the epidemiology of HIV in Victoria.
- Establishment of ongoing information sharing and education fora on the outcomes of surveillance and research efforts for the service sector.

Research

- Funding for a range of HIV/AIDS public health research activities, through the Public Health Research Program and through the Blood-Borne Viruses/Sexually Transmissible Infections Program.

HIV testing and counselling

- Strengthened capacity for Victorian testing laboratories in order to meet increasing demands.
- The redevelopment and accreditation of pre- and post-test counselling training for healthcare workers in HIV/AIDS and hepatitis C.
- The redevelopment and accreditation of an education program for general practitioners for HIV/AIDS and hepatitis C.

Health promotion

- A HIV health promotion campaign for men who have sex with men ("HIV stops with me").
- An STI testing and treatment health promotion program ("Check it Out") for men who have sex with men.

Treatment, care and support

- The development and implementation of management strategies for lipodystrophy and metabolic disorders amongst people living with HIV/AIDS.
- Improved primary healthcare service delivery to injecting drug users.
- The establishment of a pilot HIV/AIDS supported residential service in Berry Street, East Melbourne.
- The implementation of a pilot hepatitis B immunisation program in a Victorian prison.
- The provision of free hepatitis B vaccinations to injecting drug users through needle and syringe programs and drug treatment clinics.
- Development and implementation of a state-wide service for non-occupational postexposure prophylaxis.
- Implementation of outreach testing to sex on premises venues.

Legal and discrimination

- Implementation of *Victorian Guidelines for the Prevention of Sexually Transmissible Infections at Sex on Premises Venues*.
- Review and redevelopment of guidelines for the management in Victoria of people living with HIV who put others at risk.

Workforce development

- Establishment of a Multicultural Health and Support Service.
- The completion and implementation of the schoolteacher education package and teacher resource "Catching On".
- Support for a range of workforce development activities within the funded sector.

Coordination and management

- Reviews of key service providers, including the Victorian AIDS Council/Gay Men's Health Centre, People Living With HIV/AIDS Victoria, the Melbourne Sexual Health Centre and the Victorian HIV/AIDS Service at the Alfred Hospital.
- Reviews of service sector responses including, Victorian housing and support responses for HIV positive people, and a review of Victorian sexual health services.
- Improved coordination of BBV/STI responses with the correctional system.
- Strengthened capacity of HIV advocacy organisations, particularly PLWHA Victoria, which has been established as an organisation independent of the VAC/GMHC.
- Review of guidelines and advisory structures for the management of people who put others at risk of HIV infection.

Foreword

Victoria has played a leading role in Australia's response to HIV/AIDS: a response widely regarded as one of the world's best. Victoria continues to develop new initiatives and instigate the necessary responses to promptly address emerging issues in the epidemic.

Four successive National HIV/AIDS Strategies have been developed and implemented since 1989. They envisage a nation where HIV transmission and the personal and social impacts of HIV/AIDS infection are significantly minimised.

The *Victorian HIV/AIDS Strategy 2002–2004* has been developed within the broader framework of the *National HIV/AIDS Strategy 1999–2000* to 2003–2004. The Victorian Strategy outlines the challenges and clear strategic directions for future actions to minimise transmission of HIV and reduce the impact of the epidemic in Victoria.

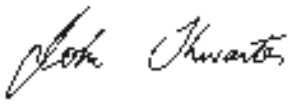
In addition, the strategy highlights the effective partnership approach between government, professional, non-government and community-based organisations in Victoria.

This strategy has been developed with the assistance of the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases and is the result of extensive consultation with Victorians from all parts of the state. As a result, it reflects the nature and impact of the HIV/AIDS epidemic, not just in metropolitan Melbourne, but throughout Victoria.

Over the years, the nature of the Victorian epidemic has evolved. Initial responses relied heavily on community mobilisation and other highly effective measures such as the Needle and Syringe Program. Later, the development of antiretroviral treatments gave people living with HIV and AIDS the chance to improve their quality of life.

We are currently facing new challenges with the reported increase in HIV notifications in Victoria. In the year 2000, there was a 41 per cent increase in notifications when compared to 1999. This represented the highest annual number of notifications since 1994. A further increase of 11 per cent was reported in 2001. Once again, the Victorian Government has responded strongly to increases in HIV notifications with a comprehensive HIV Action Plan. This plan has a three-pronged approach in the areas of education and prevention, research and surveillance, and sexual health testing.

The implementation of this strategy will rely on the cooperation and participation of the wider HIV sector. It will narrow the gap between infected and affected communities, health, medical and research professionals and the State Government, in responding to the constant challenges presented by HIV/AIDS. I commend to you the *Victorian HIV/AIDS Strategy 2002–2004*. I am confident that the strategy will tackle emerging issues, put national and international issues into a Victorian perspective and build on proven local initiatives and successes.



Hon John Thwaites MP
Minister for Health
31 July 2002

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Ms Helen Clarke	Department of Human Services
Dr Nick Crofts	The Macfarlane Burnet Institute for Medical Research and Public Health
Mr John Daye	People Living With HIV/AIDS Victoria
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1 Introduction

This is the first HIV/AIDS Strategy to be developed in Victoria. Since 1989, when the first National HIV/AIDS Strategy was endorsed, Victoria has used the national framework and successive national strategic frameworks for the development and implementation of its HIV/AIDS program. This strategy has been developed within the framework of the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*, however it takes account of the Victorian context, the successful initiatives that have been undertaken in the state and the responses that are necessary to address emerging issues.

As was the case for the third National HIV/AIDS Strategy, the fourth National HIV/AIDS Strategy is framed within a Commonwealth-State funding structure where dedicated specific purpose payments for public health programs and strategies are broad-banded within bilateral Public Health Outcome Funding Agreements (PHOFA). This strategy will assist as the basis for the HIV/AIDS component of the Victorian PHOFA.

It is important to maintain a strategic approach to HIV/AIDS in Victoria. There is evidence of some community complacency about HIV/AIDS and a sense in which many people believe that infection rates are low and treatments are effective. The recent increase in HIV notifications together with unacceptably high levels of sexually transmissible infections (STI) in the gay community have highlighted the fact that there are still people who are vulnerable to HIV infection and that health promotion gains can only be maintained with sustained and responsive effort.

Optimism about HIV treatments is balanced by the real experience of people living with HIV/AIDS who experience difficulties with treatment side effects and with the demanding requirements of treatment regimes. The existence of significant national HIV/AIDS epidemics in many parts of the world, and the regular movement of people between Australia and these countries, also presents an opportunity for increased risk of HIV transmission.

An effective response to HIV/AIDS in Victoria requires the cooperation of a wide range of sectors, organisations and communities. This strategy provides a mechanism for ensuring that the response in Victoria is consistent, flexible and comprehensive. This document provides the strategic directions for Victoria for the development and implementation of HIV/AIDS programs over the period 2002 to 2004. It should be recognised that the initiatives identified under the various sections of the strategy should be prioritised within the formation of annual or operational plans for government, professional, non-government and community-based organisations in Victoria.

It should also be recognised that, as is the case for the national strategies, this strategy is not a funding document. Rather, it provides the framework under which separate mechanisms may be developed to reprioritise existing resources or may lead to additional support, based on priorities identified within the strategy.

1.1 HIV/AIDS in Victoria

HIV/AIDS has had a significant impact on public health in Australia since the early 1980s. To December 2001 there were 21,722 notifications of HIV, 8,756 cases of AIDS and 6,152 deaths reported following HIV/AIDS diagnosis[1]. In Victoria, from 1983 and to 2001 inclusive, 4,629 notifications of HIV, 1,942 cases of AIDS and 1,615 deaths following HIV or AIDS diagnoses have been recorded[2]. The state has the second highest reported number of HIV notifications and AIDS diagnoses in Australia, representing about 21 per cent of the national total for each[3].

In Victoria, cases of AIDS peaked in 1994 when 203 diagnoses were recorded. Since that year, the number of AIDS diagnoses reported has fallen with the lowest level reported, at 50 cases, in 2000[4]. This dramatic drop in cases largely reflects the impact of combination therapies readily available since the mid-1990s. Although there are an increasing number of people living with advanced HIV infection, improved clinical management has reduced the number of AIDS-related illnesses and opportunistic infections, resulting in better health status for a majority of people living with HIV/AIDS and a reduced illness

1 National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, Vol.18, No.2, April 2002.

2 Victorian Department of Human Services, *Victorian Infectious Diseases Bulletin*, Vol.5, Issue 2, June 2002.

3 National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report,* Vol.18, No.2, April 2002.

4 Victorian Department of Human Services, *Victorian Infectious Diseases Bulletin*, Vol.4, Issue 1, March 2001.

burden within the health care system. Nevertheless, the hospitalisation rate due to treatment toxicities, neuropsychiatric complications and illnesses that are not AIDS-related has remained relatively stable over this period. AIDS affects men later in life, with the median ages 39 and 29 years of age respectively for males and females[5].

The number of notifications of HIV infection in Victoria peaked at 528 in 1985 and declined to 139 notifications in 1999. In 2000, however, 197 notifications of HIV were recorded, representing a 41 per cent increase over 1999 figures. The increased level of notifications was sustained in 2001 with 218 notifications received, representing an 11 per cent increase over the total of 197 in 2000 and a 56 per cent increase on the 1999 total of 139. HIV notifications are at the highest level since 1994, representing a significant public health concern.

In Victoria, HIV is transmitted primarily by sexual contact between men (78 per cent of male notifications during 2001 reported male-to-male sexual contact). During 2001, eight per cent of newly diagnosed men reported heterosexual contact as an exposure category. Injecting drug use as a sole exposure category accounted for five per cent of HIV infections in men during 2001, about the same as for the previous year. Men who reported both injecting drug use and male-to-male sexual contact accounted for three per cent of male infections diagnosed in 2001.

5 State of Victoria, *Surveillance of Notifiable Infectious Diseases in Victoria 2000*, Communicable Diseases Section, Public Health Division, Victorian Department of Human Services, Melbourne, 2001.

The median ages for HIV notifications in males and females in Victoria in 2001 were 32 and 30 years of age, respectively. Around 94 per cent of all HIV notifications in Victoria from 1983 to 2001 were male and approximately 86 per cent of these men reported male-to-male sexual contact. Women account for roughly five per cent of notifications of HIV and transgender individuals and individuals who did not specify their sex, represent one per cent.

The pattern of HIV infection is not uniform across the state or within Melbourne. In 2001, 85 per cent of newly-diagnosed individuals lived in metropolitan Melbourne regions of the Department of Human Services, with the largest number residing in the Southern Metropolitan region (36 per cent), followed by the Northern Metropolitan region (24 per cent). Eight per cent resided outside of the metropolitan regions and postcode information was not provided for seven per cent.

1.2 Impact of the epidemic

The HIV/AIDS epidemic in Victoria has affected different populations within the community disproportionately. While it has the potential to affect all people, the epidemic has been concentrated among gay and homosexually active men living in metropolitan Melbourne.

Since the epidemic became evident in early 1980s, the response in Australia has largely come from within affected communities, working in partnership with health care providers, public health and government officials. This has driven the broader response at the national and state levels.

It is clear that the epidemic has been predominantly confined to gay and other homosexually active communities and that priorities for the response in this state will be directed towards these men. However, it is also necessary to understand the determinants of the pattern of HIV/AIDS in Victoria to identify modes of transmission and levels of risk and vulnerability among other population groups, such as people with haemophilia, injecting drug users, people from high-prevalence countries and women.

1.3 Vulnerable populations

There are many groups and individuals in Victoria who are at risk of HIV infection and a comprehensive HIV/AIDS Strategy needs to take them into account.

The most likely mode of transmission of HIV in Victoria at present is unprotected anal sex between men. For this reason, the gay community and other men who have sex with men continue to be priority targets for health promotion programs and activities. Risk for this population is compounded by the presence of relatively high levels of STI. The gay community is having to develop a range of ways to deal with the continuing presence of HIV/AIDS in their community. Safe sex fatigue, the effects of multiple bereavement and safe sex complacency are very real issues for a community that has been dealing with HIV/AIDS for almost 20 years.

Recent evidence of increased infections among this group in Victoria suggests that greater attention is needed to find new ways to sustain behavioural changes in the context of a changing epidemic.

Some of the factors that may be impacting on risk behaviour are treatment advances, young gay men who have had little contact with the epidemic, older gay men who are experiencing safe sex fatigue, mental health problems and increasing patterns of drug use in the gay and wider community. These issues pose new challenges for prevention strategies, for both people living with HIV/AIDS and for men who are HIV-negative.

While it is understood that a connection to the gay community provides greater access to information and education interventions, as well as to a supportive safe sex culture, there are homosexually active men who do not consider themselves gay, who remain isolated from the gay community and who have little opportunity to assess their risk of HIV infection and to take action to prevent infection. Recent research in rural Victoria has shown that men living outside of metropolitan areas who present with advanced HIV infection are less likely to identify as homosexual[6]. There are also other vulnerable sub-populations within the population of men who have sex with men. These include men from culturally and linguistically diverse backgrounds, men in custodial settings, men with intellectual disabilities, male sex workers and socially isolated men.

In Victoria, rates of diagnosed HIV among injecting drug users are relatively low, while the prevalence of hepatitis C infection in this group is high. Experience in other countries has shown that HIV can be rapidly transmitted through the sharing of injecting equipment. While current harm minimisation initiatives such as the Needle and Syringe Program (NSP) are contributing to a low level of HIV transmission in injecting drug users, these services are not effectively reaching some high-risk sub-populations. There is emerging evidence in Victoria of increasing rates of HIV infection among people of Indo-Chinese origin who are injecting drugs[7]. It has recently been reported that treatment and prevention services are less likely to reach these people[8].

While the risk of infection through heterosexual sex remains relatively low in Australia and Victoria, there are still people at particular risk and these people need appropriate health promotion programs and initiatives. These groups include people who have come from high prevalence countries, or who travel regularly to those countries, women who do not have the skills or power to negotiate safe sex with their partners, and sex workers working in illegal settings or in settings that do not allow them to negotiate safe sex.

The impact of HIV/AIDS on women living with HIV in Victoria needs particular attention. Although the number of women with HIV in Victoria is relatively small, women experience additional stigma and discrimination as a result of HIV infection. Women at risk of HIV infection also require particular attention. Reducing HIV transmission involves reducing general vulnerability and increasing self-determination. Issues of discrimination, power and self-determination still exist for Victorian women and this strategy needs to contribute towards a general movement to improve their freedom and health opportunities. There are also particular health promotion and care and support issues that need to be addressed for HIV-positive mothers and for women with HIV/AIDS who are pregnant.

Vulnerability to HIV infection is also influenced by:

- Environments where people live and work.
- Beliefs that govern their behaviour.
- Lack of access to services, information and education.
- Poverty, homelessness and isolation.
- Mental illness.
- Language and cultural constraints.

This strategy aims to encourage a flexible response that takes account of all vulnerable groups and individuals in Victoria. It looks not only at the behaviours that lead to HIV transmission, but the contexts in which HIV transmission is more likely to occur.

6 Hocking J, Keenan C, & Crofts N. 'Characteristics of individuals living in rural/regional Victoria diagnosed with HIV', *Australian Society for HIV Medicine*, 13th Annual Conference, Melbourne 4–7 October 2001.

7 Elliot J, Mijch A, Street A, Korman T, Read T, O' Reilly M & Crofts N. 'HIV in ethnic Australians' *Australian Society for HIV Medicine*, 13th Annual Conference, Melbourne 4–7 October 2001

8 Hocking J, Higgs P, Keenan C & Crofts N. 'HIV among injecting drug users of Indo-Chinese ethnicity in Victoria', *Medical Journal of Australia*, Volume 176, February 2002, pp.191–192.

2 Goals and principles

The goals of this strategy are consistent with those of the *National HIV/AIDS Strategy 1999–2000 to 2003–2004* and are:

- To minimise the transmission of HIV in Victoria.
- To minimise the personal and social impacts of HIV infection for people in Victoria.

The response to HIV/AIDS in Australia has been widely recognised as an effective approach to the epidemic. The following elements have been central to this approach:

- National strategic framework.
- Partnership.
- An enabling environment.
- The involvement of affected communities.
- Non-partisan political support.
- Access to quality affordable treatment.
- Health promotion and harm minimisation.
- Dedicated funds in particular areas.
- Linking closely with other strategies.

These elements have also constituted the Victorian response and will continue to underpin this strategy.

National strategic framework

A comprehensive national approach is needed for coordinated action in combating the Australian HIV epidemic. In 1989, all Australian governments endorsed Australia's first National HIV/AIDS Strategy. The current (fourth) national strategy, the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*, builds on the strong foundations established by the previous strategies. The first Victorian HIV/AIDS Strategy recognises the need for continued national coordination.

Partnership

Partnership between government, community organisations, medical and scientific communities and people living with HIV/AIDS has been a central feature of the Australian and Victorian response. This partnership is based on a commitment to consultation and joint decision making and policy development. Representatives of the partner groups are included on advisory bodies and consultative forums for policy development, program development and resource allocation. Effective partnership is achieved through this participation at all levels and jurisdictions.

An enabling environment

The Victorian Government will continue to foster the development of a social and legal environment that protects the rights of people living with HIV/AIDS and provides a supportive approach to those whose behaviour may place them at risk of HIV. The development of this environment is consistent with the principles set out in the Ottawa Charter for Health Promotion and the Jakarta Declaration.

Involvement of affected communities

The involvement of affected communities has characterised the Victorian response from the outset, with these communities being the first to mobilise and respond to the epidemic. This involvement has been critical to the relevance and success of prevention and care programs. This strategy maintains a commitment to ensure the involvement of affected communities at all levels of program, service and policy development and implementation.

Non-partisan political support

Non-partisan political support at national and state levels has been a key feature of the national and Victorian response. This has enabled the funding and implementation of highly effective and often controversial strategies, such as NSP, explicit educational material targeting homosexually active men and funding for sex worker groups. This strategy recognises that non-partisanship should play a key role in Victorian efforts to respond effectively to future challenges presented by the epidemic and that efforts will be required to secure and maintain this support.

Access to quality affordable treatment

There is substantial evidence that the reduction in AIDS and mortality in the late 1990s is attributable to effective combination antiviral therapy. Emerging evidence supports the view that the associated reduction in virus levels in individuals and populations also reduces HIV transmission rates. Jurisdictions like Victoria, which provide early diagnosis and accessible treatment services based on quality clinical and basic science research evidence, have better records of containing infection and of limiting the adverse effects of disease.

Health promotion and harm minimisation

The principles of the Ottawa Charter and Jakarta Declaration have provided the basis for Australian and Victorian prevention efforts in health promotion and harm minimisation. These principles recognise that health promotion must consider the political, social, cultural, environmental, behavioural and biological determinants of health and that effective strategies are based on understanding these determinants and their impact on people's behaviour. Harm minimisation has also been an effective approach to reducing harm associated with behaviours such as injecting drug use, as well as reducing transmission of HIV among people who inject drugs. These approaches will continue to be supported under this strategy.

Ongoing funding in particular areas

It was clear from the outset that HIV/AIDS would have an impact on the delivery of health and community services. Commonwealth and state funds were set aside early in the epidemic to ensure that community organisations and health services could respond effectively. Although general services now make an essential contribution to the HIV/AIDS response in Victoria, there is a continuing need for funding in some areas of HIV health promotion and service provision.

Linked strategies

The implementation of this strategy requires coordination with other relevant national and state strategies that have a bearing on the health and wellbeing of people living with and affected by HIV/AIDS. Nationally, these include:

- *National HIV/AIDS Strategy 1999–2000 to 2003–2004.*
- *National Hepatitis C Strategy 1999–2000 to 2003–2004.*
- *National Drug Strategic Framework 1998–99 to 2002–03.*
- *National Indigenous Australian's Sexual Health Strategy 1996–97 to 1998–99.*
- *Building on Success 3, the Commonwealth Government Response to Towards a National Strategy for HIV/AIDS Health Promotion for Gay and Other Homosexually Active Men.*
- *National Mental Health Strategy, Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians 1999–2003.*
- *Health of Young Australians: A National Health Policy for Children and Young People.*

In Victoria:

- *Hepatitis C Strategy for Victoria 2002–2004.*
- *Victorian Prison Drug Strategy 2002.*
- *Chlamydia Strategy for Victoria 2001–2004.*
- *Valuing Victoria's Women: Forward Plan 2000–2003.*
- *Victorian Women's Health and Wellbeing Strategy.*
- *Victorian Government Drug Initiative.*

3 Key priority areas

3.1 Surveillance and epidemiology

Epidemiological surveillance is an essential tool for planning health services and assessing the effectiveness of efforts to prevent and treat HIV infection. It involves the ongoing and systematic collection, analysis and interpretation of health data.

Surveillance systems work closely with research initiatives to build an accurate picture of who is becoming infected, changing patterns of HIV infection and risk and newly identified vulnerable groups.

Prior to September 1996, surveillance of HIV in Victoria was laboratory-based. Since September 1996, the notification of HIV from the diagnosing doctor has been a legislative requirement. All HIV information collected is in a coded, non-identifying format.

In Victoria, there is predominantly an enhanced passive surveillance system in place. The surveillance system relies on laboratories and diagnosing doctors providing information. This information is then followed up by the laboratory and by departmental Partner Notification Officers to determine whether the reported case is a new or repeat diagnosis and to get accurate information about the characteristics of the person who has been diagnosed. Information collected includes age, gender, area of residence, suspected mode of transmission and country of birth. One of the measures of success of the HIV/AIDS response is a decrease in the rate of new infections. As such, it is important to establish whether the person has been recently infected and, if so, in what context. This information guides policy makers and health promotion workers in their attempts to adapt to changes in the pattern of the epidemic.

Partner Notification Officers also assist the diagnosing doctor and, if appropriate, the newly diagnosed person, to identify and notify others who may be at risk of infection.

The recent increase in new HIV notifications in Victoria has highlighted the need for an examination of current surveillance systems and to consider establishing some active surveillance strategies. In an active surveillance system, the monitoring agency designs and maintains processes that actively produce data to assist in tracking the pattern of the epidemic. These do not rely only on people presenting for HIV testing and on doctors and laboratories reporting new infections. Combining the current enhanced passive system with some active surveillance strategies would provide more comprehensive information on the patterns of risk and infection.

As well as information about people diagnosed with HIV, it is important that surveillance data is collected on the risk behaviours and characteristics of people presenting for HIV testing. This gives important information about changing patterns of risk and about communities and sub-populations that may be at risk but are not accessing HIV testing and counselling.

Behavioural surveillance also provides useful information about changing risk patterns and is an important tool for health promotion workers.

AIDS has been a notifiable condition in Victoria since 1983. Diagnosing physicians mail notifications of new AIDS diagnoses to the Department of Human Services.

The pattern of HIV disease has changed considerably since the AIDS definitions were established. It is now recognised that there may be better indicators of HIV disease burden than the presence of AIDS-defining illnesses. However, the quality and accessibility of data for any new indicators would need to be assessed before they could be incorporated into active surveillance. Potential alternative indicators include hospitalisation rates and toxicity, morbidity and viral breakthrough associated with resistance to treatments or with difficulties in maintaining treatment regimes. Co-morbidities like neuropsychiatric and social factors, as well as other risks for disease, should also be considered for inclusion in active surveillance programs.

3.1.1 Principles and objectives of surveillance

The primary goal of surveillance for HIV/AIDS is to provide policy makers, field workers and researchers with accessible, relevant, accurate and timely information about epidemiological trends. This will facilitate public health action to prevent or control transmission of infection and to minimise morbidity and mortality. Achieving this goal will entail identifying who is at greatest risk of infection and when, where, how and why they are being affected.

3.1.2 Future direction

Enhance partnership mechanisms for providing advice on surveillance priorities, analysing surveillance data and feeding information back to the sector.

This strategy supports enhancing those mechanisms that bring people from the sector together: to consider surveillance priorities; review and reform surveillance strategies; analyse surveillance data; determine areas for future research; and to deliver surveillance outcomes and research data back to communities and health workers.

Investigate and implement appropriate active surveillance to complement existing passive surveillance.

This process will determine what information is required to assist in shaping health services and health promotion programs to better respond to HIV/AIDS in Victoria. It will determine the mix of surveillance and research initiatives that will deliver the information in a timely and cost-effective manner.

Among the strategies to be considered will be coordination and support for a network of sentinel clinics and the continued support for surveys specifically designed to explore important questions about risk behaviours and attitudes in vulnerable populations.

Review and modify current surveillance activities to improve their efficiency and effectiveness.

The focus on notification of AIDS may no longer be useful, given the changing patterns of HIV disease. More effective methods of mapping and monitoring patterns of HIV disease are to be investigated and identified.

Establish mechanisms to better identify new HIV infections.

A combination of new HIV testing technologies and enhanced follow-up of notifying doctors will be explored to better establish whether new diagnoses of HIV infection are the result of recent seroconversion or the diagnosis of long standing infection. This will provide a more accurate picture of the rate and pattern of new infections rather than just new diagnoses. For example, advances in the use of the 'detuned ELISA' test (a test that may provide more information about the actual time of seroconversion to HIV) will be monitored to determine the appropriateness and feasibility of the ongoing use of this test.

Ensure effective evaluation and quality assurance processes.

Evaluation and quality assurance processes will be vital components of HIV/AIDS surveillance and will focus on the following aspects of the system: completeness, timeliness, usefulness to consumers, responsiveness to changing trends and validity of findings. These measures will ensure that the system continues to deliver information that will contribute to improving the health of the Victorian population.

3.1.3 Key strategies for surveillance and epidemiology

- Enhance partnership mechanisms for providing advice on surveillance priorities, analysing surveillance data and feeding information back to the sector.
- Investigate and implement appropriate active surveillance to complement existing passive surveillance systems.
- Review and modify current surveillance activities to improve their efficiency and effectiveness.
- Establish mechanisms to better identify new HIV infections.
- Ensure effective evaluation and quality assurance processes.

3.2 Research

High quality evidence is the strongest platform from which to mount an effective response to the HIV/AIDS epidemic. To date, the Australian response has been guided by a strong, multidisciplinary research program that has been particularly successful at building links between research and practice.

Victoria has an extremely experienced, innovative and creative research community already working on HIV/AIDS issues. Research institutions in the state have established international reputations in the fields of HIV/AIDS scientific, medical and social research.

Researchers, both within and outside of the Commonwealth-funded National Centres in HIV Research, have made significant contributions to the body of HIV/AIDS knowledge in a number of disciplines. Community-based organisations have developed innovative strategies based on strong relationships with researchers. Such links will continue to be encouraged.

3.2.1 Principles of HIV/AIDS research

The guiding principles and objectives for HIV/AIDS research in Victoria will be based on those outlined in the N*ational HIV/AIDS Strategy 1999–2000 to 2003–2004* and those recommended in the Review of Australian HIV/AIDS Research (1999):

- Research evidence will continue to guide the Victorian HIV/AIDS response.
- Research is undertaken within the framework of the Ottawa Charter for Health Promotion.
- The community will continue to be involved in the determination of HIV/AIDS research priorities, including through the ministerial advisory committee (currently MACAHRD).
- Research will be conducted in partnership with affected communities.
- Treatment and vaccine trials will be conducted in an ethical manner and complement health promotion initiatives or continued access to treatment programs.
- Innovative interdisciplinary research and speculative research will continue to be supported, where appropriate.
- Resources will be allocated, according to identified priorities, to areas lacking data and where the greatest population benefit can be obtained.
- Methods of research that are appropriate to the subject area or population under investigation will be deployed.

3.2.2 Future direction

Strengthen existing research infrastructure and maintain a broad research agenda.

Leadership and funding for HIV/AIDS research in Australia is primarily the responsibility of the Commonwealth, however, the state has the capacity to initiate research to address issues specific to Victoria. Victoria also has a role in supporting key Victorian research organisations. These organisations will continue to play a role in informing policy makers and the community about the HIV epidemic in Victoria.

This strategy will support mechanisms for ensuring that the research questions of relevance to the HIV/AIDS response in Victoria are included in the national HIV/AIDS research agenda. It will also ensure that the research agenda in Victoria includes research and evaluation of treatment, care and support models. Monitoring and advising on research falls within the terms of reference of MACAHRD.

Improve collaboration and coordination between researchers.

Effective collaboration between biomedical and social researchers is necessary to strengthen the Victorian response and to advocate for a greater involvement in determining national research priorities. Mechanisms to coordinate and determine Victorian research priorities should be established by researcher groups. These coordinating arrangements will play a key role in monitoring research needs in the community, in determining ways in which research may be undertaken and in disseminating research findings.

The link between surveillance and research will be strengthened so that strategic decisions can be made about the most appropriate way to monitor changes in the epidemic. The feasibility of establishing a multidisciplinary consortium of Victorian HIV researchers could be explored as a way of building the strength of the research effort.

Develop local responses through commissioned research and support of appropriate investigator-driven research.

Research focused on state and local issues is needed to reflect the differing contexts of the epidemic in Victoria and bring together and build on the expertise available in Victoria. Although the Victorian context must be the primary focus for the research component of this strategy, national and international research findings and approaches can provide important reference points for research in Victoria.

Increased notifications of HIV in 2000 in Victoria resulted in funding for a number of new research initiatives. These included case control studies of recent seroconverters and gonorrhoea cases. Targeted local research in response to signals about changes in the epidemic will continue to be supported.

Facilitate partnerships between researchers, practitioners and the community.

The development of research partnerships between researchers, practitioners and the affected community

will be encouraged under this strategy. Key outcomes of this partnership will be the development of practitioner and community awareness and understanding of research methodology and processes and an increase in their capacity to interact with researchers and research activities. This partnership should work in both directions and should, therefore, also strive to provide a mechanism for practitioners and the community to actively contribute to research questions, research design and implementation, and the dissemination of research findings. This partnership should also assist in identifying community research priorities and linking more closely with issues and concerns of target communities.

Improve mechanisms for research dissemination.

Research forums that include periodic updates on research findings are an important means for disseminating this information to other researchers, practitioners and the community. This currently occurs in state-funded Blood-Borne Virus Updates and various conferences held in Victoria. Improved links with the Research Link Project through the National Centre in HIV Social Research may also provide an opportunity for greater information on, and input to, research being conducted in other parts of Australia. The use of video link technology will be explored as a mechanism for providing regular research updates to people in regional and rural Victoria.

Maximise opportunities for participation in vaccine research at all levels.

The International AIDS Vaccine Initiative is currently planning trials of preventive vaccines in Australia. Researchers and practitioners in Victoria will develop ways to work together towards the development and implementation of these HIV vaccine trials and these will be clarified during the term of this strategy.

Use research to strengthen program evaluation and development.

Research will also play a greater role in monitoring and evaluating HIV/AIDS program outcomes, particularly in identifying effective health promotion interventions and training initiatives. Appropriate resources should be made available to enable effective program evaluation.

3.2.3 Key strategies for research

- Strengthen existing research infrastructure and maintain a broad research agenda.
- Improve collaboration and coordination between researchers.
- Develop local responses through commissioned research and appropriate investigator driven research.
- Facilitate partnerships between researchers, practitioners and the community.
- Improve mechanisms for dissemination of research findings.
- Maximise opportunities for participation in vaccine research at all levels.
- Use research to strengthen program evaluation and development.

3.3 HIV testing and counselling

Laboratory testing for HIV in Victoria is delivered through a three-tiered system. In the first tier, blood banks and Department of Human Services-approved public and private laboratories undertake screening tests to detect antibodies to HIV. Blood banks have also recently commenced nucleic acid testing (NAT) as an additional safeguard to protect the blood supply.

In the second tier, reactive specimens are referred to the Victorian Infectious Diseases Reference Laboratory (VIDRL), which is the State Reference Laboratory (SRL). The SRL performs confirmatory antibody testing and, in selected cases, qualitative diagnostic NAT. The SRL also provides monitoring of HIV antiretroviral therapy with quantitative NAT, monitoring of HIV antiretroviral drug resistance and, from time to time, testing for relatedness between HIV strains. It also circulates HIV antibody quality assurance panels to all Victorian HIV testing laboratories and undertakes some applied HIV research.

In the third tier, the National Serology Reference Laboratory (NRL) evaluates new diagnostic tests, provides additional confirmatory tests, provides quality assurance panels and develops consensus on the interpretation of laboratory results.

Access to free, confidential and voluntary HIV testing and counselling for groups vulnerable to HIV infection is a key element of any successful HIV/AIDS response and will remain a key element of the response in Victoria. On an individual level, it is important that people with HIV know their HIV status, so that they

can take steps to avoid opportunistic infections and maximise their health. Confidential testing and counselling for people at risk of HIV infection is also an important personal and public health measure, as it provides these people with an opportunity to assess risk behaviour, to learn about HIV transmission and to develop the skills needed to reduce risk practices and thereby avoid HIV transmission. These services also provide policy makers with essential information on rates of notification and on changing risk patterns in the community.

In 1994, Victoria introduced a user pays system in an attempt to reduce levels of unnecessary HIV testing, while still maintaining access to free testing for those at high risk of infection. There has been some concern expressed that, despite the current arrangements for free HIV testing, the user pays system may act as a barrier to HIV testing for people who do not have the capacity to pay. An analysis of the impact of this system on access for those at high risk has shown that since introduction, there has been a reduction overall in the number of tests performed[9]. Further efforts are required in order to determine whether the user pays system is acting as barrier to testing for people at genuine risk, particularly for people from culturally and linguistically diverse backgrounds, people on reduced incomes, people who inject drugs, young people and people in rural areas with limited access to free testing.

Despite widespread acceptance of the practice of voluntary and confidential testing, the practice of pre-test information and post-test counselling needs to be strengthened. There has been concern about the extent of testing that is occurring without the provision of adequate or appropriate informed consent, information and counselling. Establishing that a person is HIV negative is of marginal value if not accompanied by an assessment of risk, provision of information on modes of HIV transmission and counselling to enable the person to reduce risky behaviours. In response, the Department of Human Services is currently reviewing pre- and post-test training courses for health care workers.

3.3.1 Principles of HIV testing

The principles for HIV testing are consistent with those set out in the national policy on HIV testing[10]. These are:

- That testing is critical to determine the extent and location of HIV infection in the community.
- That all testing is voluntary with the provision of counselling and confidentiality.
- That testing is accessible to those at high risk of HIV infection.
- That the quality of HIV testing is to be of the highest standard.

3.3.2 Future direction

Update laboratory algorithms and case definitions as required in response to developments in HIV testing.

With the development of new technologies and with changes in the nature of the epidemic, it is important that case definitions and laboratory algorithms are frequently reviewed.

The use of newer technologies such as detuned ELISA are under investigation as tools for determining the timing of HIV infection and could be introduced subject to the results of these investigations and their availability and efficacy in determining newly acquired cases of HIV infection. Strategies to provide access to tests for monitoring HIV disease risk and response (HIV viral load and resistance testing) will be introduced subject to availability, efficacy and evidence of improvement in treatment outcomes.

Identify and remove barriers to appropriate confidential HIV testing and counselling for at-risk populations.

Barriers presented by the current user pays testing system should be investigated and appropriately addressed. In particular, barriers to testing among vulnerable populations need further investigation, especially among indigenous and culturally and linguistically diverse communities. Some of these barriers may relate to language, culture and cost of testing, however, there may also be issues of access relating to trained health care providers, lack of confidentiality and stigma associated with seeking an HIV test. Strategies to increase access to information on HIV testing should be enhanced for people

9 Stevenson EM, Thompson SC, Crofts N. 'HIV testing and policy change, analysis based on State-wide HIV testing data, 1994–1995'. *International Conference on AIDS* 1996, July 7–12 1996.

10 Australian National Council on AIDS and Related Diseases, and the Intergovernmental Committee on AIDS and Related Diseases, *HIV Testing Policy*, Commonwealth of Australia, September 1998.

who are newly arrived in Victoria, as well as to those who have less access to mainstream services, including those who inject drugs and those with intellectual or psychiatric disabilities.

Limited access to bulk-billing general practitioners in rural areas may be a constraint for people seeking free testing for HIV. This issue may require investigation.

Develop a partnership with the Royal Australian College of General Practitioners and the Divisions of General Practice to improve the consistency and quality of pre- and post-test counselling.

For people diagnosed with HIV, the post-test counselling process is extremely important. Effective post-test counselling and referral attempts to ensure that newly diagnosed people receive the support and information that they require to stay as healthy as possible and to prevent further transmission. For people who test as negative for HIV, post-test counselling provides an important opportunity to reinforce health promotion messages. The Department of Human Services will work with appropriate organisations including the Royal Australian College of General Practitioners, the Divisions of General Practice and the Australasian Society for HIV Medicine to improve the consistency and quality of pre and post-test counselling. The department will also explore strategies for maintaining high quality services in the future.

Strengthen risk assessment and informed consent practices associated with antenatal HIV testing.

Antenatal testing for STI and HIV remains a voluntary and consensual process, however, where appropriate, HIV testing should be discussed with pregnant women. The national testing policy identifies that pre-test information and post-test counselling should be provided routinely to all pregnant women when tests for HIV are offered. Women who are considered to be at higher risk of HIV infection should be encouraged to consider testing for HIV and the benefits of early diagnosis and management of HIV as well as the prevention strategies available for mother and child discussed.

Develop processes to enable people being tested for HIV infection to understand the issue of informed consent and their rights to pre- and post-test counselling.

Strategies to improve the quality of pre- and post-test counselling will be complemented by dissemination of information about the rights of people considering or undertaking HIV testing.

Provide training for health workers about occupational exposure testing protocols and policies.

There is an identified need for improved training for health workers about occupational exposure to HIV. Training should be undertaken to ensure that the rights of patients and the health workers are protected. This will include issues of informed consent and the need for pre- and post-test information and counselling for the patients and workers.

Provide training about non-occupational post-HIV exposure prophylaxis policies.

There is also a need for dissemination of information and provision of training about policies relating to non-occupational post exposure prophylaxis (N-PEP).

N-PEP involves the use of antiretroviral therapy for people who may have been recently exposed to HIV, for example, by unprotected sex, condom breakage, needle sharing with a person known to be HIV-positive or through sexual assault.

3.3.3 Key strategies for HIV testing and counselling

- Update laboratory algorithms and case definitions as required, in the light of developments in HIV testing.
- Identify and remove barriers to appropriate confidential HIV testing and counselling for at-risk populations.
- Develop a partnership with the Royal Australian College of General Practitioners and with Divisions of General Practice to improve the consistency and quality of pre-and post-test counselling.
- Strengthen risk assessment and informed consent practices associated with antenatal HIV testing.
- Develop processes to enable people being tested for HIV to understand the issue of informed consent and their rights to pre- and post-test counselling.
- Provide training for health workers about occupational exposure testing and treatments protocols and polices.
- Provide training about non-occupational post-HIV exposure prophylaxis policies.

3.4 Health promotion

Australia has received international acclaim for its efforts to prevent the spread of HIV and for its innovative education programs. In the early part of the epidemic, a range of general

community and health promotion strategies targeted towards affected communities were adopted to raise awareness about HIV/AIDS and to minimise the transmission of HIV. For the general community, people were encouraged through media and community education strategies to understand HIV risk and to use condoms with casual sex partners.

Although the focus of health promotion was on unsafe behaviours rather than on high-risk groups, the value of targeting populations at particular risk, such as gay men, sex workers and injecting drug users, was acknowledged. Given the marginalisation of these groups, community or peer organisations with particular links to these groups were used to develop and deliver health promotion programs.

Schools, education institutions and organisations dealing with young people were encouraged to incorporate HIV health promotion messages into their programs and curricula. People who inject drugs were encouraged to use new injecting equipment and not to share needles. Health promotion for people who inject drugs was delivered through NSPs and peer organisations.

At the time of embarking on the general community campaigns and programs, it was not clear to what extent the HIV/AIDS epidemic would move outside the groups thought to be at highest risk. Data on HIV seroconversions in Victoria in the last two years would suggest that the epidemic is contained primarily within the communities at greatest risk. In 2001, approximately 69 per cent of new HIV infections reported male-to-male sex as their assumed mode of transmission. Roughly five per cent reported needle sharing as the primary mode[11]. These figures justify the continuation of a focus of health promotion programs on these risk behaviours. Information gained from social research will be used to further identify the context of HIV infection, so that programs can be targeted towards individuals and groups that remain at risk and at the settings of high-risk behaviour.

Sexual health promotion is also relevant for sexually active Victorians of all ages. Unacceptably high rates of gonorrhoea amongst young people and amongst men who have sex with men in Victoria highlight the need for an increased focus on sexual health promotion. An increase in the incidence of gonorrhoea, particularly among men who have sex with men, was noted in early 1998. This increase was sustained through 1999 and 2000. In 2001, 718 gonorrhoea notifications were received. This total is similar to that for 2000 (742 cases) and is the second highest annual count since 1986.

It is important that efforts be made to reduce the incidence of STI, as infection with an STI is known to be a cofactor for infection with HIV. The risk of progression to AIDS for people with HIV also increases in the presence of other STIs. STIs increase HIV viral load and studies show a 4.8-fold increase in the risk of HIV transmission in the presence of gonorrhoea[12]. This signals the need for health promotion activities in two areas:

1 General sexual health promotion, including increased activity aimed at early detection and treatment of STI, for young people and men who have sex with men.

2 Specific initiatives to reduce STI amongst people with HIV.

3.4.1 Principles of health promotion

Key principles that will guide the implementation of health promotion strategies are consistent with those of the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*. These are:

- Health promotion programs for specific communities are best delivered by the communities themselves, through peer-based initiatives and in partnership with government, health professionals and researchers.
- The participation of people living with or affected by HIV/AIDS is essential to any HIV/AIDS-related health promotion program.
- Each person has the right to information and education about HIV to enable him or her to protect themselves and others from infection.
- Links between HIV/AIDS-related health promotion activities and health promotion activities associated with other population health strategies and programs should be identified and

11 Department of Human Services, *Victorian Infectious Diseases Bulletin*, Vol.5, Issue 2, June 2002.

12 Cohen & Eron, Joseph J, 'Sexual HIV Transmission and Its Prevention', *Continuing Medical Education Spotlight*, Medscape Portals Inc., 2001. Accessed 15 February 2002, at: http://www.medscape.com/viewarticle/416415.

strengthened, to improve combined efficiency and effectiveness.

- Health promotion initiatives should be based on sound social, behavioural and epidemiological research, which should be conducted with due regard to cultural context.
- Health promotion initiatives must take into account cultural and linguistic backgrounds, gender, age, sexual orientation, mental health, literacy standards, disability and geographical location, to improve access to such initiatives.
- People in custodial settings should receive prevention and health education services that are appropriate to the setting but equivalent to those applying to the broader population.
- The control of STIs, particularly those that are markers for and act as cofactors to increase risk of HIV infection, is an area for further activity. Where appropriate, health promotion activities should incorporate messages about STIs and encourage treatment.
- The social and economic status of women can be barriers to women protecting themselves from infection. Reproductive rights of HIV infected women and risk of transmission of HIV to the child need to be taken into account within strategies targeting women.
- Materials designed to prevent transmission of HIV and STI must be presented in such a way as to have maximum effect on the risk-related behaviours of specific groups. It is acknowledged that the use of explicit images and language may be warranted when appropriately and carefully targeted.
- Promoting HIV/AIDS awareness, including through school-based education initiatives, must continue in the general community to ensure that gaps in the reach of education, prevention and health promotion initiatives are minimised.

3.4.2 Future direction

There are ongoing challenges to maintaining the engagement of people at risk of HIV in prevention efforts and in sustaining safe behavioural responses. Perceptions in the community that the rate of HIV infection has been significantly reduced and that HIV treatments are having a positive impact on life expectancy need to be balanced with information and programs that reinforce safe sex and safe using messages and that allow people to make informed choices to reduce their risk.

Specific HIV/AIDS health promotion programs in Victoria will focus on promoting safe behaviour and will identify individuals, groups and communities who remain at particular risk of HIV infection. The approach will be to identify vulnerability and to use Ottawa Charter health promotion principles to devise a broad range of strategies to address this vulnerability. These principles include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services[13].

Vulnerable populations not accessing information and education initiatives are a key concern. A greater understanding is needed of these groups and the contexts in which they live and work that may give rise to their vulnerability to HIV infection.

The particular risk behaviours that continue to make people vulnerable to HIV infection in Victoria include:

- Unprotected anal sex between men.
- Unprotected heterosexual sex while visiting high HIV prevalence countries, or unprotected heterosexual sex with people from high HIV prevalence countries.
- Unprotected heterosexual sex in non-monogamous relationships, particularly if the male partner is also having unprotected anal sex with other men.
- Unprotected heterosexual sex between sex workers and their clients.
- Needle sharing when injecting drugs.

Efforts to reduce risk behaviours will be complemented by implementation of, and education about, non-occupational post-exposure prophylaxis policy. This is particularly important for people in HIV serodiscordant relationships and for the victims of sexual assault.

13 Ottawa Charter for health promotion, http://www.who.dk/policy/ottawa.htm

This strategy focuses on reducing levels of these risk behaviours. This will be achieved by identifying and targeting individuals, groups and communities at particular risk and by identifying particular risk settings and working to increase safety in these settings. Surveillance data and research and evaluation findings will be used to ensure that programs are evidence-based and responsive to changes in patterns of risk behaviour. As well as identifying who is becoming HIV infected and why and targeting programs to reduce the risk of HIV infection in these contexts, health promotion programs will continue to reinforce and support communities and individuals who have adopted safe behaviours to sustain these behaviours.

3.4.3 Priority target populations

One of the most effective methods of reaching people at risk of HIV infection has been the targeting of communities and groups at particular risk. This will continue, with particular focus on vulnerable sub-populations within these groups. Future directions are set out below under each of the identified priority areas.

Comprehensive surveillance data and social research findings will be used to develop a set of health promotion priorities that focus on those most vulnerable to HIV infection in Victoria. A broad approach will be developed to identify innovative ways to get health promotion programs and messages to those people at risk who have not been previously targeted. This will involve the development of new partnerships between HIV/AIDS organisations and services and other health promotion and community health agencies.

3.4.3.1 Gay and other homosexually active men

In 1998, a national review of HIV/AIDS health promotion strategies targeting gay and other homosexually active men found that:

- Australia had been successful in containing the spread of the epidemic over the last decade.
- There had been a high volume of educational activity addressing target groups within the gay men's community and using a range of educational methods.
- There are high levels of literacy about HIV/AIDS and safer sexual practice among gay men and high levels of safer sexual practice.
- Effective partnerships and structures have been developed at national, state and territory and community levels to design and deliver effective HIV/AIDS education[14].

The report stressed that the changing epidemic continued to present new challenges for gay men's education, especially in reinvigorating safe behavioural responses among gay men and providing support to people living with HIV/AIDS around adherence to HIV treatments.

The majority of health promotion activities targeting these groups in Victoria are conducted through the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC). This organisation has been pivotal in conducting health promotion programs for gay men in the state since 1985.

In Victoria, the recent increases in HIV infections and other STIs in 2000 and 2001 has resulted in the identification of a number of new government initiatives (the HIV Action Plan) that focus on education and prevention, research and surveillance and sexual health testing. Under the HIV Action Plan, the VAC/GMHC was resourced to:

- Strengthen its current gay men's health promotion programs.
- Work with high risk settings, such as sex-on-premises venues, to increase the safety of these environments.
- Establish new partnerships with other health promotion organisations, as a way of developing initiatives to reach gay and other homosexually active men at risk.
- Strengthen its work with particular sub-groups at risk, such as men who have sex with men from particular communities that have not yet had access to health promotion programs, men in HIV serodiscordant relationships and young gay men.

In order to strengthen and refine its work in this area, VAC/GMHC will work in collaboration with MACAHRD to develop a comprehensive health promotion plan. Elements of this plan will include:

- A collaborative study with the Australian Research Centre in Sex, Health and Society (ARCSHS) to establish international best practice in gay men's health promotion and to identify more clearly the context of risk for gay men and other men who have sex with men in Victoria.

14 Commonwealth of Australia, *Building on success 3: Towards a National Strategy for HIV/AIDS Health Promotion for Gay and Other Homosexually Active Men*. Commonwealth Department of Health and Family Services 1998.

- Development and maintenance of an ongoing relationship between VAC/GMHC and ARCSHS and between VAC/GMHC and other research groups, to ensure that program design is based on evidence of effectiveness and that health promotion practitioners are able to participate in setting the research agenda (including the development of research strategies that examine psycho/social issues that have negative health impacts, such as isolation, gay identity and homophobia).
- Development of mechanisms to identify particular sub-populations at risk (such as men in HIV serodiscordant relationships and young gay men) and of initiatives to reduce HIV transmission amongst these sub-populations.
- Identification of opportunities to take a broad sexual health approach to HIV/AIDS health promotion, focusing on the reduction of STI rates as a way of reducing vulnerability to HIV infection.
- Development of specific programs to improve the sexual health of people with HIV/AIDS.
- Development of specific programs to improve the sexual health of gay men, youth and men who have sex with men, but are not attached to the gay community.
- Development of strategies to address specific behaviours related to risk settings (for example, drug and alcohol dependence or use).
- Development of a set of strategic partnerships with other health promotion agencies and community groups.
- Development of effective monitoring and evaluation mechanisms for health promotion programs.

Other agencies, such as those in contact with men who have sex with men but who do not identify as gay, young men and men with mental health conditions, will also be encouraged to incorporate HIV health promotion initiatives into their work. This is particularly so with schools and youth organisations that are uniquely placed to provide information and support to young men who are not identifying as gay, but who may be exploring their sexuality in ways which expose them to infection with HIV. Identifying as a gay man cannot be regarded as a necessary precursor to accessing HIV prevention messages relating to sexual activity between men.

Key health promotion strategies for gay and other homosexually active men

- Identify high risk settings, such as sex-on-premises venues and beats, and work to reduce risk in these environments.
- Establish relationships to strengthen the link between research and practice.
- Identify and work with sub-populations at particular risk.
- Identify and implement strategies to reduce STIs amongst gay men and other men who have sex with men.
- Develop a comprehensive gay men's health promotion plan.
- Strengthen the capacity of educators and program managers to design, implement and evaluate HIV health promotion programs.

3.4.3.2 People living with HIV

Education and support for people with HIV is a key health promotion activity. While community organisations have successfully provided a comprehensive range of information, counselling and support services for people with HIV, there are still sub-populations of people with HIV who are marginalised and who may not be receiving adequate support. This is particularly true for people from culturally and linguistically diverse backgrounds, sub-populations of injecting drug users, people with pre-existing mental health disorders, and people with intellectual disabilities. Programs and services will be encouraged to design and implement broad health promotion programs and services to provide appropriate levels of service to these sub-populations.

These programs need to take account of the social determinants of health and to focus on issues of housing, income support, employment, emotional and spiritual wellbeing, social isolation and poverty, as these all contribute to overall health. Health promotion for people with HIV should be incorporated into the work of community organisations and health services. Agencies need to work together to ensure that particular sub-groups of people with HIV do not remain isolated from these programs and services.

New developments in treatments and HIV viral load testing technologies have the potential to lead people with HIV to believe that it is less likely that they will transmit HIV during unprotected sex if HIV levels in their serum are low. Health promotion programs need to understand and address the implications of these issues for HIV transmission. People in serodiscordant

relationships have become an important focus for education programs and these will continue to be supported.

This strategy acknowledges the importance of positive education programs. Areas to be addressed may include:

- Health maintenance–nutrition, drug and alcohol management, mental health, relationships, life skills.
- Treatment issues–information and support for people to make treatment decisions, to maintain treatment regimes and to manage toxicity and side effects.
- Social support–housing, income, employment, legal issues, reduction of social isolation.
- Information and educational needs of positive women–sexual health, reproductive rights, social issues.

The development of appropriate strategies will require close collaboration between community groups, educators and health care service providers. Particular emphasis will be placed on ensuring that people living with HIV/AIDS have an active role in determining and providing information and education initiatives that address their needs. Mechanisms to ensure that these groups meet regularly and are actively involved in planning, implementation and evaluation of programs should be established.

Key health promotion strategies for people living with HIV

- Identify strategies to improve health maintenance and mental health amongst people with HIV/AIDS.
- Provide information to assist people with HIV to make treatment decisions and to follow treatment regimes.
- Explore opportunities to further develop social support programs, with a focus on isolated and marginalised people with HIV/AIDS.
- Ensure that there is a focus in programs on the information, education and support needs of women with HIV.
- Identify mechanisms for the greater involvement of people with HIV/AIDS in the design, implementation and evaluation of programs and services.

3.4.3.3 People who inject drugs

People who inject drugs remain a priority target group because of the risk of HIV transmission through sharing of injecting equipment. Health promotion initiatives have focused on harm minimisation strategies that have proved highly effective in reducing the transmission of HIV. The involvement of user groups in the design and delivery of programs has also been an effective strategy to access people using drugs who are marginalised from mainstream services. This strategy supports initiatives that will strengthen the capacity of user groups and the development of peer education activities.

A key harm minimisation initiative has been the provision of sterile injecting equipment and health promotion information to injecting drug users through NSPs. These programs have been effective in reducing practices of needle sharing and promoting the safe disposal of injecting equipment. The significance of NSPs lies beyond their capacity to provide sterile injecting equipment. As NSPs have the most frequent and ongoing relationships with users, this provides opportunities for providing health promotion messages and links to other services. NSPs provide non-judgemental and friendly environments for people who inject drugs and, as such, they are a valuable means of targeting networks of users who are otherwise hard to reach.

While injecting drug users are a priority group under the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*, the development of new initiatives targeted to people who inject drugs will need to be consistent with those outlined in the *Victorian Hepatitis C Strategy 2002–2004*, *National Hepatitis C Strategy 1999–2000 to 2003–2004* and the *National Drug Strategic Framework 1998–99 to 2002–2003*.

These strategies are consistent in their endorsement of harm minimisation approaches to reduce the spread of blood-borne viruses in the community.

The NSP will continue to be the cornerstone of efforts to reduce HIV and hepatitis C transmission in the injecting drug user community and funding of peer-based education and prevention programs will remain a priority. UNAIDS has set targets for safe injection and these targets will be examined for their applicability in the Victorian setting. These targets rely on the availability of an estimate of the number of injecting drug users in the community and efforts should be made to work with social researchers, injecting drug user groups and others to determine the extent and patterns of injecting drug use across Victoria and to set targets for safe use.

The availability of high quality drug treatment services is also a key element of the response to HIV and hepatitis C. The desirability of setting targets for the proportion of injecting drug users in treatment will also be examined.

Programs to promote the health of injecting drug users with HIV and those with HIV and hepatitis C co-infection should continue to be supported and opportunities to strengthen these should be explored.

Programs delivered by peer-based organisations should continue to be supported and the Department of Human Services should work with VIVAIDS and the Hepatitis C Council of Victoria to determine an appropriate range of peer-based and community development programs.

Key challenges in this area to be addressed during the term of this strategy are:

- Maintaining commitment to the principle and practice of harm minimisation.
- Improving the sexual health of injecting drug users.
- Identifying ethnic communities with sub-groups at particular risk and working with those communities on a range of strategies to promote safe use.
- Enhancing access to programs that promote safety in the face of changing patterns in practices associated with injecting drug use.
- Adapting to changing patterns of injecting drug use by identifying and working with new groups and individuals at risk.
- Extending community development among user groups, through strengthening peer-based health promotion initiatives and increasing the capacity of these groups to contribute to the partnership.
- Incorporating health promotion initiatives into drug treatment options for people who inject drugs.
- Working with school-based and other education programs for young people to promote harm minimisation strategies.
- Developing and maintaining an awareness of health among injecting drug users.

Key health promotion strategies for people who inject drugs

- Increase the availability of sterile injecting equipment to injecting drug users.
- Work with social researchers and peer-based groups and others in order to determine the extent and patterns of injecting drug use and risk.
- Strengthen the capacity of user groups and the development of peer education activities.
- Strengthen programs to promote the health of injecting drug users with HIV and those with HIV/hepatitis C co-infection.

3.4.3.4 Sex workers and their clients

The prevalence of HIV remains low in this population group. However, they are a priority for health promotion initiatives because of the level of risk associated with their work. Although knowledge and safe behavioural practices are generally high among sex workers working in legal premises, there are many sub-groups of sex workers that are at particular risk. These sub-groups include students using sex work to supplement their income, sex workers brought into Australia illegally who work in settings that do not allow them to negotiate safe sex, street workers and others working in settings such as truck stops on major highways and sex workers in country areas who often set up informal businesses that are not easily reached by health promotion programs. Male sex workers are at particular risk of HIV infection and will remain a key target for health promotion activities.

Health promotion for sex workers in Victoria is primarily delivered by Resourcing Health and Education in the Sex Industry (RhED), a combined peer and professional health promotion organisation. Other agencies, such as the Melbourne Sexual Health Centre, community health centres and non-government organisations, also have a role to play in health promotion for sex workers and their clients. Sex workers are in a position to provide important sexual health information to their clients, assisting them in diagnosing STI and learning about safe behaviour. This role will be supported by the development of programs and resources to assist sex workers.

There have been steps taken in Victoria to reform laws relating to the sex work industry to improve the environment for sex workers. However, there are still areas that warrant attention. These include strategies to access people who work alone, street workers, newly arrived migrants and male sex workers. The involvement of sex worker groups is important in ensuring the success of these programs. The national sex worker organisation, Scarlet Alliance, has developed a set of occupational health and safety guidelines for sex workers. Under this strategy these guidelines will be considered for use in Victoria.

An Attorney General's Street Prostitution Advisory Group has been convened to examine the issue of street prostitution in the City of Port Phillip. Their final report is pending.

Key challenges in this area are:

- Enhancing and implementing prevention and health promotion programs that suit the various contexts in which sex work takes place.
- Expanding the capacity of sex worker organisations to design, manage and participate in peer-based health promotion activities and to participate in the broader partnership response.
- Enhancing programs that deliver health promotion messages to the clients of sex workers.

Strengthening the capacity of sex worker organisations to design and implement programs will remain the focus of health promotion initiatives in this area. Accessing isolated and difficult-to-reach sex workers should be a priority area for education and prevention activities.

Key health promotion strategies for sex workers

- Continue efforts to review and appropriately reform laws relating to sex work.
- Strengthen the capacity of sex worker organisations to design and implement programs and to develop peer education activities.
- Enhance programs to deliver health promotion messages to clients of sex workers.

3.4.3.5 Aboriginal and Torres Strait Islander people

The potential risk of HIV infection among Aboriginal and Torres Strait Islander people remains high for a number of reasons–the high rate of STIs among this population, high rates of incarceration, injecting drug use, poor housing, unemployment and other socioeconomic issues. Aboriginal women in some areas also have higher rates of HIV infection than non-Aboriginal women.

Key challenges identified in the *National HIV/AIDS Strategy 1999–2000 to 2003–2004* are:

- Improving sexual health of Aboriginal and Torres Strait Islander people.
- Augmenting the capacity of Aboriginal and Torres Strait Islander communities and community-controlled organisations to control, develop and monitor prevention and health promotion programs.
- Extend the capacity for screening and control of STI, to prevent HIV transmission among Aboriginal and Torres Strait Islander people.
- Develop partnerships between Aboriginal community-controlled health services and HIV/AIDS service providers and community organisations to improve prevention and health promotion efforts for Aboriginal and Torres Strait Islander people.

The *National Indigenous Australian's Sexual Health Strategy 1996–1997 to 1998–1999* (NIASHS) provides long term strategic direction for the development of programs to address the sexual health needs of this population, through a primary health care framework and in the context of partnerships between government and community-controlled organisations.

In Victoria, a partnership between government and Aboriginal community-controlled organisations, health services and community representatives provides direction and monitoring of initiatives funded via the NIASHS. Commonwealth funds have been allocated towards sexual health services, Aboriginal sexual health worker positions, primary health care screening programs, educational and resource materials and training programs. These initiatives have increased the profile of sexual health issues among health workers and indigenous communities[15].

This strategy recognises the important role of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) as the peak body in indigenous health in Victoria. The successful management of HIV and related issues can only be achieved by involving the community in the development, planning and implementation of policy and practices around prevention, treatment, care and support.

Indigenous sub-populations of injecting drug users, prisoners and HIV-positive people were identified in Victoria in the mid-term review of NIASHS as warranting particular attention. Health promotion initiatives in these areas need to take greater account of the needs of indigenous people and should facilitate greater access to prevention, treatment and care programs. Involvement of

15 Urbis Keys Young, *Mid-term Review of the National Indigenous Australian's Sexual Health Strategy*, Department of Health and Ageing, Office for Aboriginal and Torres Strait Islander Health, September 2000.

indigenous communities in research undertaken in these communities will also increase the relevance of interventions developed and strengthen the skills of these communities. Developing these initiatives within the framework supported by the partnership arrangement is essential.

The possibility of building on existing HIV/AIDS prevention and health promotion initiatives should also be explored during the lifetime of this strategy. For example, the Well Person's Health Check is a Commonwealth-supported program that is directed at Aboriginal and Torres Straight Islander people. These health checks include testing for STIs, including HIV screening, and provide opportunities for prevention education and health promotion to those who are at risk of, or who have, HIV/AIDS.

Key health promotion strategies for Aboriginal and Torres Strait Islander people

- Develop strategies to ensure greater access to prevention, treatment and care programs for indigenous sub-populations of injecting drug users, prisoners and people with HIV/AIDS.
- Incorporate HIV/AIDS in general programs to improve the sexual health of indigenous people.
- Increase the involvement of indigenous people in planning, design, implementation and evaluation of prevention, treatment and care programs.

3.4.3.6 People originating from countries with high prevalence of HIV and people who travel regularly to these countries

Victoria has several communities of people that have immigrated from countries that have significant HIV/AIDS epidemics. There is also considerable movement of people between Victoria and high HIV prevalence countries, to conduct business, to visit extended family or as tourists.

Health promotion programs and activities that target these communities will be implemented during the term of this strategy. This will involve working in partnership with these communities to design appropriate interventions.

New strategies to target Victorian tourists who are visiting high prevalence countries will also be considered.

Key health promotion strategies for people originating from countries with high prevalence of HIV

- Develop health promotion programs to target people originating from countries with high prevalence of HIV and people who travel regularly to these countries.
- Examine strategies to target Victorian tourists travelling to high prevalence countries.

3.4.3.7 People moving through custodial settings

People in custodial settings, both public and private, have the right to an equivalent level of prevention, education and health promotion initiatives that are available to the broader community. During the term of this strategy, efforts to address inequities will be of high priority.

The implementation of harm minimisation strategies in prisons is recognised as a public health approach to reducing transmission of HIV and hepatitis C among these populations. In Victoria, condoms are available in residential visiting facilities for prisoners and families, although their availability in prisons is presently being considered. Bleach, made available in prisons for sanitation, is also used by prisoners for cleaning needles. Access to injecting equipment for prisoners to reduce sharing behaviour has not been supported to date.

While harm reduction initiatives have recently been implemented in prisons in accordance with the *Victorian Prison Drug Strategy 2002*, the Department of Human Services will continue to work with the Department of Justice to develop ways to make custodial settings safer in relation to HIV and hepatitis C transmission through the introduction, expansion or tailoring of appropriate public health strategies. This could be achieved by examining a range of measures, including:

- Reducing the number of people moving through custodial settings by broadening sentencing options.
- Reducing levels of illegal drug use in custodial settings by reducing the supply of drugs and ensuring appropriate access to the recently expanded methadone program.
- Implementing and evaluating recent expansions to education, training and work programs in custodial settings to reduce isolation and provide meaningful alternatives to drug use.
- Identifying and implementing ways of reducing sexual assault in custodial settings.

- Educating prisoners about safe tattooing and piercing and providing them with the means to avoid HIV and hepatitis C transmission.
- Further enhancing harm minimisation principles where feasible, including access to condoms, needles and syringes and bleach.
- Supporting prisoner education programs.

Development of working relationships between the Department of Justice, the Department of Human Services, key community organisations that work with prisoners and prisoner groups and health care providers will be a focus of this strategy. Inter-sectoral forums, training for prison officers and peer education programs for inmates are strategies that will be explored. While it is clear that health promotion initiatives are needed in custodial settings, the support of staff and organisations working in these settings is important to the success of these initiatives.

Juvenile justice settings require particular attention to ensure that they are safe environments for the people who move through them.

Key health promotion strategies for people moving through custodial settings

- Develop mechanisms for ongoing collaboration between the Department of Human Services and the Department of Justice to identify and implement initiatives to improve the safety of custodial settings.
- Target juvenile justice settings for particular strategies to reduce HIV and hepatitis C transmission.
- Develop partnerships between government, health services, community-based organisations and non-government organisations that work with prisoners and their families, to reduce HIV risk and impact.

3.4.3.8 Sexually active young people

Sexual health education is important for young people, as teenage pregnancy and rates of STI are still unacceptably high. Messages about HIV should be incorporated into broader programs about sexual health. The Department of Education and Training is addressing the sexual health information and awareness needs of young people in schools through initiatives such as those identified in the *Chlamydia Strategy for Victoria 2001–2004*. Other initiatives include sexuality education through school curricula and strategies such as peer-based education and youth events.

There is clear research evidence[16] however, that current programs in schools that provide sexual health information to heterosexual young people do not always meet the information needs of young people questioning their sexuality. These young people, who do not identify as gay or access information through the gay community, may be exposed to significant risk for HIV without any accompanying information to enable them to protect themselves. Schools have a responsibility to develop inclusive sexual health programs that meet the needs of all young people, and to take measures to combat homophobia in schools, which can prevent same sex attracted young people seeking appropriate information and support. Other initiatives include the Rural Same Sex Attracted Youth projects funded by VicHealth in a number of regions in Victoria. These projects focus on improving access to youth health services and developing peer-based networks among these young men and women. People Living with HIV/AIDS (PLWHA) Victoria has also been working actively in schools to raise awareness of HIV and reduce the potential for discrimination against people living with HIV/AIDS.

Under this strategy, the Department of Human Services will work with the Department of Education and Training, VicHealth, Family Planning Victoria, sexual health services, youth services and other agencies working with young people, to develop a coordinated approach to targeting young people who are vulnerable to HIV infection in school and community settings.

This strategy also recognises that not all youth can be accessed through schools. There is a need to investigate innovative methods to communicate information to this group of young people to ensure that early school leavers have access to HIV/AIDS prevention and education initiatives. For example, youth culture and youth cultural events present prime opportunities to access diverse groups of young people including early school leavers. Further, the close relationship between young people and innovation in information and communication technologies could also be explored as a

16 Hillier, L., Harrison, L., Dempsey, D., Matthews, L., Beale, L., Rosenthal, D & Walsh, J. (1998) Writing Themselves In: A National report on the Sexuality, Health and Well-Being of Same-Sex Attracted Young People Melbourne: National Centre in HIV Social Research: Program in Youth/General Population, Centre for the Study of Sexually Transmissible Diseases, La Trobe University

medium to deliver relevant and accurate information to young people online.

Key health promotion strategies for sexually active young people

- Develop an intersectoral approach to target sexually active young people in a range of settings.

3.5 Treatment, care and support

HIV-positive Victorians have had access to a comprehensive set of treatment, care and support services for many years. The continuum of care has included inpatient and outpatient services, general practice, community and home-based care and support provided by family and carers, trained volunteers and community health nurses and other health workers. There has been a focus on improving the quality of life of people with HIV/AIDS by providing a range of health, welfare, housing, transport and other support services. Community-based organisations such as PLWHA Victoria, Positive Women Victoria, the VAC/GMHC and Straight Arrows, have provided essential peer support and information.

In the absence of a comprehensive HIV/AIDS treatment, care and support plan for the state, services and groups have developed a range of ad hoc strategies to coordinate and integrate care and support. While many of these have worked well, they have relied on the commitment of individual staff members and services and have not been consistently available across Melbourne or Victoria.

Advances in the treatment and management of HIV infection have brought significant changes in the care and support needs of people with HIV/AIDS. Many people with HIV/AIDS have experienced an improvement in health, with a consequent decrease in morbidity and mortality. However, this has not necessarily led to a significant decrease in need for care and support services, as people still require support to deal with treatment side effects and the psychosocial effects of living longer with a debilitating illness and with associated issues of poverty, social isolation and mental health.

There have also been continuing shifts in service requirements and utilisation patterns. Prior to the emergence of more effective antiretroviral treatments and opportunistic infection prophylaxis, people with HIV/AIDS were regularly hospitalised for the treatment of AIDS-related illnesses and opportunistic infections. Individuals with HIV/AIDS are now hospitalised either because they have not accessed or tolerated these treatments, or because of neuropsychiatric complications or co-morbidities. New hospital funding arrangements that focus on episode funding based on AIDS illnesses have put pressure on hospitals to minimise the length of hospital stay and this has put additional pressure on community care services, families and carers.

There is increased reliance on hospital outpatient, general practitioner and community services, as the need for hospitalisation declines. This shift in patterns of treatment and care has highlighted the need for integration and coordination of services and for better communication between specialists and general practitioners and between hospital, outpatient, general practice and community services. Social workers, drug and alcohol workers, mental health providers and counsellors are playing an important role as members of multidisciplinary care teams.

VAC/GMHC, PLWHA Victoria and other community groups also play a key role in providing information to assist people to access the care that they need and to make informed choices about treatments.

Metabolic and body shape changes associated with antiretroviral treatments that can result in disfigurement have lead to the examination of treatment alternatives, including changes in therapy, plastic surgery, and treatment of hyperlipidaemia and osteopenia. Further exploration of these options should be undertaken.

Not everyone infected with HIV has the same pattern of illness. Some have chosen not to take up new treatments, while others have experienced significant toxicity and side effects and have ceased treatment. Some remain isolated and marginalised, due to factors such as pre-existing mental health conditions, drug and alcohol use, low literacy or English language skills, poverty or cultural and social isolation.

This strategy will support initiatives to ensure that all HIV-positive people in Victoria have access to a network of treatment, care and support services. These initiatives should include integrated care strategies to break down barriers to optimal health care and support for people from marginalised sub-groups.

In relation to the provision of community-based support, AIDS Councils nationally are finding it increasingly difficult to attract volunteers to undertake care and support

tasks, due to the perception that the need is less urgent. The rising number of people with complex psychological care needs has also had an impact on volunteer satisfaction levels. AIDS Councils have long held the view that their volunteer carers are performing tasks that are the responsibility of health professionals and that carers' efforts would more appropriately complement services provided by such health professionals.

In areas such as supported accommodation, there is now recognition that people with high support needs require specialised services. Mental health issues, including depression, anxiety and social dislocation, require particular attention as there are still noticeable gaps in services in these areas.

The long term efficacy of treatments remains uncertain and responses for the future will need to be flexible to meet changing needs. Many of the current arrangements for provision of care may need to be reviewed to deal with changed health circumstances of people with HIV/AIDS. For example: access to short term home care, appropriate supported accommodation services, respite and attendant carer services for people with advanced illness. This strategy supports an examination of service delivery models to identify forms of care, type of services and mechanisms for coordination. There is a need for strengthening links between HIV/AIDS and mental health services to improve health outcomes for people with HIV/AIDS who also have mental health conditions.

HIV-positive people still experience marginalisation. Poverty, stigma and discrimination, lack of support from family/friends, geographic isolation, lack of adequate accommodation and reduced capacity to access information and services are some of the factors that influence the level of marginalisation. Social and behavioural research also shows that HIV-positive people are still experiencing a poor quality of life with nagging chronic health problems, poverty and social isolation.

Access to public housing has been difficult for many people living with HIV/AIDS. HIV-positive people often require single accommodation while stock of appropriate public housing is not consistently or uniformly available. There are also consistent reports of discrimination and stigma experienced by HIV-positive people housed in large public complexes. Improved housing for people with HIV/AIDS is a focus in this strategy.

HIV-positive people who are well enough to work or to be involved in some form of social participation require resources and services to help them with this process. Programs aimed at helping with life reconstruction can assist to reduce isolation and increase confidence and skills.

3.5.1 Principles of treatment, care and support

The principles that will guide the planning and implementation of treatment, care and support services in Victoria are based on those set out in the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*. These are:

- People living with HIV/AIDS have the same right to comprehensive and appropriate health care as other members of the community, without fear of discrimination.
- Particular attention should be paid to meeting the needs of people living with HIV/AIDS who may experience difficulty gaining access to appropriate services and treatments.
- People living with HIV/AIDS should be involved in planning and implementation of treatment, care and support programs. This includes representation on relevant bodies.
- Early intervention and health maintenance and monitoring are the basis of best practice.
- The access, quality, safety and efficacy principles of the *National Medicines Policy 2000*[17] should be observed in relation to the management of HIV/AIDS medication.
- Training for health workers, both professional and volunteer, will continue to promote non-discriminatory behaviour and treatment, as well as adherence to infection control procedures.
- Community-based volunteer services will be encouraged and supported.
- HIV-positive people in correctional facilities have the same right to treatment and care services that are available to other people living with HIV/AIDS.

3.5.2 Future direction

Develop and implement models and systems to improve integration, coordination and management of care.

Case management approaches will be investigated to identify the best ways

17 Commonwealth Department of Health and Aged Care, *National Medicines Policy 2000*, Commonwealth of Australia, Canberra, 1999.

to assess and manage the changing needs of people with HIV/AIDS. These approaches are best placed within a continuum of care that sets out the range of services needed and the mechanisms for referral and coordination.

New and innovative ways to keep specialists, general practitioners and other service providers and people with HIV/AIDS informed should be developed. This includes initiatives such as patient-held medical record summaries, e-health, Health Connect and other government online services. Ways to improve access to these services for consumers and community-based organisations and to keep people updated with the latest information through online services will also be investigated. These high technology advances should be accompanied by low technology solutions that bring about improved coordination of care for people without access to computers.

There are a number of Commonwealth initiatives, such as the Sharing Healthcare initiatives and coordinated care trials, that can provide useful information for developing new models of HIV/AIDS care. Lessons from these initiatives will be incorporated into future service planning.

Developments such as the Nurse Practitioner Program, the attachment of nursing and allied health services to general practices and Divisions of General Practice and the development of Primary Care Partnerships, will also examined to determine their relevance to HIV/AIDS service planning.

A Model of Care project, designed to improve care coordination and case management of people with HIV/AIDS through key general practitioner services, is being piloted in inner city Melbourne. The feasibility of piloting this model in a small number of general practices during this strategy will be explored. If feasible, further scaling up would be supported.

Effective management of treatments and side effects.

There are a number of initiatives that may lead to improvements in the management of treatment side effects. These include:

- Research to identify and understand the clinical and social impact of side effects related to treatments.
- Identifying and facilitating more effective treatments to manage side effects, in particular metabolic disturbances.
- Improving knowledge of interactions between prescription and illicit drugs.
- Improving self-esteem related to lipodystrophy impact on people living with HIV/AIDS.
- Clarifying the impact of structured treatments interventions on health outcomes.
- Developing adequate diagnosis-related groups (DRGs) for these conditions.

Strategies to simplify antiretroviral therapy, improve adherence to treatments, and processes for monitoring of resistance and therapeutic drug levels are necessary to maintain and strengthen treatment service delivery.

Increased understanding of the realities of living with HIV/AIDS and of the changing support needs of people with HIV/AIDS.

The development of initiatives to provide information, education and awareness raising among people with HIV/AIDS, service providers and community organisations may improve responses towards those for whom treatments are less effective and will facilitate increased support for these people.

Promoting the value and clarifying the role of volunteers and carers in the provision of care and support services.

A review of current needs, tasks and roles of volunteers and other carers should be undertaken to ensure that volunteers and carers are able to play a safe and effective role in complementing the work of professional health services. Flexible and responsive service models will be developed to better match the changing needs of people with HIV/AIDS. Volunteer-based services will continue to ensure that there is appropriate training and support provided to sustain their programs and maintain the level of skills and knowledge of volunteers.

Support for carers in rural areas should receive attention, with the development of information resources to assist carers to identify and access local support services.

Developing a response to housing and supported accommodation needs.

An exploration of the housing and supported accommodation needs of people with HIV/AIDS will be carried out early in the life of this strategy. It will identify gaps in availability of housing and services and propose strategies to meet these needs. It will examine issues such as the availability of appropriate public housing stock, the feasibility of a private rental support scheme, the adequacy of current rental assistance, levels of safety

in public housing, and the availability of supported accommodation and respite care, including respite care for people with mental health conditions. To deal with these issues, greater collaboration between government and community-based organisations involved in provision of housing services will be necessary.

The contribution of community-based housing and supported accommodation programs, along with other flexible models of care, will be examined in order to develop an appropriate mix of community and home-based care services.

Improved access to treatment, care and support services for all people with HIV/AIDS.

Sub-groups of people with HIV/AIDS continue to experience difficulties in accessing treatment care and support services. Agencies are encouraged to identify vulnerable groups of people with HIV/AIDS and to design a range of strategies and services to better meet their needs. These strategies include:

- Training general practitioners and other health workers within communities with emerging populations of people with HIV/AIDS.
- Making existing services more flexible and available to people from marginalised sub-groups.
- Developing collaborative partnerships between HIV/AIDS services and mental health, migrant health, homeless youth, NSPs and women's health services.

The Department of Human Services has initiated a number of activities that will address some of these needs, including a review of GP education, a review of pre- and post-test counselling courses and engaging officers to work with culturally and linguistically diverse communities around HIV/AIDS issues.

Participation of people with HIV/AIDS in planning and evaluating health services.

Strengthening the linkages between community organisations and groups, such as PLWHA Victoria, Positive Women, and Straight Arrows and with community health centres, relevant ethnic community groups and government departments, will provide a forum for improved communication and information sharing. Mechanisms to improve consultation with these groups should also be strengthened to enhance their participation in decision making and information processes.

Strategies are needed to reduce social isolation, increase access to mainstream and specialist services and to improve access to information, training and skills development for people with HIV/AIDS across a range of contexts.

Identifying and developing services to address mental health and drug and alcohol needs.

People with HIV/AIDS are experiencing an increase in mental health and drug and alcohol related concerns. A greater understanding is needed of the type and extent of issues facing people with HIV/AIDS and those at risk of HIV infection. Of concern is that many of these people are unable to access current mental health services. Strengthening service provision in this area may be necessary through training and support of existing mental health and community health teams as well as community volunteer services. Strategies for consideration include facilitating the training of mental health counsellors and reorienting mental health services to respond more appropriately to the needs of people at risk of HIV infection and to people living with HIV/AIDS.

Areas for special support include the development of services for HIV-related dementia. Existing models for this type of care in other states should be explored for their applicability and feasibility for introduction in Victoria. An evaluation of the recommendations of the current Mental Health in HIV Project may be considered for integration into service delivery, particularly by addressing the regionalisation of all current psychiatric care.

Developing responses to reduce poverty, social isolation and improving work and income opportunities.

For many people with HIV/AIDS, an inability to sustain adequate income support has resulted in relatively high levels of poverty. This is particularly the case for women living with HIV/AIDS[18]. Ways to reduce the costs associated with chronic illness, particularly of treatments and transport, will continue to be developed through ongoing negotiation between advocacy groups and relevant government departments at state and Commonwealth levels.

Of particular concern to many people with HIV/AIDS are Commonwealth Government changes to welfare programs

18 Jeffrey Grierson, et al, *HIV Futures II: The Health and Well-Being of People with HIV/AIDS in Australia*, Australian Research Centre in Sex, Health & Society, Melbourne, 2000.

that have the potential to further reduce their earning capacity and entitlements while on benefits.

Programs to help with returning to work, retraining and other life reconstruction issues may be appropriate areas for investigation following consideration of similar programs for people with HIV/AIDS in other states.

Evidence-based treatment and research on complementary therapies will be investigated.

Complementary therapies have been shown to be widely used by people living with HIV/AIDS to manage treatment side effects and improve health and wellbeing. There is an urgent need to establish evidence of the efficacy of many of these treatments and the feasibility of doing this will be explored during the strategy.

Strengthening mechanisms for research and data collection on service planning.

As treatment options continue to advance, services and programs need to remain adaptable and flexible. More effective monitoring of data on morbidity and service use will assist with better projections on client load and allocation of resources. Evidence derived from clinical, basic science and models of care research should be used to inform treatment and care planning. Developing effective networks across services will also enable better planning and monitoring of services and client needs. The involvement of people with HIV/AIDS in service review and development remains central to ensuring the effectiveness of programs in this area.

3.5.3 Key strategies for treatment, care and support

- Develop and implement models and systems to improve the integration, coordination and management of the care of people with HIV/AIDS.
- Develop protocols and mechanisms for the effective management of treatments and side effects.
- Increase understanding of the realities of living with HIV/AIDS and of the changing needs of people with HIV/AIDS.
- Promote the value and clarify the role of volunteers and carers in the provision of care and support.
- Develop initiatives to ensure that the housing and supported accommodation needs of people with HIV/AIDS are met.
- Improve access to treatment, care and support services for people with HIV/AIDS, with a focus on marginalised sub-groups, such as people with a mental illness, people from isolated ethnic communities and people with an intellectual disability.
- Identify and develop services to address the support needs of people with HIV/AIDS who have mental health and drug and alcohol problems.
- Develop mechanisms to reduce poverty and social isolation and to improve work prospects for people with HIV/AIDS.
- Investigate the efficacy of complementary therapies.
- Strengthen mechanisms for service monitoring and planning.

3.6 Legal and discrimination issues

The development of an appropriate legislative and public policy framework is central to the objective of creating an enabling environment as described in the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*. The development of this environment requires a 'whole of government' approach to health and an environment that enables individuals and communities to exercise control over their health.

In 1992, the Intergovernmental Committee on AIDS Legal Working Party (IGCA LWP) undertook an extensive review of Commonwealth and state legislation relevant to HIV/AIDS and made recommendations for an agenda for national law reform. These recommendations related to state laws in the areas of anti-discrimination, public health, civil liability and criminal matters relating to HIV/AIDS.

Since 1992, there has been considerable progress in Victoria in implementing the recommendations of the IGCA LWP. These achievements include:

- Expansion of anti-discrimination legislation to prohibit discrimination on grounds of homosexuality.
- Amendment to public health legislation, in particular, uniform notification requirements for HIV and AIDS, privacy provisions to protect information relating to a person's HIV status, informed consent provisions for voluntary HIV testing, a system to deal with complaints relating to unauthorised HIV testing through the Health Services Review Council, and

provisions for management of HIV-infected persons whose behaviour places others at risk of infection.

- Provisions to protect health care providers through procedures for standards of care.
- Legalisation of sex industry work in brothels and escort agencies and codes of practice for premises where sex workers are employed.
- Amendments to the *Drugs, Poisons and Controlled Substances Act 1981* to enable the operation of NSPs and repeal of legislation relating to possession of needles and syringes.
- Legal recognition of domestic relationships.

While there has been significant progress in law reform, there are still reported cases of discrimination and concern about implementation of consent and privacy provisions. The situation relating to reckless endangerment needs further clarification, particularly relating to the design of satisfactory processes other than legal options.

3.6.1 Principles of legal and discrimination

The guiding principles are based on those outlined in *National HIV/AIDS Strategy 1999–2000 to 2003–2004*. These are:

- A supportive legislative environment at all levels of government must underlie efforts to respond to HIV/AIDS.
- The legal environment should emphasise a rational, humane, non-coercive and responsive approach to the problems of the HIV/AIDS epidemic. Laws specifically created to deal with HIV/AIDS require particular justification.
- The government should promote policies designed to eliminate discrimination against, marginalisation of, and prejudice and violence against, people living with or affected by HIV/AIDS.
- People living with or affected by HIV/AIDS have the same right to accessible, high quality and confidential legal information, advice and assistance as other members of the community, without fear of discrimination.
- Reform measures should be as uniform as possible across the different Commonwealth and state/territory jurisdictions.
- The principles of access, equity, participation and equality for all people living with or affected by HIV/AIDS are integral to Australia's response to HIV/AIDS.

3.6.2 Future direction

Development of a coordinated government approach to the review of legislation and development of policy initiatives.

It is clear that a coordinated government approach is the best way to pursue reforms and ensure that appropriate public policy responses are developed to address the epidemic. Gaining a broader understanding of the public health approach to preventing the spread of HIV can enable the introduction of innovative and often controversial measures that have been required to address new challenges, especially in relation to injecting drug use and increased notification rates. The establishment of liaison positions within the Police Department, working parties to review the legislation and regular processes for communication across government departments are all strategies that have worked elsewhere to ensure good public policy responses.

Ongoing review of legislation in following areas:

Public health law

The *Health Act 1958* and the *Crimes Act 1958* contain provisions relevant to this issue.

Victorian law and Department of Human Services procedures relating to people who are HIV-positive and knowingly put others at risk is currently being considered by a working party of the Department of Human Services.

Anti-discrimination legislation

Anti-discrimination legislation should act to reduce levels of stigma and discrimination in the community. Issues such as vilification and violence associated with HIV/AIDS may need to be addressed through appropriate legislation and community awareness campaigns.

HIV/AIDS prevention, homosexuality and the law

Maintaining an effective response requires measures that can access all people engaging in risk activities. Developing an environment where people are recognised and protected in relation to their lifestyle not only builds community acceptance, but also enables more effective interventions. Age of consent laws and a program of community education to give practical effect to the recent legislative changes, which enabled the recognition of same sex relationships, are key areas that warrant further attention.

Sex workers and their clients

While there has been substantial reform in the area of laws relating to sex workers, there are a number of areas that may need to be strengthened to enable more effective prevention work with this population group. Specifically, implementing the Scarlet Alliance/Australian Federation of AIDS Organisations (AFAO) Occupational Health and Safety Guidelines[19] across the sex industry should be considered. Better conditions of service and benefits for sex workers should also be explored.

Sex workers who work on the street remain outside the law and are clearly a group that require access to education and support services. Without legal support, these sex workers are at higher risk of HIV, STI and hepatitis C infection and physical violence. The Attorney General's Street Prostitution Advisory Group is currently considering issues in relation to this group. The importation into Australia of women from developing countries as sex slaves remains an important human rights issue and requires ongoing attention.

Injecting drug use

Ongoing interventions targeting injecting drug users will require innovative and sometimes controversial strategies. Australia has been at the forefront of harm minimisation and adopting a pragmatic approach to preventing transmission of HIV. This should continue to be supported and strengthened. NSPs were supported early in the epidemic in Victoria and there have been legislative changes to facilitate their operation. Drug diversion programs have been established and provide an alternative for injecting drug users found guilty of minor drug offences.

In recent years, there has been a cultural shift toward street-based drug markets in Victoria that has contributed to an increase in unsafe injecting practices. Police enforcement of section 75 of the *Drugs, Poisons and Controlled Substances Act 1981*, makes it an offence to use a drug of dependence. Further, possession of needles and syringes has been used as evidence of drug use.

Reports indicate that one reason why street users inject unsafely is fear of arrest under section 75. In addition, it has been shown that street-based drug users are likely to dispose of needles and syringes as quickly as possible after injecting and, in some cases unsafely, because if intercepted by police while carrying a needle or syringe, they could be searched, questioned and possibly charged with use of a drug of dependence. Further, there is concern about the level of unsafe disposal of needles and syringes in the community because of the potential risk of needlestick injuries.

There have been calls for review or repeal of section 75 from advocacy groups and support for this from the Drug Policy Expert Committee[20] on public health grounds in order to facilitate safer injecting practices and appropriate disposal of injecting equipment. However, the Victorian Government did not support that Committee's recommendation, responding: 'A number of police and court programs are underway as part of the COAG Drug Diversion Program and until these have been evaluated this matter will not be further considered'[21]. To inform future decisions in relation to this issue, this strategy supports the timely evaluation of these diversion programs to ensure an appropriate assessment of the merits of reviewing section 75.

Therapeutic goods

The availability of therapeutic goods, such as condoms, needles and syringes and injecting equipment in prisons, youth detention facilities and other institutions (such as for people with intellectual or psychiatric impairments), was a key recommendation of the Intergovernmental Committee on AIDS (IGCA) Legal Working Party. In Victoria, residential programs in some prisons provide condoms. Also, bleach provided for sanitation is used by prisoners for cleaning injecting equipment. The implementation of a range of appropriate prevention measures in correctional and other institutions may require further investigation and assessment.

3.6.3 Key strategies for legal and discrimination

- Ongoing review of legislation that impacts on HIV/AIDS prevention and care.
- Increase efforts to develop a coordinated government approach to legislative reform.

19 *A guide to best practice: occupational health and safety in the Australian sex industry*, Scarlet Alliance and the Australian Federation of AIDS Organisations, 2000.

20 Victoria: Drugs Policy Expert Committee, *Drugs: Meeting the Challenge*, Stage 2 Report, November 2000, p.15.

21 Victorian Government, Victorian Government Response to the Second Stage Report of the Drug Policy Expert Committee, State Government Victoria, 2000.

3.7 Workforce development

The development of a highly skilled workforce is an important component in ensuring that the outcomes of this strategy can be delivered. There is a diverse range of people and organisations working in HIV/AIDS. Some work exclusively on HIV/AIDS issues; others incorporate HIV/AIDS into broader duties. While people working in HIV/AIDS-specific organisations can easily be seen as working in the HIV/AIDS sector and can be targeted for sector development, there is a much larger workforce in health and in other areas that also requires development.

In broad terms, the HIV/AIDS sector can be defined as incorporating people and organisations working exclusively in HIV/AIDS, as well as people and organisations that take HIV/AIDS issues into consideration as part of their work. It is the strengthening of this broad HIV/AIDS sector that will lead to a more comprehensive HIV/AIDS response.

There has been an ongoing investment in training among the HIV/AIDS sector in Victoria and through national training initiatives. Within Victoria, training has occurred through general practice courses provided by the Royal Australian College of General Practitioners, continuing medical education programs, seminars and courses in community-based organisations, hospitals and other health centres. There have also been national initiatives such as courses through the Australasian Society for HIV Medicine (ASHM) and the training of gay educators through AFAO. Additionally, there have been other opportunities for learning through participation in a range of national workshops and conferences, many of which have been held in Victoria.

An important national research initiative has been the Community Education Workforce and Training (CEWT) study based at ARCSHS at La Trobe University. This study is investigating the HIV/Hepatitis C community-based health education sector in Australia with a view to informing policy, training and capacity strengthening initiatives. CEWT provides national baseline data on training needs of community educators and is identifying some of the ways that this can be provided.

Levels of skills and knowledge about HIV/AIDS vary among health service providers. While there has been considerable training provided for medical practitioners, there is still only a small number who have the capacity to effectively manage new treatments and HIV clinical issues.

Most of these practitioners are concentrated in metropolitan areas and access to high quality medical care for people with HIV/AIDS living in outer metropolitan and regional areas can be difficult.

Workforce training for educators and care and support workers, including volunteers, has not been provided in a consistent or planned way. People working in this area are often left to develop their own skills, without clear guidance or support. Most training is reliant on individual initiative and there is little recognition of skills necessary for working in this area or for developing strategies to keep training up-to-date.

3.7.1 Principles and objectives of workforce development

The objectives of the strategy in relation to workforce development are to ensure that Victoria has an appropriately trained HIV/AIDS-specific and generalist workforce, including all types of health care providers, who are capable of delivering high quality services. Consistent with the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*, the key principle underlying this strategy is:

- All health care workers, pharmacists, dentists, carers, educators and law enforcement and correctional personnel should have access to appropriate HIV/AIDS workforce development programs.

3.7.2 Future direction

Creation of a workforce development plan

This plan will be developed early in the strategy. The plan will include an identification of needs of health care providers, identification of existing training opportunities and the development of new courses or strategies to ensure ongoing learning within this workforce. Ways to enhance existing programs, such as continuing medical education courses, prescribing courses for the Highly Specialised Drugs Program (S100), educator training and volunteer training programs, will be identified. A focus on regular seminars and short courses will be considered as a way to keep the workforce updated and responsive to changes in the epidemic. These activities need to be accessible to service providers across Victoria.

Learning strategies and reflexive practice within organisations and across health services are also important means to promote exchange of ideas and new initiatives.

This plan will identify training and learning opportunities for:

- People working in HIV/AIDS services.
- Health care providers working in mainstream services.

The plan will also:

- Identify ways that community-based organisations and health services can create opportunities for career development and strategies to reduce burnout among staff.
- Identify training resources/institutions in Victoria that could provide training opportunities from existing programs.
- Link closely with training initiatives being undertaken through national programs and with Victoria's Hepatitis C Strategy.
- Focus on improving skills and knowledge in specific priority areas.

Other issues of workforce development to be considered are:

- Training for mental health care workers to improve their understanding of the needs of people with HIV/AIDS and those at risk of HIV infection.
- Training for counsellors and youth workers working with out-of-school, homeless young people and people with disabilities.
- Working with police and custodial officers to improve their understanding of the needs of people with HIV/AIDS and people at risk.
- Training programs for indigenous sexual health workers.
- Building the capacity of staff working with culturally and linguistically diverse communities to incorporate HIV/AIDS issues into their work.
- Building the capacity of HIV/AIDS organisations and services to better meet the needs of marginalised sub-groups, such as people from culturally and linguistically diverse communities, people with intellectual disabilities, people with mental health conditions, injecting drug users and sex workers.
- Development of skills to encourage integration and communication between hospital-based services and community services.
- Development of initiatives to engage unions, major private employers and groups like the Chamber of Commerce in HIV/AIDS training for their members and staff.
- Strengthening the governance skills of voluntary boards of management.
- Improving the quality of selection, training and support systems of organisations using volunteers in HIV health promotion, care and support.

This plan should also consider issues such as redirection of existing capacity within agencies to meet identified needs and processes for securing additional resources, if required.

3.7.3 Key strategies for workforce development

- Design and implement a workforce development plan to ensure that the workforce is better able to participate in the delivery of programs in HIV/AIDS prevention and care.
- Develop collaborative partnerships between government, employers and unions to implement the plan.

4 Coordination and management

The coordination and management of the response to HIV/AIDS in Victoria will depend on the continued cooperation of the partners and through clearly defined roles and responsibilities.

4.1 Department of Human Services

The majority of the Victorian Government's HIV/AIDS program is coordinated through the Blood-Borne Virus/Sexually Transmissible Infections Program of the Department of Human Services. The department will have primary responsibility to oversee the implementation of this strategy. Its responsibilities will include:

- Establishing, coordinating or facilitating the establishment and monitoring of state-funded HIV/AIDS activities.
- Supporting the ministerial advisory committee, currently MACAHRD.
- Coordinating or facilitating the development of public policy and legislative frameworks that are consistent with aims of the *National HIV/AIDS Strategy 1999–2000 to 2003–2004* and this strategy.
- Investigating, analysing and monitoring the epidemiology of HIV/AIDS within Victoria.
- Developing, funding or delivering appropriate services that reflect the prevalence and changing needs of populations at risk.
- Monitoring and facilitating appropriate workforce infrastructure and development for people working in the HIV/AIDS sector.
- Facilitating effective intersectoral cooperation between state and local government agencies.
- Working to ensure that resources are allocated in accordance with the guiding principles outlined in the strategy.
- Measuring, evaluating and reporting to government on the implementation of the strategy.
- Liaising and coordinating with the Commonwealth and other states and territories on HIV/AIDS issues.

4.2 Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases

The role of the Ministerial Advisory Committee is to provide expert advice to the Minister for Health on any issue that will assist in combating the spread of HIV/AIDS, hepatitis C, other blood-borne viruses and STIs. This committee will assist the Department of Human Services to monitor the implementation of the strategy.

The terms of reference of MACAHRD are:

- To provide expert advice to the Minister for Health on any aspect of HIV/AIDS, hepatitis C, other blood-borne viruses, and STI.
- To oversight the development and review of a Victorian HIV/AIDS Strategy and the Victorian Hepatitis C Strategy.
- To provide advice in the context of relevant national strategies, such as the *National HIV/AIDS Strategy 1999–2000 to 2003–2004* and the *National Hepatitis C Strategy 1999–2000 to 2003–2004.*
- To provide advice on significant areas for policy and program development in relation to prevention, health promotion, treatment and care, research and training.
- To monitor scientific developments relevant to the control and treatment of HIV/AIDS, hepatitis C and related diseases to help ensure that Victoria retains its excellent record in these areas.
- To consider and respond to specific requests for advice from the Minister.
- To liaise, as appropriate, with other relevant groups, such as the Victorian Ministerial Advisory Committee on Gay and Lesbian Health.

4.3 Local government

Local government provides a range of services at the community level that can contribute to the health and wellbeing of people living with HIV/AIDS. This level of government is in the best position to identify local needs and to assist with developing local responses. As their primary function is urban planning and development, they have an important role in assisting with location and operation of NSPs and sex work premises. Their responsibilities in this area should reflect the principles and priorities of this strategy.

Local government urban planning decisions are important in relation to urban spaces, such as parks and public toilets, where high-risk behaviours may occur, such as unsafe sexual encounters between men and unsafe injecting drug use.

Much unsafe sexual behaviour is furtive and occurs in public spaces between men who often do not identify as homosexual or bisexual and beat culture is driven in part by homophobic attitudes and behaviours such as 'gay bashing'. Much can be done with toilet design, park lighting, toilet opening times, layout and selection of plants in parks, removal of used condoms, provision of needle disposal containers, and so on, to deter attacks that occur at beats, to improve safety for beat users and to improve perceptions of safety for the wider public.

Local governments should examine, and be transparent about, the social and cultural aspects of the use of public places and should be aware of the social and health impacts of planning decisions.

4.4 Research, medical, scientific and health care professionals

Research, medical, scientific and health care professionals will play a crucial role in the development and implementation of treatment and care programs, health promotion, training, research and policy development in the implementation of this strategy. They also have a particular role in ensuring standards of practice in service provision, training and workforce development. Intersectoral cooperation and collaboration between these professions is essential for effective implementation of the strategy. The role of research institutions, colleges and medical establishments in contributing to the response in Victoria should be emphasised.

4.5 Community-based organisations/Non-government organisations

People living with HIV/AIDS and affected communities in Victoria have played a key role for many years in the HIV/AIDS response. They bring particular expertise and knowledge as well as substantial involvement in service delivery at the community level. They have responsibility in the following areas:

- Advocacy for the interests of affected communities in decision making and policy formulation.
- Developing, implementing and evaluating policies and programs.
- Participating in and devising health promotion initiatives, especially peer education and social mobilisation programs.
- Providing counselling, support and care for people living with HIV/AIDS, their partners, carers, families and friends, through networks of trained volunteers and staff.
- Delivering HIV/AIDS health promotion and primary health care services to Aboriginal and Torres Strait Islander people, including through Aboriginal community-controlled health services.

5 Monitoring and evaluation

Monitoring and evaluation should allow an assessment of the effectiveness and efficacy of the strategy. This will ensure that:

- The initiatives are appropriate for the context in which they take place.
- There are no detrimental consequences as a result of the initiatives.
- The capacity to deal with emerging issues is enhanced.

A range of mechanisms for monitoring and evaluation are needed to ensure that policy and practice are based on the best available evidence and reflect the goals, objectives and principles of the strategy. The objectives of monitoring and evaluation are consistent will those in the *National HIV/AIDS Strategy 1999–2000 to 2003–2004*. These are:

- Measure the strategy's performance at government and community levels in terms of health outputs and outcomes.
- Provide a mechanism for securing accountability of all levels of government and community.
- Provide a means of communicating to the wider community the successes of the strategy and challenges to be met.
- Ensure that the objectives and priorities of the strategy are informed by the best social and epidemiological evidence.
- Meet program managers' and policy makers' need for timely and accurate information on program performance.

Monitoring and evaluation will occur at the following levels:

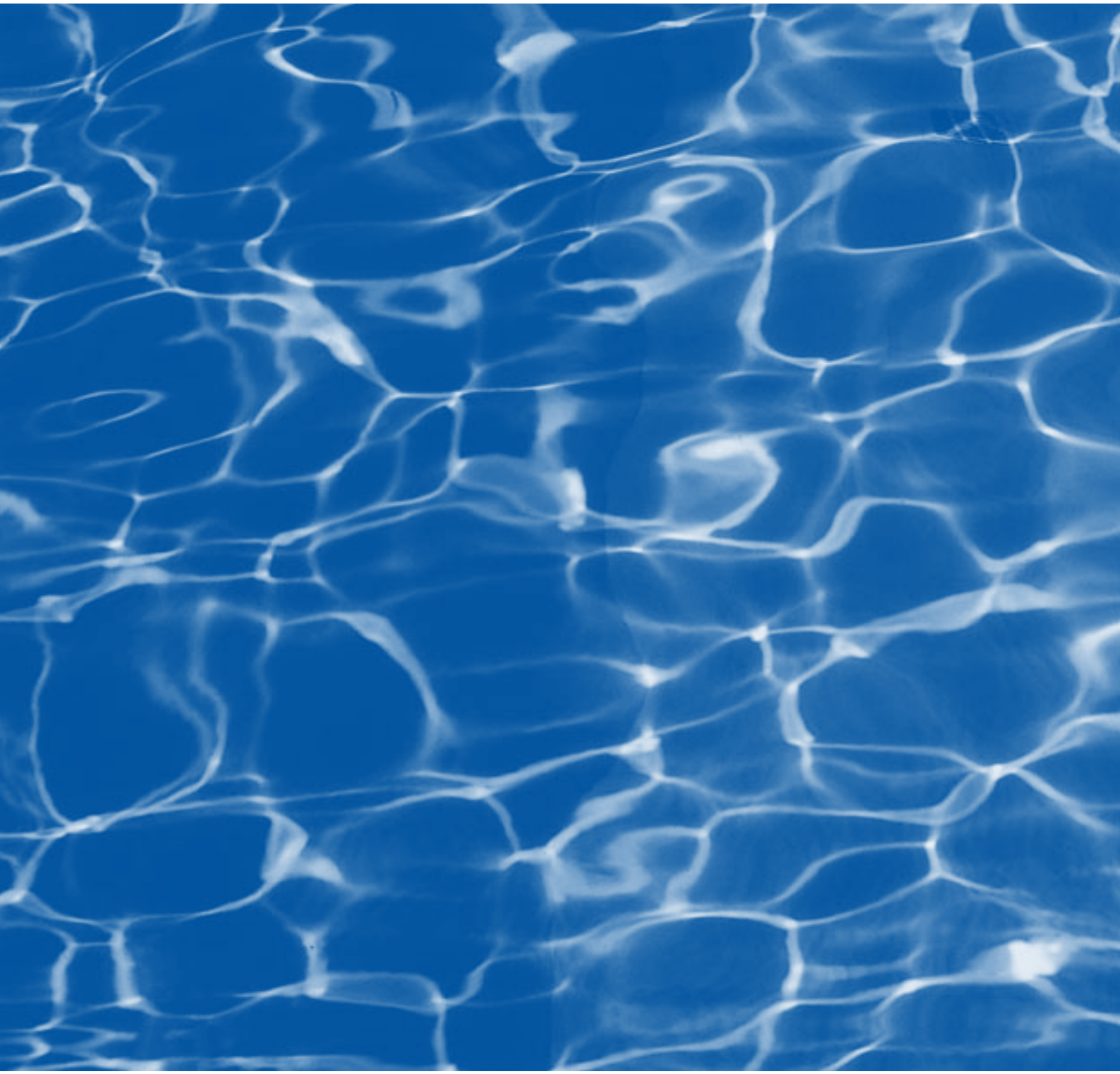
- State Government
- Community-based organisations/ non-government organisations.

Mechanisms for monitoring and evaluation include:

- An annual report from the Department of Human Services (in conjunction with MACAHRD) to the Minister for Health that will identify epidemiological trends, program expenditure, details of program implementation and program outcomes.
- Department of Human Services will develop standard performance indicators for community-based organisation/ non-government organisation program funding.
- Community-based organisations' and non-government organisations' reporting requirements will continue within guidelines and against project performance indicators, as set out in funding agreements.
- Reports commissioned to evaluate individual projects and initiatives as determined by Department of Human Services.
- Monitoring and evaluation processes will be established within community-based organisations/non-government organisations to enable more effective assessment and review of programs and to assist in regular reporting to community and funding bodies.

Acronyms

AIDS	Acquired immuno-deficiency syndrome
AFAO	Australian Federation of AIDS Organisations
ANCAHRD	Australian National Council on AIDS, Hepatitis C and Related Diseases
ARCSHS	Australian Research Centre in Sex, Health and Society
ASHM	Australasian Society for HIV Medicine
CEWT	Community Education Workforce and Training study (ARCSHS)
ELISA	Enzyme linked immuno-sorbent assay
GP	General practitioner(s)
HIV	Human immuno-deficiency virus
IGCARD	Intergovernmental Committee on AIDS and Related Diseases
IGCAHRD	Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases
MACAHRD	Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases
NAT	Nucleic acid testing
NIASHS	National Indigenous Australians' Sexual Health Strategy
NRL	National Serology Reference Laboratory
NSP	Needle and syringe program(s)
N-PEP	Non-occupational post-exposure prophylaxis
PHOFA	Public Health Outcome Funding Agreement
PLWHA	People Living with HIV/AIDS (PLWHA) Victoria
SRL	State Reference Laboratory
STI	Sexually transmissible infection(s)
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAC/GMHC	Victorian AIDS Council/Gay Men's Health Centre
VIVAIDS	Victorian Intravenous Drug Use and AIDS Group



State Government Victoria
Department of Human Services