

**Evaluation of the  
NSW HIV/AIDS Health  
Promotion Plan 2001-2003**

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# Contents

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<b>Executive Summary .....</b>	<b>i</b>	<b>4 Evaluation of the Plan –</b>	<b>18</b>
<b>Recommendations .....</b>	<b>v</b>	<b>Impact and Achievements .....</b>	<b>18</b>
<b>1 Introduction .....</b>	<b>1</b>	4.1 Key findings .....	18
1.1 Background .....	1	4.1.1 Implementation of the plan at a local level .....	18
1.2 NSW HIV/AIDS Health Promotion Plan 2001–2003 .....	1	4.1.2 Implementation of the action plan .....	19
1.3 Terms of reference .....	2	4.1.3 Achievement of objectives .....	21
1.4 Scope .....	3	4.2 Priority issues .....	22
1.5 Methodology .....	3	4.2.1 Unprotected anal intercourse among gay and other homosexually active men .....	23
1.6 Report overview .....	4	4.2.2 Post-exposure prophylaxis (PEP) .....	24
<b>2 Framework for the Evaluation .....</b>	<b>5</b>	4.2.3 Serodiscordant relationships .....	26
2.1 An outcome model for health promotion .....	5	4.2.4 Treatments and health issues (for people with HIV/AIDS) .....	29
2.2 Transmission model of HIV infection .....	6	4.2.5 Aboriginal and Torres Strait Islander Australians' sexual health .....	31
<b>3 Evaluation of the Plan –</b>	<b>7</b>	4.2.6 Illicit drug use .....	33
<b>Implementation Process .....</b>	<b>7</b>	4.2.7 HIV and sexually transmissible diseases .....	36
3.1 Development and communication of the plan .....	7	4.2.8 Vaccines .....	38
3.2 CAS Health Promotion Sub-Committee .....	8	4.2.9 Testing and late diagnosis .....	38
3.3 Forums .....	10	4.3 Infrastructure issues .....	41
3.4 HIV/AIDS Health Promotion Demonstration Projects Program .....	13	4.3.1 Quality improvement .....	41
3.4.1 Background .....	13	4.3.2 Research and evaluation .....	42
3.4.2 Summary of projects .....	14	4.3.3 Workforce development .....	44
3.4.3 Evaluation of the demonstration projects .....	14	4.3.4 Collaborative processes .....	46
3.4.4 Future considerations .....	15	4.3.5 Planning and coordination .....	48
3.4.5 Findings .....	16		

<b>5</b>	<b>Evaluation of the NSW HIV/AIDS Health Promotion program .....49</b>	<b>6</b>	<b>Additional Recommendations for the HIV/AIDS Health Promotion Program .....78</b>
5.1	Introduction.....50	6.1	Priority population groups .....78
5.2	Description of the HIV/AIDS health promotion program .....51	6.2	People from culturally and linguistically diverse backgrounds .....78
5.2.1	<i>Infrastructure to support HIV/AIDS health promotion.....52</i>	6.3	Strengthening health promotion efforts among gay men .....80
5.2.2	<i>Overview of health promotion interventions .....57</i>	6.4	Role delineation and partnership .....84
5.3	Evaluation of the program – health promotion and intermediate health outcomes .....64	<b>Appendix A: Comparisons with selected western nations .....86</b>	
5.3.1	<i>Gay and other homosexually active men .....64</i>	<b>Appendix B: HIV/AIDS Health Promotion Demonstration Projects Program .....94</b>	
5.3.2	<i>Injecting drug users .....70</i>	<b>Appendix C: Additional funding to non-government organisations .....96</b>	
5.3.3	<i>Aboriginal and Torres Strait Islander people .....71</i>	<b>Appendix D: COAG Illicit Drug Diversion Initiatives.....97</b>	
5.3.4	<i>Sex workers.....72</i>	<b>Acronyms .....99</b>	
5.3.5	<i>General population.....72</i>	<b>References.....100</b>	
5.4	Evaluation of the program – health outcomes .....73		
5.5	Evaluation of the program – financial management, funding, and cost-effectiveness.....75		

# Executive Summary

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## Background

In August 2003, the NSW Department of Health commissioned an evaluation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003* and a review of the overall NSW HIV/AIDS health promotion program.

In 2002, NSW experienced its largest annual increase in HIV diagnoses since the late 1980s. The increase in diagnoses was primarily among gay and other homosexually active men. It occurred against a backdrop of higher levels of sexual risk behaviour among gay and other homosexually active men and increased rates of sexually transmitted infections.

Profound advances in HIV treatment have been made since the mid-1990s with the advent of combination antiretroviral therapy as the standard of care and the development of new antiretroviral agents. Prior to these developments HIV was usually a fatal illness. In the period since it has become a chronic manageable illness – albeit with significant side effects and some uncertainty regarding long-term prognosis. These changes have impacted on both biological and behavioural risk factors for HIV transmission.

Unlike most comparable jurisdictions overseas, HIV in Australia has remained concentrated among gay and other homosexually active men. Whereas in Australia HIV among injecting drug users remains low, in North America and many parts of Europe it has reached epidemic proportions often subsequently resulting in higher rates of heterosexual transmission. In third world countries, and increasingly in some parts of Europe, heterosexual transmission has become the dominant or a major mode of transmission.

## Evaluation framework

A health promotion outcome model was adopted for the evaluation. This framework recognises that health program effectiveness is ultimately determined by reductions in morbidity and mortality (health outcomes). However, health promotion programs target behavioural and biological risk factors that determine health outcomes. Health outcome

evaluation assesses the impact of programs on these risk factors. A process evaluation approach is used to assess how well programs are implemented.

A transmission model of HIV has informed the evaluation team's work. The model recognises the interaction between behavioural and biological risk factors, such as infectivity and susceptibility.

Methodologies used in the evaluation included:

- review of epidemiology and social research
- review of health promotion project information
- benchmarking outcomes against interstate and overseas jurisdictions
- interviews with key stakeholders
- consultation workshops
- circulation of a discussion paper canvassing issues and inviting feedback
- written submissions.

## Program review

HIV diagnoses in NSW since the mid-1980s have fallen more than most other western industrialised jurisdictions for which comparable data is available. Most western industrial jurisdictions experienced a plateau of new diagnoses in the late 1990s and more recently an increase. At this stage the increase in NSW is not as great.

The lower increase in NSW is probably due to high levels of engagement by the population groups most affected with the public health system compared to other jurisdictions. Over 90 per cent of gay men have been tested for HIV with 68 per cent having been tested in the past year. This is most likely contributing to higher rates of identification of infection at the time of seroconversion (a period of much higher viral load and infectivity) and a greater proportion of people who are HIV-positive on antiretroviral treatment (thereby reducing viral load and infectivity). Surveys in the United Kingdom, USA and Canada show between 70 per cent and 77 per cent of gay men ever having tested. Testing rates in NSW are also higher than Victoria and Queensland.

STI testing rates are also higher among gay men in NSW than other jurisdictions.

Recent interventions targeting unprotected anal intercourse among gay men in casual sexual encounters as a risk factor, despite significant effort and some innovative programming, have been neither more nor less effective than in comparable jurisdictions. Rates of unprotected anal intercourse in this context increased significantly between 1995 and 2001 and remained steady since. The increase was similar to comparable overseas jurisdictions.

Interventions targeting sexual transmission risk in the context of gay men's relationships appear to have been effective. In the mid-1990s, the AIDS Council of NSW (ACON) promoted the concept of negotiated safety in relationships. Behavioural surveys show widespread adoption of this practice and compliance with guidelines promoted. Recent research indicates a decline from around 50 per cent of seroconversions occurring in relationships to around 25 per cent. Antiretroviral treatments may have contributed to this decline.

From 1995 to 2001, it is estimated the frequency of injecting drug use more than doubled in NSW. Over the same period distribution from the needle and syringe program increased even more while actual sharing of needles and syringes declined. Distribution of needles and syringes has been falling since 2001, although sharing has not increased significantly indicating a likely reduction in injecting drug use.

Overseas experience demonstrates highly volatile patterns of injecting drug use (eg number of people engaging in injecting drug use, frequency of injecting, types of drugs used). Where programs have been unable to respond to these changes large increases in HIV infection have generally occurred. The jurisdiction in which this has been most intensively investigated is Canada.

Injecting drug users are also in frequent contact with the public health system through the needle and syringe program. HIV testing rates are also high in this population with about 88 per cent ever having tested and 65 per cent testing in the past year.

The capacity of the needle and syringe program to respond to a large increase in injecting drug use in the later half of the 1990s probably averted an epidemic of HIV infection among injecting drug users and subsequent spread to the wider heterosexual population.

Among sex workers and Aboriginal and Torres Strait Islander populations HIV infection has remained low. However, experience in Canada where the rate of AIDS diagnoses among indigenous populations increased from about 2 per cent in the early 1990s to over 14 per cent in 2002 highlights the need to remain vigilant.

HIV transmission among heterosexuals remains low. This contrasts with Canada and the United Kingdom which have both seen a significant increase in heterosexual transmission over the past ten years. In both countries there is a significant association between heterosexual transmission and either being from a high prevalence country or having a sex partner from a high prevalence country.

The experience overseas, as well as local patterns of heterosexual transmission, indicates the need to prioritise strategies targeting culturally and linguistically diverse populations from high prevalence countries.

The NSW program has been underpinned by the principles of:

- partnership between government, community, health professionals and researchers
- non-partisanship
- central involvement of affected communities
- the creation of an enabling environment
- harm minimisation.

The complexity of HIV medicine, the sensitivity of the personal and social issues involved and the rapidly changing medical and social dimensions of the disease create the potential for HIV programs to be riven by conflict, chaos and organisational gridlock. The principles underlying the program are intended to provide a framework through which conflict can be mediated by focusing on common goals, a shared commitment to evidence-based programming and role delineation based on strategic planning. They also facilitate increased program reach and enable changes in environments and policies across sectors and organisations.

HIV has been a devastating illness at a personal and social level. However, the challenge of dealing with this disease has had wider benefits in public health. They range from contributing to a wider policy agenda around issues such as men's health and STIs to

creating new models of community engagement with the public health system.

The investment in HIV health promotion has been cost effective. Estimates of lifetime treatment costs of HIV range from \$150,000 to \$452,000. A recent study by the Australian Department of Health estimated the net treatment benefit of the needle and syringe program alone as being \$2.277 billion.

## Evaluation of the NSW HIV Health Promotion Plan 2001-2003

A major focus of the evaluation has been to assess the implementation of the *NSW HIV Health Promotion Plan 2001–2003*. Development and implementation of the plan was auspiced by the Ministerial Advisory Committee on AIDS Strategy (CAS). The plan was released in May 2001. The plan:

- identified five priority populations – gay and other homosexually active men, people with HIV/AIDS, Aboriginal and Torres Strait Islanders, injecting drug users and sex workers
- listed nine priority issues – unprotected anal intercourse among gay and other homosexually active men, post-exposure prophylaxis (PEP), serodiscordant relationships, treatment and health issues, Aboriginal and Torres Strait Islander Australians' sexual health, illicit drug use, HIV and sexually transmitted diseases, vaccines, testing and late diagnosis
- listed five infrastructure issues – quality improvement, research and evaluation, workforce development, collaborative processes, planning and coordination
- outlined an action plan to address the priority and infrastructure issues
- provided funding for demonstration projects to stimulate innovative health promotion programming and enhance infrastructure.

Overall the plan was effective in more clearly focusing the NSW Health Promotion Program on those populations and specific issues most likely to contribute to HIV transmission in NSW.

It enhanced the infrastructure necessary for effective programming. The action plan was largely implemented and demonstration projects in part

achieved their objectives. In particular, the plan was useful in:

- framing local planning
- ensuring a shared purpose
- promoting the importance of health promotion
- providing a rationale for priority groups and issues.

Actions taken to support the plan were effective. The CAS Health Promotion Sub-Committee facilitated coordination and enhanced partnership between non-government organisations, Area Health Services, social researchers and medical practitioners. A series of forums conducted to assist in the implementation of the plan were generally well attended and received positive feedback.

The demonstration projects addressed priorities and enhanced infrastructure. Generally they contributed to the quality of planning and evaluation in the sector. It is likely that about one third will contribute to innovation and new knowledge. However, there is a need to ensure dissemination of outcomes and evaluation.

## Key issues

Arising from both the evaluation of the program, and more specifically the plan, a number of key issues emerged. Some relate specifically to priority population groups – in particular gay and other homosexually active men – while others concern the program overall.

In regard to gay and other homosexually active men these issues include:

- the need for campaigns addressing unprotected anal intercourse in the context of casual sex to be more personally relevant to members of the target audience. This includes specifically targeting HIV-negative men rather than the gay community more broadly and making men more aware of their individual risk of HIV transmission
- condom use needs to be reinforced as the only reliable means to prevent HIV transmission during casual sex
- reinforcement of condom use in preventing STIs other than HIV

- more comprehensively addressing problematic drug and alcohol use and its impact on risk-taking behaviour
- periodic renegotiation of negotiated safety agreements in relationships
- specific promotion of HIV testing to men entering relationships
- ongoing promotion of HIV and STI testing
- a more sophisticated and integrated approach to the development and implementation of campaigns
- strengthening access to counselling and support services for negative partners in serodiscordant relationships.

Since the commencement of the *NSW HIV Health Promotion Plan 2001–2003* rates of unprotected anal intercourse have plateaued. However, in the context of HIV prevalence increasing (due to people with HIV living longer as a result of antiretroviral treatment) and the increasing practice of structured treatment interruptions and delayed treatment intervention for those who are newly diagnosed, thereby increasing community viral load, there will need to be a decrease in risk behaviour if infection rates are to be contained.

Strategies targeting other high priority target populations need to be maintained. Overseas experience has shown that the context of HIV transmission risk can change rapidly and that programs need to be responsive to such changes.

Strategies targeting culturally and linguistically diverse populations from countries where HIV prevalence is high should be prioritised by the health promotion program. Already in NSW people from high prevalence countries make up a significant proportion of heterosexual diagnoses.

While the infrastructure supporting the NSW HIV health promotion program is strong there are gaps. In particular, project evaluation is poor. This undermines effective quality improvement efforts and potentially creates inefficient use of resources. Recommendations are made in the report to facilitate better ongoing evaluation.

Partnership has been the key principle underlying the NSW HIV health promotion program. It has contributed to a focused approach in which the expertise of different sectors can be effectively combined. In a context of limited resources partnership at an operational level between non-government organisations and Area Health Services needs to be strengthened.

# Recommendations

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## Population groups

### **Recommendation 1:**

That the HIV/AIDS health promotion program prioritises the following population groups:

- gay and other homosexually active men.
- people with HIV/AIDS.
- Aboriginal and Torres Strait Islander people.
- people who inject drugs.
- sex workers.

### **Recommendation 2:**

That HIV prevention messages targeted at gay men:

- differentiate messages for HIV-positive men and HIV-negative men
- challenge the assumptions about HIV status that gay men make
- challenge discrimination against HIV-positive people who disclose their HIV status
- promote the personal relevance of condom use to HIV-positive gay men
- continue to promote strategies to reduce the risk of HIV transmission in relationships
- promote the need for HIV-negative gay men to reconsider personal risk-taking in the current context.

### **Recommendation 3:**

That HIV prevention messages targeted at gay men reinforce condom use as the only reliable means of HIV prevention during casual sex.

### **Recommendation 4:**

That serodiscordant relationships are identified as a priority for the HIV/AIDS health promotion program:

- the AIDS/Infectious Diseases Branch commission research to investigate factors contributing to HIV seroconversion in serodiscordant relationships

- peer support groups for people in serodiscordant relationships continue to be conducted
- need for periodic renegotiation of negotiated safety agreements should be incorporated into social marketing strategies
- consideration should be given to highlighting in social marketing interventions the extent of seroconversions in relationships where HIV status is unknown and where the relationship is new
- non-government organisations and health services that have high levels of contact with HIV-positive people should canvas issues relevant to seroconversion risk in serodiscordant relationships more extensively
- GPs and sexual health services should be assisted in making an offer of referral to counselling for negative partners at time of partners HIV diagnosis a routine event.

### **Recommendation 5:**

That ACON undertakes to develop a gay men's HIV prevention strategy, in consultation with community members and stakeholders, that outlines:

- factors contributing to HIV prevalence and incidence
- target audience
- aims and objectives
- key messages
- interventions planned
- partnerships and collaborations
- an evaluation framework.

### **Recommendation 6:**

That, as the lead agency, ACON auspice a working group including SESAHS, NSAHS, CSAHS, social researchers and other community groups including PLWHA Inc, to assist in developing and implementing social marketing campaigns targeted at gay men.

**Recommendation 7:**

That social marketing campaigns targeted at gay men are strengthened by:

- ensuring rigorous and independent focus testing
- utilising a broad range of media
- incorporating a greater range of strategies
- ensuring a greater degree of reach
- addressing new issues
- monitoring changes in knowledge and attitudes.

**Recommendation 8:**

That the NSW Department of Health discusses with the Australian Department of Health and Ageing and the National Centre in HIV Social Research the need to undertake regular behavioural surveys that focus on non-gay identified homosexually active men.

**Recommendation 9:**

That the HIV/AIDS health promotion program reviews health promotion projects targeted at people with HIV/AIDS to ensure they are addressing the needs identified by the findings of the HIV Treatment, Care and Support Needs Assessment.

**Recommendation 10:**

That the HIV/AIDS health promotion program prioritises implementation of the NSW Sexual Health Implementation Plan for Aboriginal and Torres Strait Islander people.

**Recommendation 11:**

That the NSW Department of Health discusses with the Aboriginal Health and Medical Research Council the possibility of establishing mechanisms to monitor sexual health service utilisation and sexual behaviour among Aboriginal and Torres Strait Islander populations.

**Recommendation 12:**

That the NSW Department of Health ensures data collected by sexual health services be monitored to identify, on an ongoing basis, service utilisation by sex workers.

**Recommendation 13:**

That the NSW Department of Health discusses with the National Centre in HIV Social Research and the Sex Workers Outreach Project and other key service providers the development of systems to monitor the sexual behaviour of sex workers.

**Recommendation 14:**

That the HIV/AIDS health promotion program prioritises:

- the ongoing development of strategies targeted at people from culturally and linguistically diverse backgrounds who come from countries with high prevalence epidemics
- research into more clearly defining sub-populations most at risk and factors that impinge on prevention such as visa status
- strategies that include methods to reach those who don't identify on the basis of their ethnicity
- ensuring existing health promotion projects are able to effectively respond to the culturally and linguistically diverse needs of their target populations.

**Recommendation 15:**

That the HIV/AIDS health promotion program prioritises implementation of COAG Illicit Drug Diversion Initiatives.

## Issues

**Recommendation 16:**

That the HIV/AIDS health promotion program ensures a high level of post-exposure prophylaxis awareness amongst priority population groups, awareness and appropriate skills development among health care workers, and appropriate accessibility.

**Recommendation 17:**

That the HIV/AIDS health promotion program recognises that pre-exposure prophylaxis poses a possible challenge to HIV/AIDS health promotion and identifies appropriate actions to ensure capacity to respond.

**Recommendation 18:**

That drug and alcohol use is identified as a priority for the HIV/AIDS health promotion program.

Strategies include:

- support for social research into the relationship between alcohol and other drug use and unsafe sex
- promotion of access to alcohol and other drug use services for gay and other homosexually active men
- working with alcohol and other drug use services to ensure they are sensitive to the needs of gay and other homosexually active men and lesbians
- increasing the capacity of alcohol and other drug use services to deal with psycho-stimulant use.

**Recommendation 19:**

That the HIV/AIDS health promotion program continues to promote the need for regular sexual health check-ups and sexual health literacy amongst priority populations groups, particularly awareness of the contribution of STIs to increased infectivity and susceptibility to HIV infection.

**Recommendation 20:**

That the HIV/AIDS health promotion program recognises the need to ensure ongoing monitoring of the impact of vaccine trials upon the behaviour of priority population groups and, if required, to ensure the program has the capacity to respond.

**Recommendation 21:**

That late diagnosis is identified as a priority for the HIV/AIDS health promotion program.

Strategies include:

- interventions continuing to promote HIV testing to young gay and other homosexually active men and Asian gay men specifically, and as part of more broadly targeted campaigns to gay and other homosexually active men
- investigations into patterns of HIV and AIDS diagnoses in rural Area Health Services regarding possible late HIV diagnoses
- periodic inclusion of information regarding HIV seroconversion illness occur in publications for GPs.

**Program/Infrastructure****Recommendation 22:**

That the NSW Department of Health, in consultation with stakeholders, develops a four-year HIV/AIDS health promotion plan.

**Recommendation 23:**

That CAS reconvenes the Health Promotion Sub-Committee, subject to a review of membership, for the duration of the next HIV/AIDS health promotion plan.

**Recommendation 24:**

That the NSW Department of Health:

- continues to monitor the HIV/AIDS Health Promotion Demonstration Projects Program and ensures all projects submit evaluation reports to enable acquittal of the grant
- convenes a forum to enable dissemination of project outcomes
- convenes a small working group to review evaluation reports and consider strategies to enable effective interventions, where appropriate, to be widely implemented and sustained.

**Recommendation 25:**

That the NSW Department of Health proceeds with the Sexual Health and Health Promotion Data Set incorporating changes to take account of aims, settings and resources.

**Recommendation 26:**

That funded organisations submit annual project reports in accordance with the proposed sexual health and health promotion data set. Reasons should be provided for any variation from original project outlines.

**Recommendation 27:**

That the Workforce Development Program undertakes the following initiatives:

- promote access to existing HIV health promotion courses

- implements an annual professional practicum series for HIV health promotion workers
- identifies appropriate strategies, in collaboration with the AIDS/Infectious Diseases Branch, to support the implementation of the NSW HIV Health Promotion Workforce Development Guidelines.

**Recommendation 28:**

That the NSW Department of Health explores the feasibility of funding a short-term project, under the auspices of the Workforce Development Program, to develop a core-competency accredited training and learning project in HIV and sexual health promotion.

**Recommendation 29:**

That the HIV/AIDS health promotion program prioritises strategies to strengthen the interface between HIV/AIDS health promotion and primary health care.

**Recommendation 30:**

That Area Health Service funding plans report proposed expenditure against specified categories, as outlined in Table 27.

**Recommendation 31:**

That the NSW Department of Health works to ensure that the approval process for social marketing resources are expedited in a timely manner.

**Recommendation 32:**

That the NSW Department of Health facilitates a process to ensure agreement on role delineation between Area Health Services and non-government organisations when undertaking HIV/AIDS health promotion.

**Recommendation 33:**

That the NSW Department of Health develops a sexual health plan to address the health implications of STI transmission.

# Introduction

## 1.1 Background

The NSW Department of Health commissioned an evaluation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003*. The evaluation formed part of an overall process of reviewing the *NSW HIV/AIDS Statement of Strategic Directions 2000–2003*.

In August 2003, an independent consortium was contracted to undertake the evaluation.

The consortium consisted of:

- Professor Andrew Wilson, Professor in Public Health and Deputy Director of the School of Population Health, University of Queensland
- Mr David Fowler, David J Fowler Consulting
- Mr Aldo Spina, Aldo Spina Consultancy
- Ms Marilyn Wise, Executive Director, Australian Centre for Health Promotion, University of Sydney.

## 1.2 NSW HIV/AIDS Health Promotion Plan 2001–2003

The *NSW HIV/AIDS Health Promotion Plan 2001–2003* was developed under the guidance of the NSW Ministerial Advisory Committee on AIDS Strategy (CAS). The membership of the CAS includes representatives of government, clinicians, researchers and the community who together work in partnership to respond to the HIV/AIDS epidemic.

To achieve the goals and objectives outlined below, the plan:

- endorsed the continuation and consolidation of existing HIV/AIDS health promotion programs for priority populations
- identified a range of issues which threatened to undermine past health promotion successes and which could lead to increased rates of HIV transmission or poorer health outcomes for people with HIV/AIDS
- established key actions to address those issues and allocated responsibility for action in those areas
- developed the infrastructure and mechanisms necessary to support HIV/AIDS health promotion programs.

The goals of the plan follow from the goals of the *NSW HIV/AIDS Statement of Strategic Directions 2000–2003*:

- to minimise the transmission of HIV in NSW
- to enhance and maintain the health of HIV infected people
- to minimise the personal and social impact of HIV infection.

To achieve its stated goals, the plan has as its objectives:

- to improve the quality and effectiveness of health promotion interventions
- to enhance HIV/AIDS health promotion infrastructure.

Consistent with the fourth *National HIV/AIDS Strategy* and the *NSW HIV/AIDS Statement of Strategic Directions 2000–2003*, the priority target populations for NSW HIV/AIDS health promotion programs were:

- gay and other homosexually active men
- people living with HIV/AIDS
- Aboriginal and Torres Strait Islander people
- injecting drug users
- sex workers.

The plan acknowledged that within each of the populations identified above, young people, people from culturally and linguistically diverse backgrounds and people with developmental disabilities have specific needs which may require specialised targeting.

The plan also identified sub-populations of gay and other homosexually active men that should be the focus of health promotion programs. These included (in order of priority):

- gay men
- gay and other homosexually active men living with HIV
- gay and other homosexually active Aboriginal and Torres Strait Islander men

- gay and other homosexually active men who inject drugs
- young gay men and young men who are newly sexually active.

The plan reaffirmed the core principles underpinning the response to HIV/AIDS in NSW as being:

- partnership between government, community, health professionals and researchers
- the central involvement of affected communities
- non-partisanship
- harm minimisation
- transparency
- the creation of an enabling environment.

The plan identified nine priority issues that needed to be addressed during the life of the plan.

The priority issues nominated included:

- unprotected anal intercourse among gay and other homosexually active men
- post-exposure prophylaxis
- serodiscordant relationships
- treatments and health issues (for people with HIV/AIDS)
- Aboriginal and Torres Strait Islander Australians' sexual health
- illicit drug use
- HIV and sexually transmissible diseases
- vaccines
- testing and late diagnosis.

The plan identified the need to further develop parts of the infrastructure to support the response to HIV/AIDS in NSW. It nominated attention be given to:

- quality improvement
- research and evaluation
- workforce development
- collaborative processes
- planning and co-ordination.

The plan outlined monitoring and evaluation mechanisms needed to ensure the effective implementation of the plan including:

- Annual report to the NSW Minister for Health
- Annual Health Promotion Plan progress report
- Quarterly progress reports
- Annual project audits
- Annual funding plans submitted by Area Health Services and non-government organisations
- annual surveillance and monitoring reports by the National Centre in HIV Epidemiology and Clinical Research and the National Centre in HIV Social Research
- annual reporting against indicators in the Public Health Outcome Funding Agreements
- evaluation of individual projects.

### 1.3 Terms of reference

The terms of reference for the evaluation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003* include a focus on:

- process evaluation
- impact evaluation
- outcome evaluation.

The evaluation of the plan occurs in the context of considering the broader NSW HIV/AIDS health promotion program and giving consideration to recommendations to inform the development of a future strategy for the NSW HIV/AIDS health promotion program.

The process evaluation will measure how and why the plan worked. This will include whether the plan reached the defined target group, the target group were satisfied with the plan, whether all activities were implemented and whether all components were of good quality.

Key evaluation questions:

- How effectively was the plan communicated to the HIV health promotion workforce?
- How did the structure of the plan serve to achieve the goals it outlined, including the establishment of the CAS Health Promotion Sub-Committee, the Demonstration Projects Program and the action plan?
- How effective/inclusive was the consultation and process of developing the plan?
- How easy was it to effectively adopt the plan in local settings/What level of ‘ownership’ of the plan occurred?

The impact evaluation will focus on the immediate effects of the plan and the extent to which the objectives of the plan were achieved.

Key evaluation questions:

- Was the plan effectively implemented by the HIV health promotion workforce?
- What impact has the plan had on the quality and effectiveness of health promotion interventions?
- What impact did the plan have in enhancing the HIV/AIDS health promotion infrastructure in NSW? Did the plan address the key infrastructure issues nominated within the plan?
- How did the plan impact on the priority issues outlined in the plan?

The outcome evaluation will focus on what are the long-term effects of the health promotion program on the indicators of morbidity and mortality in relation to HIV/AIDS.

Key evaluation questions:

- To what extent has the program minimised the transmission of HIV in NSW?
- To what extent has the program enhanced and maintained the health of HIV infected people?
- To what extent has the program minimised the personal and social impact of HIV infection?
- Have the health promotion activities carried out in the plan been cost-effective/value for money?
- What comparisons can be drawn with other state and international HIV/AIDS programs?

## 1.4 Scope

The terms of reference include a focus on a process and impact evaluation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003*, as well as an evaluation of the outcomes of the health promotion program more generally. The evaluation of the health promotion program has been undertaken by using a health promotion outcomes evaluation framework and by comparing the NSW epidemic and program response with selected western nations.

## 1.5 Methodology

In addition to a comprehensive review of documentation and surveillance data, extensive consultation was a central component of the evaluation process. The methodology included the following:

- review of documentation, such as funding and performance agreements, CAS Health Promotion Sub-Committee papers and agendas, demonstration projects reports etc
- review of HIV/AIDS health promotion project information
- review of NSW and Australian HIV/AIDS epidemiology and research literature
- comparisons between NSW, interstate and selected international HIV/AIDS epidemics and program responses
- interviews with key stakeholders including the NSW Department of Health, Area Health Services, and non-government organisations
- consultation with advisory and coordinating committees, such as CAS Health Promotion Sub-Committee and HIV/AIDS Coordinators
- production and distribution of a discussion paper outlining preliminary findings and highlighting questions for further discussion
- four consultation workshops in Sydney, Parramatta, Dubbo and Coffs Harbour
- invitation for stakeholders to make written submissions.

## 1.6 Report overview

- Chapter two outlines the framework for the evaluation.
- Chapter three evaluates the process used to implement the plan.
- Chapter four evaluates the impact and achievements of the plan as well as discussing ongoing challenges.
- Chapter five describes the overall HIV/AIDS health promotion program and evaluates its impact and outcomes.
- Chapter six discusses additional recommendations for the NSW HIV/AIDS health promotion program.

## Framework for the Evaluation

### 2.1 An outcome model for health promotion

The terms of reference included a focus on process, impact and outcome evaluation of the NSW *HIV/AIDS Health Promotion Plan 2001–2003*, as well as more broadly the HIV/AIDS health promotion program.

To assist in evaluating the HIV/AIDS health promotion program, a health promotion outcome model was adopted. Figure 1 below outlines the model.

The logic of this model in regard to HIV health promotion, is that health and social outcomes are measured by, for example, HIV/AIDS incidence

and AIDS death. Health and social outcomes are determined by intermediate health outcomes. Intermediate health outcomes measures include behaviour, HIV infectivity and individual susceptibility etc. These are in turn determined by health promotion outcomes. Health promotion outcomes are measured by health literacy, community norms, public policy etc. These are the most immediate changes resulting from health promotion activity.

To evaluate the HIV/AIDS health promotion program we have examined outcomes, based on available data, at each of these different levels.

**Figure 1: An outcome model for health promotion<sup>1</sup>**

<b>Health promotion actions</b>	<b>Education</b> Examples include: patient education, school education, media communication	<b>Social mobilisation</b> Examples include: community development, group facilitation, targeted mass communication	<b>Advocacy</b> Examples include: lobbying, political organisation and activism
<b>Health promotion outcomes</b> (intervention impact measures)	<b>Health literacy</b> Measures include: health-related knowledge, attitudes, motivation, behavioural intentions, personal skills, self-efficacy	<b>Social action and influence</b> Measures include: community participation, community empowerment, social norms, public opinion	<b>Healthy public policy and organisational practice</b> Measures include: policy statements, legislation, regulation, resource allocation, organisational practices
<b>Intermediate health outcomes</b> (modifiable determinants of health)	<b>Healthy lifestyles</b> Measures include: tobacco use, food choices, physical activity, alcohol, illicit drug use	<b>Effective health services</b> Measures include: provision of preventive services, access to and appropriateness of health services	<b>Healthy environments</b> Measures include: safe physical environment, supportive economic and social conditions, restricted access to tobacco, alcohol
<b>Health and social outcomes</b>	<b>Social outcomes</b> Measures include: quality of life, functional independence, equity		<b>Health outcomes</b> Measures include: reduced morbidity, disability, avoidable mortality

## 2.2 Transmission model of HIV infection

The NSW HIV/AIDS health promotion program has adopted a broad social orientation approach that attempts to address a multiplicity of factors that impact upon HIV incidence.

Figure two, produced by the UK National Health Service, describes a transmission model of HIV infection that takes account of a multiplicity of factors that impact HIV transmission and incidence.

The incidence of HIV is determined by the average probability of transmission, and the number of exposures.<sup>2</sup>

The average probability of transmission is determined by biological factors. They are the infectivity of the HIV-positive person and the biological susceptibility of the negative person. This can be potentially mediated after the risk event through post-exposure prophylaxis.

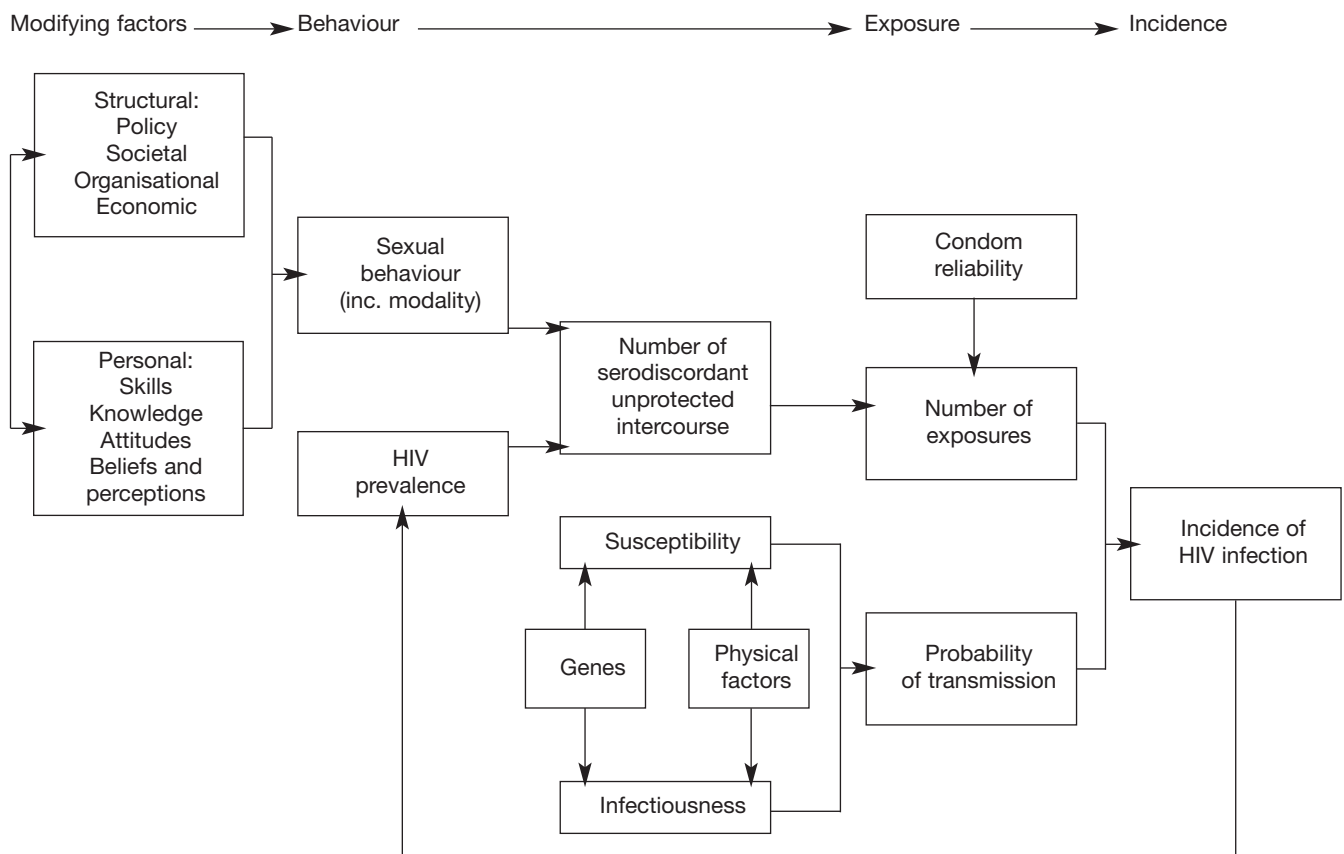
These biological factors can be influenced by particular interventions. There is extensive evidence showing that antiretroviral treatment reduces viral load thereby reducing infectivity. The presence of sexually transmitted infections (STIs) – particularly those associated with genital ulceration – contribute to both higher infectivity and higher susceptibility.

Number of exposures is the result of HIV prevalence, behaviour and the reliability of the means of protection. Behaviour is influenced by both personal modifying factors (eg attitudes, knowledge) and structural modifying factors (eg availability of clean needles, social/cultural norms).

The model provides a useful way of understanding how health promotion activity intersects with other factors to impact upon incidence of HIV infection.

The model has informed the evaluation team’s work, particularly in relation to examining the factors that may have led to a recent increase in HIV infection.

**Figure 2: Transmission model of HIV infection<sup>11</sup>**



# Evaluation of the Plan – Implementation Process

# 3

This section evaluates actions to support the implementation of the plan, including an examination of:

- the process used to develop and communicate the plan to stakeholders
- CAS Health Promotion Sub-Committee
- forums to support implementation of the plan
- HIV/AIDS Health Promotion Demonstration Projects Program.

## 3.1 Development and communication of the plan

The terms of reference included a focus on process, in particular the evaluation team were asked to evaluate:

- how effectively the plan was communicated to the HIV health promotion workforce
- how effective and inclusive was the consultation and process of developing the plan.

### **Development**

The Ministerial Advisory Committee on AIDS Strategy developed the *NSW HIV/AIDS Statement of Strategic Directions 2000–2003* to guide and coordinate efforts to respond to HIV/AIDS. The statement identified the development of a state-wide education and prevention strategy for gay-identified and homosexually active men as a priority.

Development of the *NSW HIV/AIDS Health Promotion Plan 2001–2003* commenced in 1999, and included education prevention strategies for gay identified and homosexually active men. The development of the plan was oversighted by CAS. The plan was released for distribution in May 2001.

A scoping paper that outlined the development framework was produced and submitted to CAS for feedback and utilised to stimulate discussion at a Planning Workshop held on 12 October 1999. The workshop aimed to ensure consensus on scope, focus, development process and identification of key priority issues. The planning workshop consisted of members of CAS, the NSW Department of Health, Area Health Services, researchers and non-government organisations.

A small writing group was established to assist with the drafting of the plan, with an acknowledgment that the group would need to coopt other members to progress the development of specific sections of the plan.

The writing group aimed to ensure the NSW Department of Health developed the plan with input from key non-government organisations. The writing group provided regular reports to CAS on progress and sought their input on key issues.

Apart from the input of CAS and attendees at the Planning Workshop, another thirty consultations were conducted with individuals representing a range of non-government organisations, rural and metropolitan Area Health Services, Aboriginal and Torres Strait Islander organisations and research organisations. In addition, the input of HIV/AIDS Coordinators was sought at their meetings in December 1999 and March 2000.

A draft of the plan was produced in December 2000 and distributed to a broad range of stakeholders inviting feedback by early 2001. A significant volume of feedback was received, including more than thirty written submissions from a variety of stakeholders, including rural and metropolitan Area Health Services, non-government organisations, research centres and members of CAS.

A final plan was produced, taking account of the feedback received, and it was endorsed by CAS at a meeting held on 11 May 2001. The plan was released for distribution shortly thereafter.

### **Communication**

Copies of the plan were broadly distributed within the NSW Department of Health, Area Health Services, research organisations and non-government organisations.

To further promote and support the implementation of the plan a policy officer from the AIDS/Infectious Diseases Branch visited most Area Health Services to meet with HIV/AIDS Coordinators and their staff to discuss the plan and its implication for local health promotion activities. Visits took place shortly after the plan's release in 2001.

The other main strategy to promote the dissemination and implementation of the plan was an Implementation Forum and Forum Series. The impact of the forums are explored in greater detail in section 3.3.

### **Key findings**

The consultation process to develop the plan was effective and inclusive. Opportunities for stakeholders to input into the plan occurred throughout the development process.

There was widespread agreement from stakeholders that the consultation process had been extensive and inclusive, and that the consultation process itself was an effective means to engage the sector with emerging health promotion priorities. Undertaking a comprehensive consultation process was seen as a necessity to ensure there was agreement and understanding across the sector of strategic priorities. During the evaluation, stakeholders agreed that the plan had identified the appropriate priority issues for 2001 to 2003.

The plan was believed to be well framed and written in a manner that enabled HIV health promotion priorities to be effectively communicated and implemented. The plan was thought to be concise, well written, easy to understand, and well informed by available evidence. The inclusion of a rationale for each nominated priority issue enabled the plan to be used as a tool to communicate HIV health promotion issues more effectively to those who may have limited knowledge of the field or were new to the field.

The process to communicate and promote the implementation of the plan was also seen as highly effective. A range of well planned and executed activities enabled the plan to be broadly distributed and communicated to a broad range of the HIV health promotion workforce, an important first step in promoting actions to implement the plan.

As described later, the Implementation Forum and Forum Series were seen as effective means to communicate and promote engagement with the priorities outlined in the plan. Specific comments were also received on the usefulness of the visit by a policy officer from the AIDS/Infectious Diseases Branch to Area Health Services. The visits were seen to assist health promotion and sexual health workers

in understanding how and why state-wide strategic priorities were identified.

It was generally believed, by stakeholders who participated in the review, that the plan was widely disseminated and that there was high awareness of the plan amongst the HIV/AIDS health promotion workforce (section 4.1 explores the impact of the plan on local health promotion strategies). Some stakeholders felt that the plan needed to be better disseminated among those who may not see themselves as part of the HIV/AIDS health promotion workforce, such as those working in primary health care.

## **3.2 CAS Health Promotion Sub-Committee**

The NSW Ministerial Advisory Committee on AIDS Strategy Health Promotion Sub-Committee was established to oversight the implementation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003*.

The committee's terms of reference included to:

- advise CAS on all aspects of NSW HIV/AIDS health promotion policy and strategy, with regard to both preventing HIV transmission and promoting the health of people with HIV/AIDS
- monitor and assist in coordinating the implementation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003*
- contribute to the development of an Annual Report to the Minister by the NSW Department of Health in conjunction with the CAS, as required by the *NSW HIV/AIDS Statement of Strategic Directions 2000–2003*
- act on other matters that may be referred to it by CAS.

As evident from the terms of reference, while the plan is a core focus of work for the committee, its role was not limited to the plan.

The committee met quarterly and meetings were held on:

- 22 August 2001 (inaugural meeting)
- 12 October 2001
- 15 March 2002
- 3 July 2002

- 13 September 2002
- 29 November 2002
- 23 April 2003
- 13 June 2003
- 12 September 2003.

Individuals were invited to participate in the committee due to their expertise, rather than as representatives of organisations. The membership of the committee was broad to ensure a range of views were able to input into the work of the committee. The AIDS/Infectious Diseases Branch provided secretarial support.

The committee recognised that while it had an ongoing role in relation to the priority content issues identified within the plan, its focus needed to be primarily on the infrastructure issues identified within the plan.

The committee gave particular attention to infrastructure issues relating to:

- workforce development
- research and evaluation
- collaborative processes, particularly HIV/AIDS health promotion in clinical settings.

### **Effectiveness of the committee**

- The committee was an effective mechanism to enable frank and strategic discussion of pertinent issues in HIV/AIDS health promotion.
- The committee appropriately focussed on examining and identifying strategic actions to support the HIV/AIDS health promotion infrastructure.
- The committee was proactive in responding to and overseeing coordination of activity in response to new and emerging issues that arose during the life of the plan, such as the increase in HIV notifications in NSW.
- The broad membership of the committee promoted partnership and collaboration, and enabled participants to be informed about health promotion activities being undertaken by key agencies.

- The committee was an appropriate mechanism to assist with implementation and monitoring of the plan.
- The committee members had expertise in health promotion and/or HIV/AIDS which enabled an appropriate and strategic level of discussion.

### **Areas for improvement**

- While the committee prioritised its areas of work and regularly reviewed many of the actions, its monitoring of the implementation of the plan could have been improved by an annual or mid-point review of progress.
- The committee's membership could have usefully been reviewed at the mid-point to ensure that members were still willing and able to participate, and to enable new members to be invited to participate who can contribute additional expertise and strategic thinking to the committee's work.
- The committee needs to examine how better links and coordination can be fostered when its work overlaps with other advisory committees.

### **Key findings**

The CAS Health Promotion Sub-Committee was an effective and valuable mechanism to oversee implementation and monitoring of the plan and to advise CAS on matters relating to HIV/AIDS health promotion. The committee also promoted partnership and collaboration amongst the sector.

Subject to a review of existing membership, to ensure that the skills and experience of members are congruent with the tasks at hand, the committee should be maintained as it plays a pivotal role in providing advice and input to CAS on the health promotion program in NSW and ensuring co-ordination of responses amongst key partners.

### **Recommendation:**

That CAS reconvenes the Health Promotion Sub-Committee, subject to a review of membership, for the duration of the next HIV/AIDS health promotion plan.

### 3.3 Forums

A range of forums was convened to support the implementation of the plan including:

- NSW Partnership Forum on Gay Community Responses to HIV/AIDS
- Implementation Forum
- Implementation Forum Series
- 'E' Day Forum to support the implementation of demonstration projects
- NSW HIV Surveillance Forum.

#### ***NSW Partnership Forum on Gay Community Responses to HIV/AIDS***

The NSW Partnership Forum on Gay Community Responses to HIV/AIDS was held Friday on 11 May 2001. The forum was convened by the Ministerial Advisory Council on AIDS Strategy to:

- strengthen the partnership approach in relation to HIV/AIDS risk practices among gay men
- consider the findings of a review of HIV-related epidemiological, clinical and behavioural data for NSW in light of increases in HIV notifications among gay men in Victoria and overseas
- inform the focus of social marketing, education and other programs, including research, to address risk practices among gay men and reinforce safe sex norms within the gay community.

The agenda for the forum included preliminary findings of a review of epidemiological, clinical and behavioural data, an outline of strategic directions for the response to HIV/AIDS in NSW and an overview of gay community responses to HIV/AIDS.

The forum brought together a range of invited researchers, clinicians, community, and government representatives.

#### ***Implementation Forum***

The NSW HIV/AIDS Health Promotion Plan Implementation Forum was a day long forum held in Sydney on November 2001. The forum was attended by over 220 participants including health promotion officers, nurses, researchers, doctors, support workers, educators, counsellors, psychologists and managers.

The aim of the forum was to create opportunities for members of the HIV/AIDS partnership to meet and discuss implementation of the plan.

The objectives of the forum were to:

- increase awareness, knowledge and understanding of the role and focus of the plan
- update participants on the current state of the epidemic in NSW
- examine how priority issues nominated within the plan may be progressed in local and statewide contexts, and build upon work already underway
- provide an opportunity for the development of collegial support amongst participants.

The forum was convened as consultations following the release of the plan indicated a strong support for an implementation strategy that created opportunities for the broad HIV/AIDS workforce from across NSW to meet.

A reference group was established to input into the development of the forum. The reference group consisted of the NSW Department of Health, Area Health Services and non-government organisations. It included representatives from rural and urban NSW, researchers and health promotion staff and managers.

The agenda included an opening panel on epidemiology and research to set the scene for the context in which the plan was developed and discussion that would follow throughout the day. It was then followed by workshops focusing on the nine priority areas identified within the plan. The workshops provided an opportunity to introduce participants to the plan and to discuss what actions may be required to address priority issues.

Each workshop session was planned and facilitated by a small group of people from Area Health Services, non-government organisations and the NSW Department of Health. Three rapporteurs provided feedback at the end of the forum on the discussions that took place throughout the day.

### **Implementation Forum Series**

Following the Implementation Forum, a series of smaller and more targeted half-day and full-day forums were convened to support the implementation of the plan. Small working groups were convened for each of the forums to input into the development of the agenda.

The overall aim of the forum series was to provide the HIV/AIDS partnership with an opportunity to progress the implementation of key aspects of the *NSW HIV/AIDS Health Promotion Plan 2001-2003*.

Six forums were held during 2002 and 2003, with total attendance of approximately 220 people.

The first forum was *HIV/AIDS Treatments and Health Issues Forum*. The forum was held on Friday, 24 May 2002 with sixty-five participants.

The objectives of the forum were:

- to inform participants of the latest research findings related to people with HIV
- to enable discussion on the implications of the latest research findings for health promotion programs.

The second forum was HIV Testing and Late Diagnosis Forum. The forum was held on Friday, 19 July 2002 with thirty-six people attending.

The objectives of the forum were:

- to inform participants of the latest research findings related to HIV testing and late diagnosis
- to enable discussion of projects specifically addressing HIV testing and late diagnosis issues.

The third forum in the series was Building Capacity in HIV/AIDS Health Promotion Programs which was held in Ballina on Tuesday, 30 July. The forum had twenty-two participants. The objectives of the forum were:

- to explore the concept of capacity building
- to apply the framework to the development of HIV/AIDS health promotion programs, particularly in relation to recently funded demonstration projects
- to provide an opportunity for networking and information-sharing.

The fourth forum in the series Building Capacity in HIV/AIDS Health Promotion Programs which was held in Dubbo on Tuesday, 27 August. The forum had twenty-one participants and its objectives were:

- to explore health promotion theory and the models it uses
- to apply health promotion theory and models to HIV/AIDS health education initiatives
- to explore the concept of capacity building
- to apply the framework to the development of HIV/AIDS health promotion programs, particularly in relation to recently funded demonstration projects
- to provide an opportunity for networking and information-sharing.

The fifth forum held was the Sero-Discordant Relationships Forum which was held on Friday, 27 September and had thirty-five participants.

The objectives for the forum included:

- to inform participants of the latest research findings related to serodiscordant relationships
- to enable discussion of projects specifically addressing serodiscordant relationships.

The sixth forum held was the People Living With HIV/AIDS In Correctional Settings Forum.

The forum was held on 27 June 2003 and had approximately forty participants. The objectives for the forum included:

- to identify the complexity of HIV/AIDS management issues for people living with HIV in correctional settings
- to explore opportunities to maximise the care and treatment of people living with HIV while in correctional settings, and to promote continuity of care upon release
- to further develop partnerships among service providers who provide HIV care and treatment in correctional settings and/or upon release.

### **'E' Day forum**

The aim of the 'E' Day forum, held on 8 July 2002, was to inform and support the planning and implementation of demonstration projects. Recipients of demonstration project funding were invited to attend, with forty-two people attending.

The objectives of the forum included:

- update on implementation of the plan
- outlining the NSW Department of Health's expectations of demonstration projects
- demonstration project information sharing
- providing opportunity for networking
- providing an opportunity to consider an evaluation plan
- identifying further support required to assist grant recipients.

The agenda included an outline of reporting processes, an opportunity to present demonstration projects and to consider key questions in developing an evaluation plan for individual demonstration projects.

### **NSW HIV Surveillance Forum**

The NSW HIV Surveillance Forum was organised by the NSW Department of Health and CAS Health Promotion Sub-Committee in response to a 14 per cent increase in HIV notifications in NSW, and was held on 24 July 2003.

The forum brought together thirty-two representatives of the government, clinical, research and community HIV/AIDS sectors to:

- consider the range of epidemiological, social and clinical data sources available in NSW
- discuss the extent to which each of these data sources provides a reliable and timely indication of changes in the NSW HIV epidemic
- discuss interpretation of the data as a combined body of knowledge and strategies for analysing the data as a whole
- identify opportunities to strengthen the data available, including HIV surveillance.

### **Key findings**

The forums were an effective and important means of promoting workforce engagement with the priorities outlined within the plan and encouraging discussion and debate about HIV/AIDS health promotion strategies.

The Implementation Forum was highly valued given the high level of participation and the few opportunities that exist to bring together the broad HIV/AIDS health promotion workforce, including those who may not traditionally see themselves as part of the health promotion workforce.

The Implementation Forum Series was seen as particularly useful for providing an opportunity to hear the latest research findings and finding out information about health promotion strategies being developed to respond to priority issues. It was self-reported by participants that the two rural forums that focused on capacity building and health promotion improved their skill and knowledge and enabled consideration to be given as to how to apply models to health promotion practice.

The 'E' Day Forum for demonstration project grant recipients was viewed as an effective mechanism for promoting information-sharing and networking. Some comments were received that participants felt their expectations in regard to evaluation training were not met. However, the forum was only intended to provide an opportunity for participants to begin considering issues in developing an evaluation plan. Offering evaluation skills development was not deemed necessary, given the myriad of evaluation training courses that are available to health promotion staff through established training agencies.

Some disappointment was expressed that the forums did not produce any specific actions to address priorities or networks/partnerships to further develop responses and maintain momentum. For the most part, the forums were not intended to achieve such outcomes. However, there may have been value in such outcomes being a goal of some of the forums, particularly where further interagency action to progress priority issues was required.

## 3.4 HIV/AIDS Health Promotion Demonstration Projects Program

### 3.4.1 Background

The HIV/AIDS Health Promotion Demonstration Projects Program was initiated by the NSW Department of Health to support the implementation of the *NSW HIV/AIDS Health Promotion Plan 2001–2003*.

The primary objective of the program was to stimulate innovative health promotion programming that addresses current HIV/AIDS health-promotion priorities.

A secondary objective was to enhance the infrastructure that supports HIV/AIDS health promotion across NSW.

A call for expressions of interest was distributed in late 2001. Expressions of interest were required to be submitted by 7 December 2001. Services and organisations were invited to apply for funding for either a large project or a small project. The maximum funds available for a large project were \$150,000 over three years. The maximum funds which were available for a small project were \$45,000 over three years.

Area Health Services, community-based organisations and non-government organisations were eligible to apply for funding.

The NSW Department of Health gave priority to proposals which:

- addressed priority areas
- were evidence-based or informed by health promotion/community development theories
- had a considered and appropriate project design
- included innovative interventions and/or trialed a new model of service delivery
- included a rigorous and comprehensive evaluation strategy
- build community capacity
- generated new knowledge about HIV health promotion
- identified strategies to disseminate new learnings
- were conducted in partnership

- were self-sustaining
- contributed to the HIV/AIDS health promotion infrastructure.

Proposals that did not address the priorities identified in the *NSW HIV/AIDS Health Promotion Plan 2001-2003* were also considered and funded if a strong rationale was provided.

Expressions of interest submissions formed the basis of a funding and performance agreement between the successful agency and the Department. Applicants were required to establish an advisory committee, including the option of membership by a Department officer, to oversee the design, implementation and evaluation of the project.

Upon projects receiving approval, recipients were invited to attend the 'E' day forum, which aimed to inform and support the development of projects. For more information on the forum see section 3.3.

As a key objective of the program was to generate demonstration projects which could inform the sector about innovative strategies, a strong emphasis was placed on both process and impact evaluation. Long-term outcome evaluation, and external evaluation, was expected to be considered by larger projects.

All demonstration projects were required to provide six-monthly reports. The reports required an outline of activities to date and project learning. The summary also asked recipients to outline the communication and dissemination activities undertaken during the reporting period. Summaries of project reports were compiled every six months and circulated to all other demonstration projects.

### 3.4.2 Summary of projects

Funding of projects was approved and announced in early 2002, with successful agencies receiving funding for projects in May 2002. Fifty-seven projects were funded, with funding totalling \$3,375,500 over four financial years. Of this, \$1,956,900 was allocated to Area Health Services and \$1,418,600 to non-government organisations. Sydney-based projects received 36 per cent of total funds, projects in regional and rural NSW received 25 per cent, and state-wide projects received 39 per cent of funding.

Of the 57 projects, nine were research projects, though a number of other projects also incorporated research as an important component of the project. Of the remaining 48 projects all but five addressed the priorities outlined within the plan. The other five projects addressed priority population groups, such as sex workers, young gay men, or other population groups, such as transgendered people and homeless young people.

Of the 43 projects that addressed priority issues:

- six projects addressed unprotected anal intercourse among gay and other homosexually active men
- three projects addressed post-exposure prophylaxis
- one project addressed serodiscordant relationships
- eight projects addressed treatments and health issues for people with HIV/AIDS
- eight projects addressed issues for Aboriginal and Torres Strait Islander people
- 12 projects addressed illicit drug use issues
- one project addressed HIV and sexually transmissible diseases
- four projects addressed testing and late diagnosis.

While we have categorised projects by the primary issue that the project was addressing, many projects often addressed multiple priority issues.

Of the 57 projects:

- 40 are still in progress
- 12 have been completed or are almost complete
- five are indeterminate.

The appendix includes an outline of all demonstration projects and their current status.

### ***Additional funding to non-government organisations***

In addition to the HIV/AIDS Health Promotion Demonstration Projects Program, a range of new initiatives was funded to support the implementation of the plan. The projects that were funded addressed the priority areas nominated within the plan.

Over \$519,000 was provided to a range of non-government organisations for the establishment of eight projects. Funding and Performance Agreements for each of these projects were negotiated between the Department and respective organisations.

Funding was announced shortly after the release of the plan in mid-2001. Given the earlier release of funds in comparison to demonstration project funding, most projects have been completed or are nearing completion. Five projects have conducted evaluations or evaluations of components of the project.

The appendix includes an outline of the projects and their status.

### 3.4.3 Evaluation of the demonstration projects

During the review a number of strengths of the demonstration projects program were identified.

- The program encouraged the HIV health promotion workforce to engage with the plan and consider how the priorities could be implemented locally.
- The program enabled a range of new projects to be developed and implemented to address priority issues. This would not have been able to occur without the funding the program made available.
- Innovative projects that contribute new knowledge were able to be funded. This would have been unable to occur without the funding the program made available.
- The program placed a strong emphasis on evaluation prompting most grant recipients to give the issue appropriate consideration during early project design stage.
- The program was effective in encouraging clinical staff and a broad range of services and other sectors to undertake HIV/AIDS health promotion projects.

Some issues that arose in the implementation of the program include the following.

### Evaluation and reporting

The expressions of interest submission process emphasised the importance of process and impact evaluation, and where appropriate, outcome evaluation being incorporated into project design. The assessment criteria for submissions included reviewing the evaluation strategy proposed. The evaluation team's review of submissions indicated most applicants gave serious consideration to evaluation issues.

While many recipients are providing valuable information on their achievements in their six monthly reports, these should not be considered adequate for evaluation reporting purposes.

While many project submissions indicated that the project would produce an evaluation report, there appears to be no explicit stipulation that evaluation reports must be submitted to the Department by grant recipients to enable grant closure.

Of the twelve projects that are completed, or almost completed, three are research projects, of the remaining nine projects no evaluation reports have yet been submitted.

### Capacity

Some organisations that received demonstration project funding may have lacked the organisational capacity to support the implementation of the project and to support staff skills development. Grant recipients who may not have had a strong background in health promotion, particularly clinical staff, may have required skills development in health promotion planning and management.

It may have been beneficial if the implementation of projects at the local level could have been better supported or more closely developed and implemented in partnership with organisations who have greater capacity to undertake health promotion.

### Dissemination of findings

While shared learning reports were distributed every six months to all grant recipients, it appears most grant recipients considered these inadequate to disseminate findings and showcase projects.

### Coordination

There needed to be greater coordination and partnership between projects that were addressing similar issues.

### Approval process

There was some uncertainty about the approval process required for resources produced by demonstration projects. While there has been a long standing requirement that all HIV/AIDS resources are required to be submitted to the NSW Department of Health for approval, this was not known by all grant recipients.

### 3.4.4 Future considerations

Below are some issues that need to be considered if a similar program is to be established again.

- There may be greater value in funding a smaller volume of projects that are more comprehensive and have a greater potential in terms of demonstrating innovation, building partnerships, implementing evaluation strategies and disseminating project findings.
- The quality and rigour of project proposals may benefit significantly from the review committee providing feedback on submissions, and for proposals to be re-submitted before being approved. This may also enable a reduction in similar projects being implemented, as the review committee would be able to recommend partners based on project proposals which are alike.
- There needs to be an explicit stipulation within performance and funding agreements that the submission of an evaluation report is required to ensure the conditions of the grant are met.
- Greater resourcing may need to be allocated within the AIDS/Infectious Diseases Branch to enable better support, coordination and monitoring of the program, particularly ensuring evaluation, reporting and dissemination requirements are met.
- A clear definition of what constitutes innovation and greater rigour in assessing proposals against such a criteria needs to occur if a key objective of the program is to demonstrate innovation.

### 3.4.5 Findings

#### **Innovation**

Assessing whether demonstration projects are innovative is a fraught and subjective task, particularly as most projects are still in progress. However, the evaluation team has attempted to anticipate the number of projects that may contribute to demonstrating innovation or producing new knowledge.

The evaluation team reviewed successful expressions of interest submissions and the written assessments made by the selection panel, and then applied two of the criteria used by the NSW Department of Health to assess applicants. The criteria included projects that demonstrate innovative interventions and/or trialing a new model of service delivery, and projects which generate new knowledge about HIV health promotion. Rather than make reference to specific projects we are providing overall comments.

The expressions of interest process did not require applicants to outline how they consider their project innovative, nor did the documentation provided to applicants include a definition of innovation for the purpose of this program.

Our assessment needs to be tempered by a recognition that applicants may have a different view on how their project may demonstrate innovation or contribute new knowledge, and that assessments can only be based on the project proposal. Implementation of projects may vary from how the project was originally conceived.

Of the 48 demonstration projects funded it is anticipated that:

- eight projects are likely to demonstrate innovation or trialing a new model of service delivery
- eight projects were identified as quite likely to produce new knowledge
- at least 16 projects will use existing models or strategies but implement them in different geographic areas or with new population groups, and this may produce some new knowledge
- another 14 projects are likely to enhance existing infrastructure without demonstrating innovation or contributing new knowledge.

#### **Key findings**

The primary objective of the HIV/AIDS Health Promotion Demonstration Projects Program was to stimulate innovative health promotion programming that addresses current HIV/AIDS health promotion priorities.

The program appears highly effective in ensuring that health promotion projects address the priorities nominated within the plan. The program appears to have been less effective at stimulating innovative health promotion programming, though as most projects are still in progress this remains difficult to assess. Greater clarity of what constitutes innovation and greater rigour in assessing submissions against such criteria may have been required. As outlined above, approximately a third of projects are likely to demonstrate innovation and/or contribute new knowledge to health promotion programming. Another third of projects are applying existing models or strategies but implementing them in different geographic areas or with new population groups, and this may produce some new knowledge.

The secondary objective of the program was to enhance the infrastructure that supports HIV/AIDS health promotion across NSW. This objective was achieved as the program has enabled a wide range of initiatives to be undertaken that otherwise would not have been able to occur, even if they are not necessarily innovative, and this has enabled the plan to be more effectively implemented.

As most projects are still in progress, and the few projects that have been completed have yet to complete evaluations, it is not possible to report on findings of project process, impact and outcome evaluations or the extent to which such findings have been disseminated or sustained. Further funding for non recurrent projects to organisations previously receiving demonstration project grants should be contingent on receipt of evaluation reports and acquittal of grants.

The NSW Department of Health needs to continue to monitor the program to ensure that funding obligations are met, and specifically that projects submit evaluation reports to acquit the grant (this requirement may need to be better communicated to some grant recipients who may believe their six-monthly activity and learning reports are adequate). Given the significant investment of resources in the program, NSW Health needs to consider convening a forum in which projects can be showcased and outcomes disseminated. NSW Department of Health, Area Health Services and non-government organisations need to also consider ensuring the sustainability and implementation of projects that were proven effective across the NSW HIV/AIDS health promotion program.

***Recommendation:***

That the NSW Department of Health:

- continues to monitor the HIV/AIDS Health Promotion Demonstration Projects Program and ensures all projects submit evaluation reports to enable acquittal of the grant
- convenes a forum to enable dissemination of project outcomes
- convenes a small working group to review evaluation reports and consider strategies to enable effective interventions, where appropriate, to be widely implemented and sustained.

# 4

## Evaluation of the Plan – Impact and Achievements

### 4.1 Key findings

The evaluation team endeavoured to ascertain:

- the extent to which the plan was implemented at the local level (section 4.1.1)
- the extent to which the action plan was implemented (section 4.1.2)
- how effective the plan was at achieving its stated objectives (section 4.1.3).

#### 4.1.1 Implementation of the plan at a local level

The terms of reference included a focus on impact evaluation and, in particular, identified the need to assess the extent to which the plan was effectively implemented by the HIV health promotion workforce.

This evaluation explored the impact of the HIV/AIDS Health Promotion Demonstration Projects Program and found that it was effective in ensuring that the priorities nominated within the plan were addressed. We also examined the extent to which the strategies outlined in the action plan were implemented (findings are discussed in section 4.2 and 4.3).

In addition to the Demonstration Projects Program, we have attempted to ascertain the extent to which the existing health promotion program addressed the priority issues and target population groups as outlined in the plan. To make an assessment we relied upon the health promotion information reports submitted by funded agencies to NSW Department of Health, though it should be noted many reports provided incomplete data.

While we were able to comment on the focus of health promotion projects, we are unable to ascertain the extent to which the plan may have re-directed health promotion efforts as no baseline data was collected prior to the release of the plan.

We have been able to draw some general conclusions about the focus of the health promotion program across the state, however the lack of standardisation of the data collected prevents us from being more specific.

Below we comment on the extent to which health promotion projects target priority population groups and address priority issues.

#### *Priority target populations*

Priority target populations for the NSW HIV/AIDS health promotion program are gay and other homosexually active men, people living with HIV/AIDS, Aboriginal and Torres Strait Islander people, injecting drug users and sex workers. Within these population groups the specific needs of young people, people from culturally and linguistically diverse backgrounds and people with development disabilities are acknowledged.

HIV health promotion projects across NSW largely target the priority populations nominated within the plan, the notable exception being Area Health Service projects that target young people.

Young people specifically targeted included highschool students, TAFE students, university students, homeless young people or youth workers. In some cases young people may have been targeted as they also are a part of another priority population group (for example, young injecting drug users or young gay men), although it is not possible to ascertain the extent to which this is occurring. While young people are not a priority population for HIV health promotion, the NSW Sexual Health Promotion Guidelines state that young people are a priority population group for sexual health promotion.<sup>3</sup>

Area Health Services projects that target young people generally focus on broader sexual health or blood-borne viruses. Given that young people are often a specific target group within interventions targeting population groups at high risk, the extent to which Area Health Services are specifically targeting young people may not be appropriate.

**Priority issues**

Many health promotion projects rather than just focusing on HIV or unprotected anal intercourse occur in the context, for example, of addressing sexual health or gay men's health more generally. Additionally, community development and capacity building is a common methodology used and such an approach often has benefit across a range of health issues, though often with a significant focus on HIV and sexual health.

Most of the education issues addressed by projects generally include the priorities listed within the plan, though we recognise that there may have been a tendency within project reports to over-represent the priorities nominated within the plan even if the priority issues are not a significant focus of the education.

The plan has resulted in an increased focus on the priority issues through the demonstration projects program and implementation of activities locally since the plan was adopted. However, the extent to which the nominated priorities have become a greater focus of ongoing projects is unknown.

**Reported impact**

Feedback was sought on how stakeholders viewed the impact of the plan on local health promotion planning. Much of the feedback was positive with common comments being that the document was a useful tool to frame local health promotion projects and as a guide to assist with local planning. More generally stakeholders commented that the development of an HIV health promotion plan was an important initiative to ensure the HIV/AIDS program as a whole was responding appropriately to priorities, with a shared purpose. In particular it was thought that the plan fostered greater collaboration and partnership between agencies. The plan also ensured an emphasis on the importance of agencies continuing to dedicate resources to HIV/AIDS health promotion.

Some of these positive comments were framed by an acknowledgment that many agencies were already addressing priority population groups and priority issues, and as a result the plan acted more as a checklist to ensure local projects were appropriate.

The critical comments that were received related to the plan not providing a guide on how to undertake health promotion. However, the plan's focus was on establishing strategic directions and priorities while recognising that the expertise and responsibility for implementation of health promotion projects lies at the local level.

**Findings**

Overall, the plan engaged the HIV workforce in addressing the priority population groups and priority issues outlined in the plan, as well as ensuring the program as a whole was working towards a common goal.

While funding is primarily allocated to projects targeting high priority populations there is some scope for reallocations particularly given the emergence of new challenges. Funding for projects targeting youth, particularly those who are not marginalised, is probably excessive.

**4.1.2 Implementation of the action plan**

The evaluation of the plan included a specific focus on assessing the implementation of the action plan. The achievements of the action plan have been identified and discussed in more depth in section 4.2 and 4.3, below is an overall summary of some of the key achievements followed by findings.

**Key achievements to address priority issues**

- NSW Department of Health provided over \$3.5 million, through HIV/AIDS Health Promotion Demonstration Projects Program and additional funding to non-government organisations, to enable a range of projects to be established to address priority issues.
- Implementation of a PEP social marketing campaign has led to an increase in awareness and knowledge of PEP among gay men (from 33.7 per cent to 54.3 per cent).
- A variety of health promotion interventions was developed to support both heterosexuals and gay men in serodiscordant relationships.

- Establishment of the Aboriginal and Torres Strait Islander Sexual Health Implementation Advisory Committee to advise on implementation of sexual health programs in Aboriginal communities in NSW.
- Range of initiatives to support workforce development for sexual health workers with Aboriginal communities, including continued support for regular meetings of the Aboriginal and Torres Strait Islander HIV/Sexual Health Workers Network and the development of the NSW Distance Learning Package.
- Implementation of \$8.3 million of COAG funded initiatives to support the needle and syringe program in NSW.
- Development of STI testing guidelines for priority population groups, including subsequent distribution and promotion amongst health care workers.
- Implementation of a variety of social marketing campaigns to respond to STI outbreaks, including addressing chlamydia, syphilis, hepatitis A, and shigellosis.
- Establishment and implementation of a variety of projects to strengthen the promotion of HIV testing and to target population groups who have been identified as late presenters.

**Key achievements to address infrastructure issues**

- Strengthening of a responsive and effective research program that monitors changes in epidemiology, knowledge, and behaviour of priority population groups, particularly gay and other homosexually active men and people with HIV/AIDS.
- Release of the first Annual Report that summarises NSW-based epidemiological data relating to HIV, viral hepatitis and STIs.
- Piloting of the Sexual Health and HIV Health Promotion Data Set Project to improve collection of standardised and objective data on HIV and sexual health promotion activities across NSW.
- Emphasis on ensuring research informs health promotion programming by funding nine research projects as part of the HIV/AIDS Health Promotion Demonstration Projects Program, and providing funds to establish an HIV/AIDS Social Research Brief Newsletter and Research to Practice Project.

- Implementation of a variety of forums to support the implementation of the plan and improve skills, knowledge and collaboration among health promotion workers. Forums included NSW Partnership Forum on Gay Community Responses to HIV/AIDS, Implementation Forum, Implementation Forum Series, and HIV Surveillance Forum.
- Development of HIV Health Promotion Workforce Development Guidelines to support the development of workforce development plans by Area Health Services and non-government organisations.
- Development and funding of projects to identify how to strengthen the interface between HIV/AIDS health promotion and primary health care.
- Convening CAS Health Promotion Sub-Committee to oversight coordination of the implementation of the plan and provide advice to CAS on matters relating to health promotion.

**Findings**

The strategies to address priority issues and infrastructure issues, as outlined in the action plan, were largely implemented or are in the process of being implemented.

Where actions were not implemented this occurred because the actions were deemed no longer appropriate, such as in the case of implementing an education program on vaccine trials, or because other projects were implemented to address the issue instead of the action identified in the plan, such as the Sexual Health and HIV Health Promotion Data Set progressing instead of the review of minimum levels of service for HIV/AIDS health promotion.

The only common gap in addressing actions was the implementation of evaluations of health promotion interventions, which was also often the measure of success stipulated within the action plan. In part, the lack of evaluation is due to most demonstration projects still being in progress. However, ensuring the appropriate evaluation of ongoing health promotion projects and evaluation of areas specifically highlighted in the plan, including serodiscordant relationships and health promotion programs for people with HIV/AIDS, was also lacking.

### 4.1.3 Achievement of objectives

The plan had two objectives:

- to improve the quality and effectiveness of health promotion interventions
- to enhance HIV/AIDS health promotion infrastructure.

Implementation of the plan has led to an enhancement of the HIV/AIDS health promotion infrastructure and has ensured the HIV/AIDS health promotion program is well positioned to address the challenges that arise from the increase in HIV diagnoses.

The plan resulted in a range of initiatives, identified further below, that specifically enhanced various components of the infrastructure that supports health promotion.

While the NSW research program was already well developed, there were ongoing efforts to ensure research was responsive and effective at monitoring changes in epidemiology, knowledge and behaviour among priority population groups. Efforts were also directed to enhancing processes to ensure that research informs health promotion programming.

Specific and sustainable initiatives to improve coordination and collaboration between partners in the HIV/AIDS health promotion program were implemented, such as the CAS Health Promotion Sub-Committee and Aboriginal and Torres Strait Islander Sexual Health Implementation Advisory Committee.

Capacity building and workforce development initiatives were implemented to ensure the ongoing ability of the workforce to address ongoing and new challenges that confront HIV/AIDS health promotion. Initiatives included various forums, HIV Health Promotion Workforce Development Guidelines and Aboriginal NSW Distance Learning Package. Many of these initiatives are ongoing and sustainable.

The establishment of the HIV/AIDS Health Promotion Demonstration Projects Program led to a significant enhancement of the infrastructure and enabled a wide range of health promotion interventions to be developed (importantly, all projects were required to consider issues of sustainability and learning dissemination). Likewise, the Council of Australian Governments Illicit Drug Diversion

Initiatives enabled a significant enhancement of the needle and syringe program in NSW.

Assessing whether the plan led to an improvement in the quality and effectiveness of health promotion interventions without benchmarks, baseline data or quality performance indicators hinders the evaluation team making an assessment. The plan itself prioritised quality improvement as an important infrastructure issue, and work commenced on developing and piloting the Sexual Health and HIV Health Promotion Data Set which aims to standardise collection of data on health promotion activities.

The data available to the evaluation team is limited as the data set has yet to be implemented across AIDS funded programs and the health promotion information reports did not include indicators relating to quality and effectiveness.

Improving the quality of health promotion interventions is important as it contributes to more effective interventions and ultimately better outcomes. It is likely that the plan led to some improvement in the quality of health promotion interventions, partially because it resulted in the HIV workforce considering, during planning and implementation, how their projects address or need to address priority population groups, and priority and infrastructure issues. Additionally, the HIV/AIDS Health Promotion Demonstration Projects Program appears to have made a significant contribution to improving the quality of health promotion interventions due to the emphasis given to planning, partnership, innovation and evaluation. The long-term impact of demonstration projects, given the emphasis on information sharing, is likely to result in a positive flow-on effect to the quality of the health promotion program more broadly.

The evaluation team adopted an outcome model for health promotion as a framework for making assessments on the impact of the health promotion program. It is at the health promotion outcomes level that we would expect current health promotion interventions to have a positive impact on, for example, knowledge, skills, self-efficacy, community participation, community empowerment, social norms etc.

Unfortunately, the evaluation team found very little data was available on the health promotion outcomes of specific health promotion interventions.

When completed, the evaluations of demonstration projects are likely to provide information on effectiveness, and many are showing promising signs. However, currently we are unable to make an assessment on whether the plan led to an increase in effectiveness of health promotion interventions. The future collection of data on health promotion interventions needs to ensure information is sought on the impact at the health promotion outcomes level.

The increase in HIV notifications poses ongoing challenges to the current HIV/AIDS health promotion program. Such a climate necessitates the need for a clear and articulated set of strategic directions for the program and a continued emphasis on the value of health promotion if there is to be a reduction in HIV transmission. It is the recommendation of the evaluation team that the development of another HIV/AIDS health promotion plan will be of benefit to the HIV/AIDS response in NSW. Given that the implementation of the current three-year plan is still ongoing with many activities not due to be completed for another year, it may be appropriate to consider a four-year time frame for implementation of the next plan.

It is recommended that the framework for the next plan includes:

- infrastructure to support health promotion
- key messages that need to be addressed by the program
- possible challenges to health promotion programming.

**Recommendation:**

That the NSW Department of Health, in consultation with stakeholders, develops a four-year HIV/AIDS health promotion plan.

## 4.2 Priority issues

This section of the report examines the implementation of the plan specifically in relation to the action plan.

The action plan outlined for each priority and infrastructure issue:

- what we will achieve
- how we will achieve this
- measure of success
- lead agency.

Apart from the strategies outlined in the action plan, Area Health Services and non-government organisations initiated a variety of other projects at the local level to support the implementation of the plan.

The lack of standardised reporting has meant it has not been possible to detail local activities and projects in these reports. Instead, we have made some more general observations about the health promotion program from the reports provided (see section 5.2.2) and used the reports to examine whether the program appears to target priority population groups and priority issues (see section 4.1).

The plan identified issues that were most critical for ensuring a continued effective response to HIV/AIDS. The priority issues nominated were selected because they were new issues that presented new problems and challenges, or because they were existing issues that required renewed attention or ongoing support.

The priority issues that were identified were:

- unprotected anal intercourse among gay and other homosexually active men
- post-exposure prophylaxis
- serodiscordant relationships
- treatments and health issues (for people with HIV)
- Aboriginal and Torres Strait Islander Australians' sexual health
- illicit drug use
- HIV and sexually transmitted diseases
- vaccines
- testing and late diagnosis.

The priority issues are examined in relation to the specified strategies and actions that were outlined in the action plan attached to the *NSW HIV/AIDS Health Promotion Plan 2001–2003*.

### 4.2.1 Unprotected anal intercourse among gay and other homosexually active men

The plan identified that an increase in HIV transmission rates among gay men remained a real possibility, as has unfortunately occurred. Appropriately, the plan attached significant weight to addressing the issue of unprotected anal intercourse among gay and other homosexually active men.

The action plan identified strategies as:

- monitoring epidemiology, knowledge and behaviour of gay and other homosexually active men
- innovative health promotion interventions for gay and other homosexually active men, that recognise their diversity, and target those most at risk of HIV transmission
- external evaluation of social marketing campaigns and other innovative health promotion interventions targeted at gay and other homosexually active men.

#### **Achievements**

To ensure appropriate ongoing monitoring of epidemiology and behaviour of gay and other homosexually active men, an HIV Surveillance Forum was convened to review available data and consider factors contributing to an increase in HIV notifications. Additionally, the NSW Department of Health fully or partially funded the following research studies:

- Health in Men, HIV Negative Vaccine Preparedness Cohort Study, NCHSR – a cohort study of HIV-negative Sydney gay men that monitors sexual behaviour and HIV-related issues.
- Sydney Gay Community Periodic Survey, NCHSR – a six-monthly behavioural survey of gay-community attached men.
- Investigation into HIV Risk and Sexual Adventurism Among Gay Men in Sydney, NCHSR – an investigation into sexual risk taking and drug use behaviour of homosexually active men at high risk of HIV infection.
- Monitoring Risk Practices Among Asian Gay Men, NCHSR – a qualitative study surveying Sydney men from an Asian background regarding risk practices associated with HIV transmission.

In addition to the Demonstrations Projects Program, ACON and PLWHA Inc. were provided with additional funding to undertake social marketing and strengthen prevention efforts among gay men.

ACON was funded to undertake an independent evaluation of its social marketing campaigns and to implement an action research project to inform and improve education practice with ‘sexually adventurous’ gay men at high risk of HIV acquisition. The NSW Department of Health is currently in the process of contracting an independent review of contentious social marketing material.

#### **Discussion**

The strategies to address unprotected anal intercourse, as outlined in the action plan, were implemented.

Ensuring effective monitoring of epidemiology and the knowledge and behaviour of gay and other homosexually active men has been a cornerstone of NSW’s response to HIV. Significant funds were allocated to research to ensure appropriate and timely information which can inform policy and programming decision-making.

Significant resources were dedicated to fostering the development of innovative health promotion interventions through the HIV/AIDS Health Promotion Demonstration Projects Program.

#### **Challenges**

A variety of the challenges posed to effective HIV/AIDS health promotion among gay and other homosexually active men are canvassed in section 6.3.

#### **Case Study: Negotiating Safe Sex Video For Gay Youth**

Start Making Sense workshops are run by the AIDS Council of NSW for young gay and bisexual men. Each workshop runs over five nights and provides information and education, as well as social support for young gay men. The workshops run regularly throughout the year.

Every workshop includes a discussion on safe sex. A negotiating safe sex video was developed so that it could be used in the workshop to get participants talking about sexual health issues, and how to increase their skills around sexual negotiation.

The video was developed with the input of peer facilitators and young gay men, and comprises of four vignettes. Issues raised by the video include negotiating condom use and safe sex in relationships and casual encounters, and around sero-status.

Apart from use within the workshop, the video and accompanying facilitators handbook, have been forwarded to other services that work with young gay people.

Facilitators of workshops have reported the video is highly effective at prompting good discussion about negotiating safe sex. The video is currently being evaluated.

#### 4.2.2 Post-exposure prophylaxis (PEP)

Promoting awareness of PEP amongst priority population groups was identified as an appropriate secondary prevention measure, particularly in light of increasing evidence that suggests that PEP is effective if administered shortly after exposure to HIV infection and adhered to as prescribed.

The action plan identified strategies as:

- ongoing monitoring of the impact of PEP on behaviour and HIV incidence, health services and issues associated with access
- increased knowledge of PEP among gay and other homosexually active men; people in HIV serodiscordant relationships; people with HIV/AIDS; sex workers and injecting drug users
- increased PEP knowledge, skills, and awareness of NSW Department of Health policy guidelines, among general practitioners, nurses, health educators, HIV and sexual health counsellors, sexual assault workers and employees of staff who may be at risk of needlestick injury (for example, sex venue employees, commercial venues with safe disposal facilities).

#### **Achievements**

Ongoing monitoring of the impact of PEP on behaviour has been funded by the NSW Department of Health, particularly Health In Men and Sydney Gay Community Periodic Survey studies. In addition, the NSW Department of Health funded the NCHSR's HIV PEP, Changing Community, Changing Practice study.

The NSW PEP Awareness Working Group met regularly and reviewed appropriate methods to promote PEP to priority populations. A PEP social marketing campaign was conducted by ACON, in collaboration with the PEP Awareness Working Group, and was targeted at gay men, people in serodiscordant relationships and people living with HIV. Phase two of the campaign is currently being implemented.

A secondary target group for the PEP social marketing campaign, was general practitioners and health care workers. A self-directed learning package on PEP was developed and posted on the NSW Department of Health Workforce Development Program website. The website was widely promoted among health care workers throughout NSW before the social marketing campaign was released. There were 148 hits, over a six-month period, to the site containing the learning package. General practitioners who are community prescribers of s100 HIV drugs were informed about the social marketing campaign and surveyed about its impact.

Three demonstration projects that focused on PEP were funded, two of which focused on improving access and, in addition, ACON received funding to facilitate behaviour change among those accessing PEP.

#### **Discussion**

The strategies to address PEP, as outlined in the action plan, were implemented.

A study of prescribing practices highlighted that PEP is predominantly being prescribed to gay men who have engaged in high risk behaviour that may have led to exposure to HIV.<sup>4</sup>

Promoting awareness and access to PEP among priority population groups, through a social marketing campaign, was a significant focus of actions. The plan's target was that knowledge of PEP reaches 70 per cent among the targeted priority populations. A target of 70 per cent was established because previous evaluations of social marketing campaigns had demonstrated that achieving a recognition rate of 70 per cent or higher among gay men, or specific gay sub-populations, was achievable.<sup>5,6</sup>

The evaluation of phase one of the PEP campaign indicates that at the start of the campaign, awareness of the availability of PEP among gay men was 33.7 per cent, which increased to 54.3 per cent after the campaign was conducted.<sup>7</sup> Phase two of the campaign is currently being implemented and it is anticipated that knowledge levels of PEP among the targeted population groups will increase.

### **Challenges**

The actions required to support post-exposure prophylaxis being offered as an additional strategy to reduce the risk of HIV transmission are now well developed.

The actions now required are characterised by a need for ongoing maintenance of awareness among priority population groups, health care workers' awareness and skills development, and accessibility including:

- continued incorporation of PEP information and education into general health promotion programs and education resources for priority target populations
- Area Health Services monitoring the ongoing effectiveness of processes to ensure accessibility to PEP
- Area Health Services ensuring ongoing processes for information, education and skills development among health care workers, especially in services where there is a high staff turnover.

In addition to PEP, pre-exposure prophylaxis (PREP) is currently being researched overseas to determine the efficacy and feasibility of administering HIV antiretrovirals to people at high risk of transmission. It is intended that drug/s used would require once-a-day dosing.

One such international study being conducted is to assess tenofovir as a tool for preventing transmission of the virus. The study will be enrolling some 1,600 women from developing countries – three in Africa and one in Asia – who are at high risk for sexually acquiring HIV. The main goal of the study will be information on the safety and tolerability of tenofovir in an uninfected population. The study will last for one year.

It's realistic to expect that over the next three years, PREP studies may provide some indication of both the safety and efficacy of such treatment.

Concerns were expressed during the evaluation about the potential negative impact of PREP on current HIV prevention strategies, and the maintenance of safe-sex culture, the side effects of taking PREP and the cost implications. Although the implications of PREP are not yet fully understood, concerns mirror those expressed when PEP was first canvassed as a possible intervention, yet PEP has now become accepted as another tool to reduce the risk of HIV transmission.

Over the coming years, PREP has the potential to transform current health promotion and prevention messages and pose significant challenges for the AIDS program more generally. Education and awareness raising about current knowledge and limitations of PREP may need to occur with priority population groups, particularly if media interest in overseas studies is generated in the next few years.

The health promotion program needs to monitor the studies currently underway to ensure NSW is well positioned to respond to any findings that emerge and to further consider their implications for the HIV/AIDS program.

### **Recommendation:**

That the HIV/AIDS health promotion program ensures a high level of post-exposure prophylaxis awareness among priority population groups, awareness and appropriate skills development among health care workers, and appropriate accessibility.

### **Recommendation:**

That the HIV/AIDS health promotion program recognises that pre-exposure prophylaxis poses a possible challenge to HIV/AIDS health promotion and identifies appropriate actions to ensure capacity to respond.

### Case Study: PEP NOW Social Marketing Campaign

Post-exposure prophylaxis for non-occupational exposure to HIV has been available in NSW since November 1998. PEP became available because evidence indicated that PEP may prevent HIV infection if administered quickly enough after an exposure (within 72 hours).

PEP NOW was a social marketing campaign that aimed to increase awareness of the availability of PEP among gay men, people in serodiscordant relationships and people living with HIV. A secondary aim of the campaign was ensuring general practitioners and health care workers were also made aware of the availability of PEP.

The campaign was careful to ensure that safe sex and safe injecting were still promoted as the most effective means of HIV prevention and that PEP should only be considered a secondary strategy if other strategies have failed. The campaign was innovative in promoting PEP as a last-resort risk-reduction strategy and was one of the first campaigns of its kind in the world.

The campaign was developed and implemented by the NSW PEP Awareness Working Group which included representatives of Area Health Services, non-government organisations, NSW Department of Health and research centres. The working group was seen as a good model for ensuring relevant agencies work together to coordinate and address critical issues. Each agency brought a unique set of skills and expertise to the process, as well as made a commitment of resources, including financial, to ensure the campaign could proceed.

The campaign consisted of a mix of strategies and included 24-hour state-wide public telephone information service, advertisements, posters, pamphlets, and a health care worker self-directed learning package posted on the internet.

The telephone line was established to provide information, assessment and referral, and was managed by the HIV/AIDS Information Line at the Albion Street Centre – this enabled the costs of administering the PEP line to be significantly reduced. Posters were displayed at gay venues, sex on premise venues,

gay community organisations, sexual health clinics and needle syringe program centres. Advertisements were placed in a gay community weekly newspaper, and monthly injecting drug users' and HIV-positive community magazines. In addition to advertising, editorials ran in relevant print media. A letter was also sent to general practitioners who are community prescribers of s100 HIV drugs, to inform them of the campaign.

The campaign had a positive impact on raising awareness amongst the target audience. Awareness of the availability of PEP among gay men was 33.7 per cent prior to the campaign commencing, and increased to 54.3 per cent after the campaign was conducted. Importantly, 83.5 per cent of HIV-positive men surveyed knew about the availability of PEP.<sup>7</sup>

The campaign generated 493 calls to the PEP telephone line with 87 per cent from a person who had experienced a risk episode for HIV exposure. Over 94 per cent of callers to the line stated that prior to seeing the campaign they did not know how to access PEP.<sup>7</sup>

The evaluation of the campaign found that there was no evidence that promoting PEP as a last-resort HIV risk-reduction strategy resulted in erosion of safe sex messages.

A second phase of the campaign is currently being implemented to ensure awareness of PEP increases further among the target audience.

### 4.2.3 Serodiscordant relationships

Serodiscordant relationships were prioritised within the plan as research indicated such relationships were an important context in which HIV infection occurs.

The action plan identified strategies as:

- comprehensive and sustainable health promotion programs that incorporate a variety of methodologies and that are guided by best available evidence
- increased knowledge of post-exposure prophylaxis among people in HIV serodiscordant relationships
- development of greater understanding of the outcomes and effectiveness of programs to support people in known serodiscordant relationships.

### **Achievements**

Issues relevant to heterosexual serodiscordant relationships are being addressed by the HIV/AIDS Heterosexual HIV/AIDS Service through demonstration projects such as Heterosexuality and HIV/AIDS Resource Kit, Heterosexuality and HIV/AIDS Interactive Website, and through its regular workshop program. A Mid North Coast Area Health Service demonstration project on serodiscordant relationships was funded.

In addition to the demonstration projects, ACON run regular serodiscordant relationship workshops and have addressed the issue in a magazine that addresses gay men's relationships.

See section 4.2.2 for information on the strategies to promote PEP.

### **Discussion**

The plan emphasised the need for comprehensive and sustainable health promotion programs, utilising a variety of methodologies, in recognition of the complexity of issues that arise in serodiscordant relationships. While implementation of a range of health promotion programs to address the needs of people in serodiscordant relationships (as outlined above) has occurred, it remains difficult to assess, due to the lack of evaluations and benchmarks of best practice, whether the programs that have been implemented can be considered comprehensive and sustainable.

The action plan also identified the need for formative evaluation of health promotion programs and evaluation of program effectiveness in meeting needs and the mix of strategies utilised in this area, but no recent evaluations of current health promotion programs in this area have been located by the evaluation team.

### **Challenges**

It is estimated that approximately 1710 HIV-negative men are in a known serodiscordant relationship and 342 men of unknown status are in a relationship with an HIV-positive man.\*

- The Sydney Gay Community Periodic Survey reported in 2002 that 39.2 per cent of HIV-negative men and 50 per cent of men of unknown HIV status in a regular relationship with a HIV-positive partner had unprotected anal intercourse in the previous six months.<sup>15</sup>

The practice of unprotected anal intercourse in serodiscordant relationships has not changed significantly since 1997, but there is some evidence that risk-reduction strategies are being adopted.

Between 1993 and 1996, more than 50 per cent of people interviewed in a study of seroconverters attributed their seroconversion event as having occurred in the context of their relationship. Between 1997 and 2002 this had declined to less than 25 per cent.<sup>35</sup> Another study based on interviews in recent years with gay and other homosexually active men who had seroconverted showed approximately 26 per cent attributed their seroconversion event to occurring in the context of a relationship. Of these, 36 per cent had been certain their partner was HIV-negative, 36 per cent had not known their partners serostatus and 27 per cent suspected or had been certain their partner was HIV-negative (9 per cent suspected, 18 per cent certain).<sup>8</sup> While these studies indicate a reduction in HIV transmission in relationships the number of people interviewed is relatively low and there are differences in recruitment methods.

While there appears to be a large decline in the proportion of seroconversions occurring in regular relationships since the early to mid-1990s the level of risk associated with any episode of unprotected anal intercourse in the context of serodiscordant relationships is many times greater than any episode of unprotected anal intercourse in casual sex where serostatus is unknown.

\* As at 30/6/03 it is estimated that approximately 9500 people were living with HIV in NSW of whom about 80 per cent are male homosexual/bisexual (ie 7600).<sup>39</sup> The HIV Futures study undertaken in 2002 reported that 45 per cent of respondents were in regular relationships.<sup>9</sup> Over the past three Sydney Gay Community Periodic Surveys between 33.7 per cent and 53 per cent of HIV-positive respondents were in a relationship. The proportion with HIV-negative partners ranged from 47.9 per cent to 54.5 per cent and the proportion with partners of unknown status ranged

Information available from behavioural studies and other social research about serodiscordant relationships is limited. On the basis of what information is available the following points are made:

- Approximately 25 per cent of seroconversions occur in the context of serodiscordant relationships.<sup>8</sup>
- While serostatus is known in approximately 90 per cent of serodiscordant relationships,<sup>15</sup> perhaps more than 50 per cent of seroconversions in the context of serodiscordant relationships is occurring where serostatus is unknown.<sup>8</sup>
- While most men in relationships have been together for at least one year (69.7 per cent in the 2002 Sydney Gay Community Periodic Survey),<sup>15</sup> 72 per cent of those attributing their seroconversion in a recent study to occurring in their relationship, had been in that relationship for less than one year.<sup>8</sup>
- Accounts of seroconversion in relationships are couched in terms of love and intimacy or attributed to a breakdown in communication and/or trust.<sup>35</sup>

Discussions with key informants regarding interventions targeting men in serodiscordant relationships have raised the following points in addition to those listed above:

- Social research on this topic has been limited.
- Interventions promoting negotiated safety have:
  - focused on seroconcordance
  - not addressed the need for periodic renegotiation
  - not addressed renegotiation where agreement has been breached
  - have not been given priority in recent social marketing interventions.
- Little attention has been given to addressing the needs of a newly diagnosed person's HIV-negative partner.
- While peer support groups have been conducted for HIV-negative partners many men are not attracted to this type of intervention.

- Most HIV-positive men do not have unprotected anal intercourse with their regular HIV-negative partner and most are very committed to ensuring their partners do not become infected.
- Greater emphasis in health promotion interventions needs to be given to newly formed relationships, as HIV transmission more frequently occurs within newer relationships.

Given the relatively small number of people in serodiscordant relationships the role of social marketing in addressing the issue is limited. However, campaigns that reinforce HIV testing and negotiation in relationships will contribute to addressing the incidence of seroconversion where serostatus is unknown. Consideration should also be given to publicising the extent to which seroconversions in relationships occur where serostatus is not known.

Peer groups should continue to be conducted but will appeal to only a sub-population who are attracted to such interventions.

The HIV Futures study indicates the majority of HIV-positive people have contact with HIV community-based organisations.<sup>9</sup> The issue of serodiscordant relationships should be more broadly canvassed in relevant forums and publications.

Work currently being undertaken by the Australasian Society for HIV Medicine to enhance the health promotion role of GPs should incorporate this issue. This could include, given support from the positive partner, the routine offering of referral to counselling for HIV-negative partners especially when a person is newly diagnosed. There may need to be discussion with the Attorney General's Department regarding any legal implications associated with this.

The issue should be prioritised for social research.

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from 7.4 per cent to 10.2 per cent.<sup>15</sup> Assumptions underlying our estimate of the number of HIV-negative and men of unknown status in regular relationships with HIV-positive men are as follows:

- 7600 HIV-positive men
- 45 per cent of the above in regular relationships ie 3420 men
- 50 per cent of the above in relationships with HIV-negative men ie 1,710 men
- 10 per cent in relationships with men of unknown status ie 342 men

**Recommendation:**

That serodiscordant relationships are identified as a priority for the HIV/AIDS health promotion program:

- the AIDS/Infectious Diseases Branch commission research to investigate factors contributing to HIV seroconversion in serodiscordant relationships
- peer support groups for people in serodiscordant relationships continue to be conducted
- need for periodic renegotiation of negotiated safety agreements should be incorporated into social marketing strategies
- consideration should be given to highlighting in social marketing interventions the extent of seroconversions in relationships where HIV status is unknown and where the relationship is new
- non-government organisations and health services that have high levels of contact with HIV-positive people should canvas issues relevant to seroconversion risk in serodiscordant relationships more extensively
- GPs and sexual health services should be assisted in making an offer of referral to counselling for negative partners at the time of their partner's HIV diagnosis a routine event.

#### 4.2.4 Treatments and health issues (for people with HIV/AIDS)

The plan recognised that the health needs of people with HIV/AIDS extended beyond clinical care and support. It highlighted treatments and broader health issues, such as workforce re-entry, relationships, social isolation, and co-infections, as important focuses for health promotion programs.

The action plan identified strategies as:

- monitoring the health and needs of people with HIV/AIDS
- HIV and health services that are responsive to the changing needs of people with HIV/AIDS
- improved understanding of effective practice in health promotion for people with HIV/AIDS which informs program planning and implementation and strengthens service integration
- increased collaboration between health promotion planners and general practitioners.

**Achievements**

The NSW Department of Health provided funds for research to monitor the health and needs of people with HIV/AIDS including:

- *Positive health cohort study, NCHSR* – a cohort study of people with HIV/AIDS in Sydney to monitor health status and behaviour.
- *Living with HIV and cultural diversity, NCHSR* – a qualitative study investigating the lived experience of being HIV-positive and coming from culturally diverse backgrounds.
- *A spatial analysis of the needs and lives of HIV/AIDS affected people living in the Hunter Valley, School of the Environment and Life Sciences, University of Newcastle* – a needs assessment of HIV-positive people in regional NSW.
- *Negotiating ambiguity: making sense of HIV treatments, Centre for Critical Psychology, School of Psychology, University of Western Sydney* – a qualitative study investigating the diversity of peoples' lived experience of HIV.
- *Demographic and social-economic and behavioural risk factors for AIDS in the HAART Era, NCHECR* – a case control study investigating the feasibility of recruiting people living with HIV into research to establish the risk factors for AIDS in the HAART era.

To promote improved understanding of effective practice in health promotion for people with HIV/AIDS eight demonstration projects were funded.

Action to increase collaboration between health promotion practitioners and general practitioners has been addressed in section 4.3.4

**Discussion**

The strategies to address treatments and health issues for people with HIV/AIDS, as outlined in the action plan, have been partially implemented.

Monitoring of the health and needs of people with HIV/AIDS has been extensive.

The plan stated that given the rapid changes in the environment there needs to be a systematic process to ensure services, both HIV specific and general health and human services, respond to the changing needs of people with HIV/AIDS. The action plan

included initiating meetings between HIV services and other health services, such as mental health, women's health, community health and drug and alcohol. The meetings did not progress. While the meetings at a state-wide level did not progress it should be noted that many local HIV agencies have established working relationships with other local services to address specific issues as required, particularly with drug and alcohol services.

The action plan placed an emphasis on formative evaluation of health promotion programs for people with HIV/AIDS. It is unclear as to the extent that formative evaluation of current health promotion programs has occurred.

### **Challenges**

During the consultation process, the role of people with HIV in preventing HIV transmission was frequently a topic of discussion and while there was an acknowledgment that people with HIV have health promotion needs of their own, there was generally very little specific identification of what those needs are or how effectively they are currently being met.

The one consistent issue that did emerge was on the need to ensure a supportive environment for people with HIV by reducing stigma and discrimination and ensuring confidentiality was protected. This issue particularly arose in rural and regional settings. Stigma and discrimination was thought to have a negative impact on people with HIV accessing health services and seeking community support.

The NSW Department of Health has initiated an HIV Treatment, Care and Support Needs Assessment that aims to identify the needs of people with HIV/AIDS. The needs assessment is in progress at the time this report was being completed. The needs assessment is supported by the evaluation team as it should enable a review of health promotion projects targeted at people with HIV/AIDS to ensure they are appropriately focussed and addressing needs.

### **Recommendation:**

That the HIV/AIDS health promotion program reviews health promotion projects targeted at people with HIV/AIDS to ensure they are addressing the needs identified by the findings of the HIV Treatment, Care and Support Needs Assessment.

### **Case Study: Information Package For GPs Providing HIV Diagnoses**

This project trialed a new way of extending the reach of HIV resources, and particularly ensuring that information resources reach people who have just been diagnosed with HIV.

The Australasian Society for HIV Medicine (ASHM) undertook to examine how to ensure general practitioners, who may occasionally provide an HIV-positive diagnosis, had appropriate resources available for themselves and for their patients.

An information package was developed to distribute to general practitioners. The information package consisted of a letter to the general practitioner and a patient fact sheet. The fact sheet provided introductory information on HIV and treatment, and contact details for HIV/AIDS organisations.

To ensure the package could reach general practitioners, and particularly those that may not have such information readily available, ASHM negotiated with laboratories undertaking HIV testing in NSW to distribute the package to all general practitioners when an HIV-positive test result occurs. All laboratories were highly supportive and keen to participate in the project. Whenever an HIV-positive test result occurs, the information package accompanies the tests results that are forwarded to the general practitioner.

The fact sheets, in conjunction with the Multicultural HIV/AIDS and Hepatitis C Service, were translated into a number of different community languages including Arabic, Chinese, Indonesian, Khmer, Spanish, Thai, Vietnamese, Maori and the translations were made available on the ASHM website.

The project was unique and highly effective in using laboratories to ensure general practitioners have appropriate information available when they have to provide a patient with an HIV-positive test result. Given the success of the initiative, the Australian Department of Health and Ageing has provided additional funds for the project to roll out in other jurisdictions. The project was a highly commended entry for the first NSW Multicultural Communication Awards.

#### 4.2.5 Aboriginal and Torres Strait Islander Australians' sexual health

HIV/AIDS was identified within the plan as continuing to pose a serious threat to Aboriginal and Torres Strait Islander people. The plan recognised the need for Aboriginal and Torres Strait Islander HIV/AIDS health promotion initiatives to be located within a broader sexual health context.

The action plan identified strategies as:

- ongoing monitoring of sexual health and behaviour within Indigenous communities
- partnerships between Aboriginal community-controlled health services, sexual health services and HIV/AIDS non-government organisations to enable the effective implementation of sexual health programs within Indigenous communities
- improved capacity within Aboriginal community-controlled health organisations, sexual health services and HIV/AIDS non-government organisations to provide general community sexual health programs within Indigenous communities as well as targeted programs for those individuals within Indigenous communities at greatest risk of infection with HIV and other sexually transmissible diseases
- implementation of strategies which affirm the sexuality of Indigenous people, including non-heterosexual Indigenous people, in a culturally appropriate manner
- Indigenous workers being supported to meet established sexual health and generic core competency standards through providing them with professional and peer support
- greater linking with other NSW Department of Health plans and strategies, for instance, the Aboriginal Men's Health Implementation Plan.

##### **Achievements**

An important partnership initiative was convening the Aboriginal and Torres Strait Islander Sexual Health Implementation Advisory Committee (ASHAC). The committee includes representatives from: Aboriginal Health and Medical Research Council (AHMRC); AIDS/Infectious Diseases Branch; Aboriginal Health Branch; Aboriginal Community Controlled Health Services; ACON; Area HIV/AIDS Coordinators; Directors of Sexual Health Services;

Aboriginal sexual health workers; Corrections Health; and representatives from a gay, lesbian, transgender and injecting drug user (IDU) populations committee.

The main role of ASHAC is to advise on effective implementation of sexual health programs in Aboriginal communities in NSW. Its terms of reference include ensuring transparency of research and ethical practices provided for Indigenous Australians in NSW, therefore providing a forum for social and epidemiological research to be considered.

To ensure ongoing monitoring of sexual health behaviour, the NSW Department of Health is supporting a research project currently being undertaken by the AHMRC on access to services by Aboriginal people at risk of blood-borne infections and those who have blood-borne infections.

Another important partnership initiative is the NSW Aboriginal and Torres Strait Islander HIV/ Sexual Health Workers Network which continues to meet regularly to review health promotion strategies and support networking among workers. Its annual meeting includes a component set aside for professional development.

Several initiatives have sought to assist the workforce to improve the quality of health promotion programs working with Indigenous communities. The NSW Distance Learning Package, Diploma in Health Science (Aboriginal Sexual Health) is currently being piloted. The package aims to support Core Competency Standards for Aboriginal and Torres Strait Islander Sexual Health Workers in NSW. A Placement Program has been established through the NSW Department of Health Workforce Development Program in Hepatitis, HIV and Sexual Health and the NSW HIV Health Promotion Workforce Development Guidelines has a section specifically addressing the Aboriginal health workforce.

Other workforce development initiatives include the NSW Department of Health funding the Australasian Society for HIV Medicine to develop a short course on HIV medicine for health care workers in the Aboriginal and Torres Strait Islander community and Durri Aboriginal Medical Service demonstration project to run sexual health workshops for youth workers.

To affirm the sexuality of Indigenous people, including non-heterosexual Indigenous people, ACON has four projects which specifically address strategies, in partnership with the Aboriginal and Torres Strait Islander HIV/Sexual Health Workers Network, which affirm the sexuality of Aboriginal people including gay men, lesbian women, sisters, girls, and sex workers.

An important initiative to ensure greater linking with other related plans is NSW Department of Health's *Sexual Health Implementation Plan for Aboriginal and Torres Strait Islander People* which is in development. The plan will position sexual health programs and strategies for Aboriginal people in relation to the overall state and national HIV, sexual health and hepatitis C programs and strategies, as well as national and state Aboriginal Health policies, plans and strategies.

### **Discussion**

The strategies to address Aboriginal and Torres Strait Islander Australians' sexual health, as outlined in the action plan, have been implemented.

### **Challenges**

Aboriginal and Torres Strait Islanders need to remain a priority population group for the HIV/AIDS health promotion program.

The next HIV/AIDS health promotion plan needs to take account of the recommendations included in the AHMRC research project and ensure prioritisation of the actions outlined in the NSW Sexual Health Implementation Plan for Aboriginal and Torres Strait Islander People.

### **Recommendation:**

That the HIV/AIDS health promotion program prioritises implementation of the NSW Sexual Health Implementation Plan for Aboriginal and Torres Strait Islander People.

### **Case Study: Play Your Cards Right**

Among Aboriginal communities there continues to be a high rate of sexually transmitted infections. Play Your Cards Right are a set of playing cards that incorporate health promotion messages on blood-borne viruses and sexually transmitted infections. The cards were developed primarily for young Aboriginal people in the greater west of Sydney, though feedback has indicated that the cards are acceptable to a broader age range.

South West Sydney Area Health Service developed the project in collaboration with other Area Health Services and local Aboriginal medical services.

The cards were developed as an innovative way to promote health messages. Aboriginal health workers and community members considered cards as an appropriate resource as card playing is a popular leisure activity in Aboriginal communities and across all age ranges. The strategy was considered to be an effective way to tap into existing cultural structures in a non-threatening way while using simple and non-jargon language.

An Aboriginal artist designed original artwork for the back of the cards. A range of focus groups were conducted with Aboriginal health workers, elders and community members across the greater west of Sydney to ensure the cards were relevant and acceptable to the target audience.

The cards will be distributed through Aboriginal youth services and programs, Juvenile Justice Detention Centres, Aboriginal medical services, and other Aboriginal organisations across the greater west.

To support the distribution of the cards training will be offered in sexual health and blood-borne viruses and other related issues to workers in settings where the cards are being distributed. The training will support staff to provide more in-depth information to their clients.

#### 4.2.6 Illicit drug use

While the plan acknowledged that Australia has been successful in maintaining extremely low rates of HIV infections among injecting drug users, it recognised that the risk of an HIV epidemic within this population group remained substantial.

The action plan identified strategies as:

- continued monitoring of patterns of illicit and injecting drug use, of HIV and HCV infection rates among injecting drug users, and usage of needle and syringe program
- increased levels of access to needles and syringes, including, where required, an increase in secondary outlets, vending machines and an expansion of the Pharmacy Fitpack Scheme
- improved access and referral pathways to appropriate drug treatment and other services for needle and syringe program users
- increased community support for NSW needle and syringe program
- innovative health education interventions focussing on injecting drug users most at risk, increased risk or with identified needs.

#### Achievements

To enable continued monitoring of patterns of illicit and injecting drug use, the NSW Department of Health has funded a range of research studies including:

- Patterns of Injecting Drug Use, Risk Behaviours and Blood-Borne Viral Incidence Following Changes in the Drug Market: A Survey Of Metropolitan and Rural Injecting Drug Users, NDARC – a quantitative study aimed at examining the patterns of drug use in a cohort of IDU following changes in the drug market, as well as HIV risk.
- Validation of Saliva Hepatitis C Antibody Testing, NCHECR – the study aims to optimise and validate an alternative method of hepatitis C antibody testing.
- Surveillance of Hepatitis B And Hepatitis C, HIV and Related Risk Behaviour Among Prison Receptions in NSW, NCHECR – the study aims to determine prevalence of hepatitis B and hepatitis C and HIV among prison entrants and to identify risk factors.

- Periodic Survey of Drug Use Among Young People, NCHSR – the study aims to collect information on drug use among youth.
- Exploration of Drug Injectors' Understanding of Hepatitis C Infection and Implications for Transmission, NDARC – the study aims to assess IDUs knowledge of hepatitis C.
- Investigation into the Impact of Cultural Beliefs and Practices on Hepatitis C Risk-Taking and Help-Seeking Among Indo-Chinese Injecting Drug Users, School of Public Health and Community Medicine, University of NSW – the study aims to identify cultural beliefs and practices of Indo-Chinese IDUs.
- An Investigation of the Barriers and Facilitators for Hepatitis C Prevention Among Sex Workers in the Hunter Region, Centre for Clinical Epidemiology and Biostatistics, University of Newcastle – the study aims to identify barriers and facilitators to hepatitis C prevention and education service provision and to document environmental risk factors.

The Australian Department of Health and Ageing through the Council of Australian Governments Illicit Drug Diversion Initiatives – Supporting Measures Relating to Needle and Syringe Programs made available \$8.3 million to fund initiatives in NSW. The initiatives aimed to:

- diversify existing needle and syringe programs by increasing the numbers of pharmacies and other outlets distributing needles and syringes and providing them with information and support
- increase rates of voluntary entry into treatment through existing non-government organisations and community-based needle and syringe programs, including increased training and recruitment of counsellors.

The key project areas progressed in NSW through this funding over the last four years were:

- a referral, monitoring and evaluation study
- development of an NSP data and reporting system
- staff training grants
- education, counselling and referral
- enhancement of Redfern services
- safe disposal of household medical waste (used injecting equipment)

- employment of NSP development officers in Area Health Services
- pharmacy recruitment and support.

The appendix includes a list of Area Health Services projects that were funded. In addition to COAG funding, a further twelve demonstration projects were funded to demonstrate innovative health education interventions.

### **Discussion**

The strategies to address illicit drug use, as outlined in the action plan, were implemented.

### **Challenges**

The Australian Department of Health and Ageing through the Council of Australian Governments Illicit Drug Diversion Initiatives – Supporting Measures Relating to Needle and Syringe Programs has advised NSW Department of Health that for 2003/04 – 2006/07 over \$10 million will be made available for activities to support the needle and syringe program in NSW. The NSW Department of Health is currently developing a submission for this funding. Implementation of the initiatives need to be reflected in the next health promotion plan.

An important issue that has been identified during the evaluation is the higher levels of alcohol and other drug use among gay and other homosexually active men than in the broader community. The level of use is not unproblematic. Some indicators of the scope of the problem are:

- up to 25 per cent of all clients of ACON's counselling and enhanced care services being people with poly-drug use issues
- as many as 10 per cent of people with HIV being co-infected with hepatitis C
- HIV among homosexual injecting drug users
- drug use being associated with HIV seroconversion.

One submission to the evaluation suggested discussion and research about any relationship between alcohol and other drug use and unsafe sex have been a no-go area. This was not our experience during consultation for this evaluation. Stakeholders from Area Health Services and non-government organisations acknowledged the seriousness of the issue.

The actual relationship between unsafe sex and alcohol and other drug use is unclear. While alcohol and other drug use is associated with unsafe sex, whether this indicates a causative or situational (eg bars are a frequent site for meeting sex partners and alcohol use is likely to occur) is unknown. However, in a recent study of seroconverters 19 per cent reported use of crystal/ice/shabu/base at the event to which they attribute their seroconversion.<sup>8</sup> This level of use is much higher than those reporting any use over the past six months in Sydney Gay Community Periodic Surveys.<sup>15</sup> However, it is not clear whether the use of crystal is independently a factor contributing to high risk sexual practices or rather one of a range of behaviours adopted by a sub culture of gay men who engage in high-risk sexual behaviour.

A submission to this review proposes that activity in this area should include:

- research into the relationship between alcohol and other drug use and unsafe behaviours
- increasing access to alcohol and other drug-use services for gay men
- ensuring that alcohol and other drug use services for gay men and lesbians are community sensitive to these target populations
- increasing alcohol and other drug-use services around psycho-stimulant use
- health promotion and peer education within a harm reduction framework.

We endorse these proposals. We are also aware of efforts being made by ACON to place alcohol and other drug use among gay men and lesbians on the broader policy agenda of the drug and alcohol sector. We believe this is an important initiative given the high levels of morbidity associated with alcohol and other drug use in the gay and lesbian community and the extent to which socio/cultural trends established in this community often become adopted in the broader community.

### **Recommendation:**

That the HIV/AIDS health promotion program prioritises implementation of COAG Illicit Drug Diversion Initiatives.

**Recommendation:**

That drug and alcohol use is identified as a priority for the HIV/AIDS health promotion program:

- social research into the relationship between alcohol and other drug use and unsafe sex be supported
- access to alcohol and other drug-use services for gay and other homosexually active men be promoted
- work be done with alcohol and other drug-use services to ensure they are sensitive to the needs of gay and other homosexually active men and lesbians
- alcohol and other drug-use services increase their capacity to deal with psycho-stimulant use.

**Case Study: SHARP – Identifying Service Patterns And Health Promotion Opportunities Targeting Illicit Drug Users**

The Service, History, Activities and Registration Program (SHARP) is a networked database information management system that aims to broaden the information that is collected on needle and syringe program clients. The aim of the system is to profile the client group, increase brief interventions around risk behaviour, increase referral to other services and enhance the skills of NSP workers.

The system is implemented in outlets where there is face-to-face contact with clients, such as in primary outlets.

The Central Coast Area Health Service has developed, piloted and implemented the system. Every client of the NSP is offered the opportunity to opt-in to the system. If they choose to opt-in then a range of demographic and risk behaviour information is collected and entered into the system. To ensure their confidentiality, names and addresses are not collected. Each client is provided with a unique identifier, which they then use when accessing the NSP. It was important that the establishment of the system didn't dissuade clients from using the program and that it continued to protect their confidentiality. Clients were assured that whether or not they opted-in to the system, it would not affect their access to services or their rights.

All staff were provided with training in using the system, and in strengthening their education, intervention and counselling skills.

An important feature of the database are its flag and prompt features. These features facilitate brief intervention with clients. Every month a new question is prompted when the client accesses the service. The question facilitates discussion of health issues with clients, builds client rapport with staff and has generated a higher level of referral to other services. Flagging enables, for example, a client to be followed-up if they had previously been referred to another service.

To date 1395 clients have registered since the system commenced. During the reporting period, 70 per cent of syringes distributed through the five staffed NSP outlets went to registered clients.

Since the system commenced operation there has been a significant increase in client referral requests to other services from 222 in 2000/2001 (one referral in every 44 occasions) to 432 in 2002/2003 (one referral in every 23 occasions). The system has enabled referral requests to be recorded and, in conjunction with a referral project, has facilitated an increase in client referral.

Another important advantage of the system is it has enabled the NSP to better service the needs of its clients. The database can help inform service provision by identifying client demographics, drug trends, risk behaviours and at-risk groups. It has enabled service provision to be evidence-based.

Anecdotal evidence has suggested clients are receptive to the increased level of interaction that occurs with staff as a result of the implementation of the system.

The success of the database has resulted in it being sold to other Area Health Services.

#### 4.2.7 HIV and sexually transmissible diseases

Sexually transmitted diseases (STDs) were addressed within the plan where they were specific to or overlap with HIV. There was a particular focus on the role STDs play in facilitating transmission of HIV, STDs impact on the health of people with HIV and increasing rates of gonorrhoea among gay men.

The action plan identified strategies as:

- improved understanding of the sexual health promotion needs of priority population groups, and of the sexual health promotion approaches most likely to be effective
- increased knowledge, testing and treatment of sexually transmissible diseases within priority population groups
- development of clinical guidelines for sexually transmissible diseases management among priority population groups.

##### **Achievements**

Two specific projects were funded to improve understanding of the sexual health promotion needs of gay men. The NSW Department of Health provided funding to NCHECR to examine the Prevalence Incidence and Risk Factors for STIs Among Gay Men and to South Eastern Sydney Area Health Service to implement Sexual Health Promotion for Gay Men demonstration project.

The Sexually Transmissible Infections in Gay Men Action Group continued ongoing initiatives to address the health promotion needs of gay and other homosexually active men and worked to produce and promote STI Testing Guidelines Among Men Who Have Sex With Men. The STI Testing Guidelines were developed with extensive input from general practitioners and health care workers. Health care workers were invited to the launch of the guidelines in 2002. The launch was followed by additional promotion and distribution strategies, such as coverage in the medical press, and Area Health Service initiated STIs training for general practitioners. Further training courses are currently planned.

The NSW Department of Health also provided funding to the Australasian College of Sexual Health Physicians to enable the production of Clinical

Guidelines for the Management of STIs Among Priority Populations. The guidelines were broadly distributed by the College.

The NSW Department of Health implemented or provided funding for other organisations to implement a range of social marketing campaigns in response to outbreaks. Initiatives include:

- The NSW Department of Health multi-phased public information and awareness campaign in 2003 on chlamydia, which was enhanced by local Area Health Service initiatives
- syphilis campaign produced by ACON and jointly implemented with South Eastern Sydney Area Health Service
- hepatitis A campaign produced by an interagency group
- shigellosis campaign produced by an interagency group
- sexually transmitted diseases information booklet produced by ACON.

##### **Discussion**

The strategies to address HIV and sexually transmissible diseases, as outlined in the action plan, were implemented.

One measure of success was knowledge of STDs, on data items to be determined, reaches 70 per cent within agreed populations. While a range of information campaigns targeting specific STDs were implemented, pre- and post-campaign knowledge levels among the target audience was not collected, which prevents us from assessing the effectiveness of such campaigns.

Strategies to promote the sexual health guidelines amongst gay men are currently in development.

##### **Challenges**

Chlamydia and gonorrhoea rates remain high among gay and other homosexually active men, and syphilis rates are now increasing.

Considerable evidence demonstrates that sexually transmitted infections can play a significant role in facilitating transmission of HIV, and in people with HIV can result in increased viral load and reduced immune function. Reducing transmission of STIs and, more generally, promoting good sexual health needs to

remain an important goal for HIV health promotion programs as well as reducing the morbidity independently associated with sexually transmitted infections.

The development of clinical guidelines for management of STIs within priority population groups, and accompanying promotion of guidelines and skills development among health care workers, was a significant achievement, as were the implementation of campaigns improving awareness of specific STIs among gay men and people with HIV/AIDS.

Actions now need to focus on promoting the need for regular sexual health check-ups amongst priority population groups and ensuring increased sexual health literacy.

**Recommendation:**

That the NSW Department of Health develops a sexual health plan to address the health implications of STI transmission.

**Recommendation:**

That the HIV/AIDS health promotion program continues to promote the need for regular sexual health check-ups and sexual health literacy among priority populations groups, particularly awareness of the contribution of STIs to increased infectivity and susceptibility to HIV infection.

**Case Study: STIGMA and the STI Testing Guidelines For Men Who Have Sex With Men**

Sexually Transmitted Infections in Gay Men Action Group (STIGMA) was convened by South Eastern Sydney Public Health Unit to respond to outbreaks in infectious diseases, including hepatitis A, shigella and gonorrhoea, that were experienced by the inner Sydney gay community.

The group includes researchers, ACON, South Eastern Sydney Area Health Service, Central Sydney Area Health Service, HIV Study Group, and Division of General Practice. Area Health Service representatives include HIV and sexual health promotion units, sexual health clinics and public health units.

STIGMA's purpose is to provide a structure for ongoing communication, collaboration and public health action. It provides a mechanism whereby

surveillance data can be used to inform the development of prevention and health promotion activities. STIGMA has proven an effective model for working across areas and ensuring public health researchers, general practitioners and health promotion workers coordinate responses to infections.

A key initiative of the group was the development and dissemination of STI clinical testing guidelines for men who have sex with men. The guidelines were produced to respond to identified sexual health needs of homosexually active men, and to encourage the development of regular testing for sexually-transmitted infections.

The guidelines aimed to assist health care workers who care for homosexually active men, particularly doctors providing HIV/AIDS care, in looking after their sexual health needs. The broad and consultative process to develop the guideline was in itself an important part of raising GP awareness of STI issues for gay and other homosexually active men.

Following the completion of the guidelines a range of strategies were developed to ensure they were well promoted and distributed, to support health care workers in their implementation and to make sexually active gay men aware of their need to regularly test for STIs.

The guidelines were launched in 2002 and were followed by additional promotion and distribution strategies, such as coverage in the medical press and GP newsletters. It was recognised that ensuring clinicians were aware of the guidelines and supported in their implementation meant providing appropriate training. A range of workshop sessions have been held for GPs and health care workers. The focus of many of these workshops has been on addressing the sexual health needs of patients, with a significant focus on the sexual health needs of gay and other homosexually active men. This has ensured that the workshops attract a broad audience.

The workshops have been collaboratively staged and have been very effective at attracting health promotion and allied health professionals. To date over 250 people have attended the sessions staged in South Eastern Sydney Area Health Service and Central Sydney Area Health Service. Further training courses are planned.

Another important component in implementing the guidelines is the promotion of regular STI testing to gay and other homosexually active men. Currently a social marketing campaign, which includes press advertisements, posters, pamphlets and a website, is being finalised. The campaign aims to raise gay men's awareness of the need for regular STI testing, and will complement the work already undertaken with health care professionals.

#### 4.2.8 Vaccines

The plan prioritised vaccines as an important issue for HIV/AIDS health promotion due to the expectation that a human trial of an HIV vaccine was scheduled to occur in Sydney during 2002.

The action plan identified strategies as:

- monitoring of the impact of vaccine trials on risk-taking among population groups recruited to the trial
- increased knowledge of vaccine trials among population groups recruited to the trials.

#### Achievements

To ensure the impact of vaccine trials on behaviour could be specifically monitored the NSW Department of Health provided funding to the NCHSR's Health in Men study. Health in Men is a cohort study of HIV-negative Sydney gay men that monitors sexual behaviour and HIV-related issues and in preparedness for vaccine trials. The establishment of the cohort ensures necessary behavioural data is obtained before commencement of a vaccine trial.

#### Discussion

The impact of vaccines was minimal during the implementation of the plan as vaccine trials, specifically large-scale phase three trials, did not commence recruitment as was originally anticipated. As a result, the implementation of health information and education projects on vaccine trials, as outlined in the action plan, was not required at this point in time.

Strategies to ensure the potential impact of vaccines trials on risk-taking among HIV-negative gay men could be monitored, when such trials commence, were implemented.

#### Challenges

The HIV/AIDS health promotion program will need to acknowledge that vaccines may emerge as an issue that requires prioritisation over the coming period. It also remains important that there is ongoing monitoring of the impact that media coverage of local and international vaccine trials has, if any, on safe behaviours.

#### Recommendation:

That the HIV/AIDS health promotion program recognises the need to ensure ongoing monitoring of the impact of vaccine trials upon the behaviour of priority population groups and, if required, to ensure the program has the capacity to respond.

#### 4.2.9 Testing and late diagnosis

The plan identified that while HIV testing rates among gay men generally remained high, there was some research indicating that gay men under 25 may increasingly not be presenting for HIV testing and that Asian gay men were also less likely to have had an HIV test.

The plan also identified that while AIDS diagnosis had dropped dramatically, there was a concern about the increasing proportion of AIDS diagnoses which occur within three months of an HIV diagnosis and that HIV late diagnosis has been associated with increasing age, heterosexual contact and being born in countries in sub-Saharan Africa or Asia.

The action plan identified strategies as:

- continued monitoring of HIV testing patterns and frequency among gay and other homosexually active men, and monitoring of characteristics of late presenters
- strengthening of HIV testing messages, particularly those targeted at gay men under 25 and people from a non-English-speaking background, and promotion of a pattern of HIV testing that is appropriate to risk behaviour
- increase targeted promotion of HIV testing among those groups who have been identified as late presenters.

### **Achievements**

To ensure ongoing monitoring of HIV testing patterns the NSW Department of Health funded the Health in Men and Sydney Gay Community Periodic Survey studies.

A range of projects were funded to strengthen HIV testing messages and target population groups who have been identified as late presenters. Four demonstration projects were funded to strengthen HIV testing messages and strategies including: Promoting HIV Testing Among Young Gay Men, Western Sydney Area Health Service; General Practitioner Liaison Project, Northern Sydney Area Health Service; Non-English-Speaking Background Gay Men's Project, Multicultural HIV/AIDS and Hepatitis C Service (MHAS); and Developing Culturally and Linguistically Appropriate Resources, MHAS. Evaluations of demonstration projects has yet to occur given most projects are still in progress.

The NSW Department of Health also provided funding to ACON's Strengthening of HIV Testing Messages Project. The project strengthened HIV testing messages through social marketing, 'Get tested for free' campaign, that targeted Asian gay men.

### **Discussion**

The strategies to address HIV testing and late diagnosis, as outlined in the action plan, were implemented. While the action plan included an audit of HIV-testing messages targeted at gay men, rather than undertake a separate audit this was incorporated into projects funded to address HIV testing and late diagnosis.

### **Challenges**

The February 2003 Periodic Survey reports that HIV testing rates among young gay men are now similar to that of the overall gay community.<sup>38</sup> Ongoing promotion of HIV testing among gay and other homosexually active men, including specific targeting of young gay men and Asian men, will contribute to HIV testing levels increasing in these groups.

Some rural Area Health Services show similar levels of HIV diagnoses to AIDS diagnoses. This may be an indication of late diagnosis and should be further investigated.

Until the early 1990s there appeared to be a greater likelihood of HIV spreading more broadly across the population. Because of this the possibility of HIV infection outside the population groups most at risk was more likely to be considered by GPs. While unnecessary HIV testing should be minimised, increasing the awareness of seroconversion illness among GPs might contribute to earlier diagnosis among those usually considered to be at lower risk. This could include, for example, consideration of flu-like symptoms outside normal flu season as a possible indication of seroconversion illness. In this situation, GPs could be encouraged to discuss with patients any possible HIV risk behaviour.

More generally strengthening the involvement of GPs in sexual health as discussed elsewhere in this report may assist in earlier diagnosis.

Issues relevant for people from culturally and linguistically diverse backgrounds, including HIV testing and late diagnoses, are discussed in section 6.2.

### **Recommendation:**

That late diagnoses is identified as a priority for the HIV/AIDS health promotion program:

- interventions continue to promote HIV testing to young gay and other homosexually active men and Asian gay men specifically, and as part of more broadly targeted campaigns to gay and other homosexually active men
- patterns of HIV and AIDS diagnoses in rural Area Health Services be investigated regarding possible late HIV diagnoses
- periodic inclusion of information regarding HIV seroconversion illness occur in publications for GPs.

### Case Study: HIV Late Presentation Project

Addressing the issue of HIV late diagnoses was an important priority area within the plan. Research has identified that late HIV diagnoses are significantly associated with heterosexual contact and/or being born in a non-English speaking country, particularly in Sub-Saharan Africa or Asia.

To address HIV late diagnoses the Multicultural HIV/AIDS and Hepatitis C Service has established a three-year project. The project aims to target particular communities with HIV/AIDS information and education and enhance those communities capacity to respond to HIV/AIDS issues. The project, to date, has largely focussed on working with both community members and community workers.

The project commenced by undertaking a consultation process which identified African communities, Cambodian, Thai, Spanish and Vietnamese communities as priorities. A consultation process among people with HIV/AIDS from culturally and linguistically diverse backgrounds identified the barriers to early presentation as being poor knowledge of HIV and HIV services, as well as fear of HIV test results.

Working with such diverse communities meant that a range of different approaches were used, particularly as some individual communities are small in numbers. An important first step was establishing a rapport with community workers and organisations. In some communities there was hesitation, distrust and a reluctance to become involved. The reasons varied but a common theme was due to the stigma attached to HIV/AIDS and fear about their community being further stigmatised. At other times the reluctance was due to HIV/AIDS not been accepted as an important community issue.

All initiatives were developed collaboratively with community organisations. This was important to

ensure that such activities were well supported and also as a way of enhancing the capacity of organisations to address HIV/AIDS issues. Importantly, the project recognised that work with communities needs to be ongoing to build and sustain rapport and maximise community participation.

A range of education initiatives were implemented targeted at different priority communities. For example an HIV workshop for Cambodian women attracted more than seventy participants. HIV radio dramas, developed by a Vietnamese playwright, were broadcast on 2-VNR, a 24-hour Vietnamese radio station, and evaluated strongly with listeners.

African communities' initiatives involved developing the *African Australians Against AIDS* poster, and sponsoring and organising a small soccer tournament featuring four African country teams in October 2002. The soccer tournament was a novel way of attracting community members to an event and ensuring HIV messages could be disseminated. The tournament was organised again in October 2003 with four different teams and there are plans to expand this initiative in 2004.

In addition, the project has focussed on developing the capacity of community workers. For example, the project has established an African Workers HIV/AIDS Network that meets regularly and supports workers in responding to HIV/AIDS issues. In addition to providing training to Network members in HIV/AIDS issues, the project is developing workers' understandings of the HIV sector and HIV services to ensure there is ongoing capacity within communities to respond to HIV/AIDS.

To date the project has demonstrated considerable success in working with communities and community workers to address HIV/AIDS issues, in 2004, the project will focus more closely on initiatives with HIV sector workers and general practitioners.

### 4.3 Infrastructure issues

The plan recognised that while the infrastructure to support the response to HIV/AIDS is well developed in NSW, that some elements required ongoing attention and further development.

The issues identified within the plan included:

- quality improvement
- research and evaluation
- workforce development
- collaborative processes
- planning and coordination.

The infrastructure issues are examined in relation to the specific strategies and action outlined in the action plan attached to the *NSW HIV/AIDS Health Promotion Plan 2001–2003*.

#### 4.3.1 Quality improvement

The plan emphasised the importance of ensuring high quality HIV/AIDS health promotion programs. It placed a particular emphasis on ensuring minimum levels of service for HIV health promotion.

The action plan identified the strategy as:

- development and implementation of minimum standards of health promotion service levels.

#### Discussion

Overall, there was significant effort and resources directed towards improving data collection systems for sexual health and health promotion projects. While the action plan identified the need to review and update minimum levels of service for HIV health promotion, as outlined in *A Guide to AIDS Program Funding for Area Health Services and Regions 1992/93*, efforts were instead directed to NSW Department of Health's Sexual Health and HIV Health Promotion Data Set Project.

The Sexual Health and HIV Health Promotion Data Set Project aims to develop a data collection system for sexual health and health promotion projects.

The project has been piloted in four sites.

Further protocol and policy work needs to be undertaken before the project can be implemented across the state.

#### Challenges

We recommend that the Sexual Health and HIV Health Promotion Data Set proceed and that consideration be given to including information on:

**Aims** – Within the proposed minimum data set is a data item 'sexual health promotion issue'.

We recommend that the specification of fields be amended to reflect contributory factors – the modification of which will constitute project aims.

**Settings** – Settings needs to describe the primary place where an intervention occurs. A new data item will need to be added to the proposed data set to incorporate settings.

**Resources** – Resources include direct costs of salaries used to implement the project and costs of goods and services. It should not include overheads such as time spent by managers managing project staff. The proposed minimum data set provides a basis for determining human resource costs. Goods and services costing would need to be reported separately.

Standardised annual project reports will allow organisations to benchmark inputs and outputs of projects they implement against similar work as well as provide the data necessary for evaluating health promotion outcomes.

#### Recommendation:

That the NSW Department of Health proceeds with the Sexual Health and Health Promotion Data Set incorporating changes to take account of aims, settings and resources.

#### Recommendation:

That funded organisations submit annual project reports in accordance with the proposed sexual health and health promotion data set. Reasons should be provided for any variation from original project outlines.

### 4.3.2 Research and evaluation

Research and evaluation was recognised as playing a critical role within the plan. The NSW Department of Health acknowledged its commitment to a collaborative approach to research that involves affected communities, and support for the funding of both quantitative and qualitative research which can inform HIV/AIDS health promotion programming and policy. The plan identified developing greater understanding of what constitutes effective health education and promotion as an area requiring further attention.

The action plan identifies strategies as:

- HIV/AIDS health promotion practice which is informed by timely and reliable NSW HIV and AIDS surveillance data
- improved planning, coordination and utilisation of research in NSW
- improved understanding of effective practice in HIV/AIDS health promotion.

#### **Achievements**

To ensure ongoing monitoring of HIV and AIDS, the first *Annual Report of NSW Based Activities* was produced by NCHECR which combined NSW-based epidemiological data relating to HIV, viral hepatitis and sexually transmissible infections. To monitor and review the quality of the HIV and AIDS surveillance system a Surveillance Forum was held in July 2003.

To improve planning and coordination of research in NSW, the Social Research Advisory Committee was convened consisting of representatives from the national centres in HIV, independent researchers, Area Health Services, non-government organisations and NSW Department of Health. The committee provided advice to the Department on strategic directions for the research program. The advisory committee met three times during the life of the plan.

Strategies to ensure research informed HIV/AIDS health promotion programming and policy included funding NCHSR to develop a quarterly HIV/AIDS Social Research Brief Newsletter that disseminates findings of research and program evaluation, and the Research to Practice Project which aimed to enhance practitioner skills in using social research. Additionally, the NSW Department of Health provided sponsorship

to the 14th Annual Australasian Society for HIV Medicine Conference and 4th Annual National Health in Difference, Gay, Lesbian, Transgender and Bisexual Health Conference.

Further dissemination of research occurred at the Implementation Forum Series and Annual State-wide NSP Workers Meeting and at the regular roundtables convened by ACON which addressed a broad range of topics.

To improve understanding of effective practice in HIV/AIDS health promotion, nine research project were commissioned as part of the HIV/AIDS Health Promotion Demonstration Projects Program.

#### **Discussion**

The actions to address research and evaluation issues, as outlined in the action plan, were implemented.

The Social Research Advisory Committee was disbanded as its role could be appropriately assumed by the CAS Health Promotion Sub-Committee.

While the research funded through the HIV/AIDS Health Promotion Demonstration Projects Program have addressed priority areas and will be able to inform health promotion programming and policy, for the most part, research projects have not focussed on examining the effectiveness and quality of health promotion interventions. There is still an ongoing need to ensure greater attention is given to developing a greater understanding of what constitutes effective health promotion.

#### **Challenges**

In section two of this document we outlined a health promotion outcomes framework which was used to review the NSW HIV/AIDS health promotion program. The model identified the need to measure health and social outcomes, intermediate health outcomes and health promotion outcomes. This model can be used for the ongoing measurement of the NSW HIV/AIDS health promotion program.

In NSW the information required to measure HIV health outcomes is readily available. For example, the NSW Department of Health surveillance system provides accurate information on HIV diagnoses, AIDS diagnoses and AIDS death. By comparison with

overseas jurisdictions information is provided on a timely basis and is readily available. A comprehensive subset of demographic and other information is also available. While the quality, timeliness and comprehensiveness of data is already high ongoing effort is being made to bring the system in line with world best practice.

In addition, the Australian HIV Observational Database maintained by the National Centre in HIV Epidemiology and Clinical Research provides more detailed information regarding disease progression and the medical management of people with HIV.

Intermediate health outcomes include risk behaviour, infectivity, regular health monitoring, treatment, susceptibility, access to health services etc. In NSW, comprehensive monitoring occurs among gay men most at risk of HIV infection.

However, there is no regular behavioural monitoring of homosexually active men outside of Sydney or not involved in the Sydney gay community. Surveys that included a wider population of gay and other homosexually active men were conducted with Australian Government funding by the National Centre in HIV Social Research in 1996 and 2000. The possibility of repeating the survey on a two-yearly basis should be discussed with the Australian Department of Health and Ageing and the National Centre in HIV Social Research.

Among other population groups the quality of information in regard to intermediate outcomes varies. The quality of information related to injecting drug users is comparable to gay and other homosexually active men. Sexual health service data could be collected on a routine basis to monitor intermediate outcomes for sex workers. Discussion should occur with appropriate authorities to enhance the quality of information available regarding Aboriginal and Torres Strait Islander populations. Surveillance data is adequate to identify any emerging needs in other population groups.

Health promotion outcome information is poor in NSW. There is no consistent or systematic collection of health promotion outcome measures. The discussion in section 4.3.1 regarding quality improvement and the associated recommendation canvasses the action required to address this deficiency.

Information is needed on improvements in health literacy, healthy public policy and social action and influence. For example, improved knowledge, skills, access to health services, enhanced social support, reinforced social norms etc.

The quality of program and project planning as well as evaluation varies widely across NSW. In some organisations there is a strong culture of planning and evaluation. This was reflected in project profiles presented to the evaluation team that have clear measurable aims, strong rationale for interventions selected, are based on both qualitative and quantitative needs analysis, explicitly quantified project inputs and include a process for evaluation. However, it was also apparent that some projects have almost none of these features.

There is also some frustration among funded organisations at the frequency of reporting requests and the variability of reporting requirements. As outlined above (section 4.3.1), work has occurred on developing a Sexual Health and Health Promotion Data Set. We recommend that Sexual Health and Health Promotion Data Set project proceed, though incorporating changes to facilitate measurement of health promotion outcomes.

**Recommendation:**

That the NSW Department of Health discusses with the Australian Department of Health and Ageing and National Centre in HIV Social Research the need to undertake regular behavioural surveys that focus on non-gay-identified homosexually active men.

**Recommendation:**

That the NSW Department of Health ensures data collected by sexual health services be monitored to identify on an ongoing basis service utilisation by sex workers.

**Recommendation:**

That the NSW Department of Health discusses with the National Centre in HIV Social Research and the Sex Workers Outreach Project and other key service providers the development of systems to monitor the sexual behaviour of sex workers.

**Recommendation:**

That the NSW Department of Health discusses with the Aboriginal Health and Medical Research Council the possibility of establishing mechanisms to monitor sexual health service utilisation and sexual behaviour among Aboriginal and Torres Strait Islander populations.

**4.3.3 Workforce development**

A skilled and knowledgeable HIV/AIDS workforce was recognised as an essential element in ensuring the development of effective health promotion responses to HIV/AIDS.

The action plan identified strategies as:

- improved skills development, knowledge and collaboration among health promotion workers, including NSP, in both government and non-government organisations
- increased opportunities for the development of workplace learning and reflexive practice.

**Achievements**

A range of forums were convened to support the implementation of the plan and improve the skills, knowledge and collaboration among health promotion workers. Forums convened included the NSW Partnership Forum on Gay Community Responses held on 11 May 2001; the Implementation Forum held on 13 November 2001 and attended by more than 220 people; the Implementation Forum Series, a series of six forums staged between 2002 and 2003 and attended by over 220 people; and the Annual State-wide NSP Workers' Meeting which was conducted in September 2002 and September 2003 and evaluated with positive outcomes.

In addition, ACON conducted a series of round-table discussion forums for ACON staff, community-based organisations, and Area Health Services. The round tables covered topics such as recreational drug use, ageing, gay men's health, social determinants of health, violence and homophobia and their links to behaviour.

Other workforce development initiatives include a core competency-based training program developed and produced by the NSP Workforce Development Project and offered in partnership with the Centre for

Community Welfare Training, and a series of seven extension modules for local implementation. An accredited training-and-learning project for gay educators in non-government organisations has been completed by AFAO with participation from AFAO member organisations. A similar project is currently underway targeting sex workers and is being auspiced through Australian Injecting and Illicit Drug Users League and based at the Sex Worker Outreach Project (SWOP).

To promote opportunities for workplace learning, the HIV Health Promotion Workforce Development Guidelines were developed to support Area Health Services and non-government organisations to produce Workforce Development Plans.

**Discussion**

A range of actions to address workforce development initiatives have been implemented. With the exception of adapting and trialing of the AFAO developed accredited training and learning framework across NSW, all actions, as outlined in the action plan, were implemented. Instead of trialing the AFAO developed accredited framework, resources were devoted to the development of the HIV Health Promotion Workforce Development Guidelines.

**Challenges**

While a range of workforce development initiatives has been implemented, many of these by the Workforce Development Program, and were generally well received, some significant gaps in workforce development have been identified.

These gaps reflect a general sense that attracting suitably qualified and experienced staff to HIV health promotion remained an ongoing difficulty for many agencies, and as a result there was a need to ensure a good mix of learning and training opportunities, both formal and informal, were available to staff.

**Training**

Throughout the consultation process there was a consistent need expressed for an HIV health promotion training workshop, particularly for workers new to the field.

There was widespread recognition that while a component of such training is about generic health promotion knowledge and skills, there is a component of such training that is specific to HIV, particularly what can be considered best practice in HIV health promotion.

Recently the Albion Street Centre Education Unit has commenced offering a three-day training course. The HIV/AIDS, Sexual Health and Hepatitis C Health Promotion course is targeted at those wanting to learn about the theory and application of health promotion for HIV/AIDS and hepatitis C.

The course addresses the workforce development needs that were identified during the stakeholder consultation. The course now needs to be widely promoted to the HIV health promotion workforce.

#### ***Annual professional practicum series***

To build evidence for and promote innovation in public health and workforce development the Workforce Development Program, as one component of a multi-pronged strategy, conducts professional practice and dissemination forums. Accompanying the release of the plan, a range of such forums were convened to support the HIV workforce. These forums were seen as useful and effective by the HIV workforce, and much value was attached to the importance of bringing together the diverse HIV workforce.

A common view expressed during the consultation process was that there were inadequate ongoing opportunities to showcase and discuss the latest in HIV health promotion practice and to consider the challenges facing HIV health promotion. Particular reference was made to the lack of such opportunities in regards to the demonstration projects.

While there are ongoing initiatives to support NSP workers and Aboriginal and Torres Strait Islander sexual health workers in developing their knowledge and skills, there needs to be a regular forum series, or similar such initiative, undertaken for general HIV/AIDS health promotion workers. Such opportunities may gain increased significance in an environment where the potential for further funding enhancements are limited, and therefore greater emphasis may need to be given on learning and adopting health promotion interventions that have already been developed, piloted and evaluated by other agencies.

#### ***NSW HIV Health Promotion Workforce Development Guidelines***

The NSW HIV Health Promotion Workforce Development Guidelines have been developed to support AIDS program-funded Area Health Services and non-government organisations to produce workforce development plans.

Workforce development plans will be developed by funded organisations on the basis of an assessment by those organisations of the learning and development needs of their HIV/AIDS health promotion workforce. The development of the plans will be a requirement of the AIDS Program funding commencing in the 2004/2005 financial year.

The NSW Department of Health and Workforce Development Program needs to develop a process to support the introduction of a funding requirement that workforce development plans are produced. Many managers of health promotion programs experience of workforce development is limited, particularly in terms of giving consideration to how informal and formal learning opportunities can occur in the workplace as encouraged within the guidelines. The implementation of workforce development plans provides an excellent opportunity for the development of innovation in workforce development.

#### ***Core-competency accredited training and learning program***

The NSW HIV Health Promotion Workforce Development Guidelines identify competency-based learning as a form of individual vocational learning. This usually recognises prior learning and includes training sessions and work-based activities, where skills and knowledge (the competencies) are measured against a set of nationally defined standards to measure an individual's level of capacity to fulfil a particular job role.

A range of competencies and accredited training and learning programs have been or are being developed for the HIV workforce. Examples include the Diploma in Social Sciences (Aboriginal Sexual Health) that supports the Core Competency Standards for Aboriginal and Torres Strait Islander Sexual Health Workers in NSW, or the competency-based training program being developed and produced by the NSP Workforce Development Program.

During the evaluation, support was expressed, as well as some reservations, regarding the introduction of core-competency accredited training and learning program for the HIV health promotion workforce. Those in favour believed such a program is particularly useful for developing the skills of those with limited formal education or for those who are new to health promotion, and for ensuring the issues of workforce development were tackled in a systemic and comprehensive manner. Those who expressed reservations, felt that while such a program in principle should be supported their previous experience with such programs meant they had some reservations regarding the rigour of processes used to assess staff skills prior to accreditation, particularly recognition of prior workplace learning, and that such a program needed to be sustainable.

If a program was to be developed for the NSW HIV health promotion workforce, it would be able to be adapted from an existing program, such as the AFAO accredited training and learning project for health educators working in non-government organisations. The development of such a program would require a short-term project to adapt and implement the initiative and establish sustainable structures.

**Recommendation:**

That the Workforce Development Program undertakes the following initiatives:

- promote access to existing HIV health promotion courses
- implements an annual professional practicum series for HIV health promotion workers
- identifies appropriate strategies, in collaboration with the AIDS/Infectious Diseases Branch, to support the implementation of the NSW HIV Health Promotion Workforce Development Guidelines.

**Recommendation:**

That the NSW Department of Health explores the feasibility of funding a short-term project, under the auspices of the Workforce Development Program, to develop a core-competency accredited training and learning project in HIV and sexual health promotion.

**4.3.4 Collaborative processes**

The plan recognised that for health promotion to be effective it requires effort from a broad range of health care professionals. The plan particularly highlighted the influential role of general practitioners in prevention and addressing the health promotion needs of people with HIV/AIDS.

The action plan identified the following strategy:

- improved collaboration between health care professionals and health promotion practitioners in the implementation of health promotion strategies.

**Achievements**

The CAS Health Promotion Sub-Committee has worked to identify how to strengthen the interface between HIV/AIDS health promotion and primary health care by initiating a review project.

The review project will provide recommendations on how more effective integration of HIV/AIDS health promotion activities with mainstream general practice infrastructure (such as the Divisions of General Practice) and the activities of general practice can be achieved and sustained. The review report will clarify the varied roles and responsibilities of relevant stakeholders and include a set of recommendations.

To further support prevention efforts in primary care settings, NSW Department of Health funded the Australasian Society for HIV Medicine to undertake the Supporting Care and Prevention Effort Project (SCAPE). The project has undertaken research examining the needs of general practitioners and is currently undertaking activities to develop the skills of general practitioners. In addition, at least two demonstration projects are underway that include a significant focus on working to increase the skills of GPs. The outcomes from these projects need to be monitored and reviewed.

**Discussion**

Strategies to review current practice and consider how to improve the interface between HIV/AIDS health promotion and primary health care are in progress.

**Challenges**

General practitioners have direct contact with the vast majority of people most at risk of HIV. Most gay men have an HIV test regularly and, in most cases, from

their general practitioner. GPs also have regular contact with people with HIV/AIDS on an even more frequent basis.

A focus on how to support GPs to more effectively work with at risk populations and individuals to further reduce the risk of HIV and STIs transmission and continue to improve the health and well-being of people already living with HIV remain a priority. Initiatives, such as the ACON Enhanced Care Project, continue to contribute to health promotion efforts to strengthen partnerships. Strengthening partnerships between health promotion, sexual health clinics, general practitioners and Divisions of General Practice also remains important.

**Recommendation:**

That the HIV/AIDS health promotion program prioritises strategies to strengthen the interface between HIV/AIDS health promotion and primary health care.

**Case Study: GP/Sexual Health Liaison Project**

An important feature of the health promotion plan was recognising the role of general practitioners in health promotion and the need for collaborative processes to be developed between partner organisations. Western Sydney Area Health Service has established a sexual health project, based at Parramatta Sexual Health Clinic, to liaise with general practitioners. The placement of the project officer in the specialist clinic environment was the first key project strategy.

The project recognises that while sexual health clinics provide an important specialist service, general practitioners regularly see patients for issues relating to sexual health. The project aims to develop strategies to support, resource and educate GPs to address sexual health issues. It is hoped that an outcome of the project will be that GPs are more skilled in sexual health medicine, with sexual health clinics providing a specialist role.

For the project to be successful it recognised that there needs to be support for and agreement on the strategies that should be adopted. A comprehensive literature review was undertaken to examine relevant issues and their implications for the project were considered. In addition, a range of interviews were

conducted with staff in the HIV/Sexual Health Promotion Unit, the sexual health clinic, the Division of GP, WentWest (private GP education consortium) and with other stakeholders.

To ensure sustainability the project sought to create an ongoing structure, which would actively involve the key partners and seek their ongoing input and support. The GP Sexual Health Liaison Forum was established to fulfil this role. The forum consists of representatives from the Division of GP and sexual health specialists (including sexual health promotion specialists).

While the project is still ascertaining the details of GPs' needs, it has already identified that a range of strategies is required to effectively achieve its goals. The implementation of this multi-strategic response has begun.

One strategy is to develop (with the involvement of local GPs) a short course on STI medicine. While external courses currently exist, often it is inconvenient for general practitioners to attend such courses. A locally implemented course can be scheduled at times that are more convenient to local GPs. Another important skills-development initiative is making available sexual health clinic placements, accredited with Continuing Medical Education points, for general practitioners. In addition, the project is working with WentWest to facilitate elective sexual health clinic placements for GP registrars, ensuring ongoing training for new GPs.

Ensuring effective and ongoing information and communication processes is another important component of the project. This already occurs through utilisation of the Division's newsletter and weekly faxes that the Division forwards to general practitioners. Improving communication processes also involves upgrading the Area Health Service's sexual health website and ensuring it includes information relevant to general practitioners such as patient information sheets, training dates, referral letter templates etc. Further development of the website will include the addition of clinical guidelines and the possibility of online sexual health education for GPs.

Other strategies being considered include developing a CD-ROM self-learning package, developing a telephone hotline, and establishing a GP Practice Enhancement Pilot Project. This will identify key practices, and work with a range of practice staff to develop policies and strategies which enhance the delivery of sexual health care in the GP practice setting. Research is also an ongoing component of the project as it will enable strategies to evolve to meet the ongoing needs of general practitioners.

#### **4.3.5 Planning and coordination**

The partnership approach has been a key feature of the response to HIV/AIDS in NSW. The plan recognised that there is an ongoing need to ensure a coordinated approach to the development and implementation of HIV/AIDS health promotion strategies in NSW.

The action plan identified strategies as:

- improved planning and collaboration between the NSW Department of Health, Area Health Services and non-government organisations
- improved accessibility and dissemination of HIV/AIDS resources.

#### **Achievements**

The CAS Health Promotion Sub-Committee was convened quarterly to oversight coordination of the implementation of the plan and provide advice to CAS on matters relating to health promotion. See section 3.2 for further comments.

A range of forums were convened to support the implementation of the plan and improve planning and coordination. Forums convened included NSW Partnership Forum on Gay Community Responses to HIV/AIDS, Implementation Forum and the Implementation Forum Series.

#### **Discussion**

The actions to address improved planning and collaboration, as outlined in the action plan, have been implemented.

A project proposal to improve accessibility and dissemination of HIV/AIDS resources is currently being developed. The project is likely to examine how 'grey' documents, such as unpublished reports and project evaluations, can be effectively distributed through existing library and resource networks.

#### **Challenges**

The evaluation team supports current efforts to identify how best to ensure health promotion evaluation, project documentation and other resources can be better disseminated. Such an initiative is an important process in promoting best practice across the sector.

# Evaluation of the NSW HIV/AIDS Health Promotion Program

# 5

## **Key findings**

In most western industrialised countries HIV/AIDS health promotion programs fit within a spectrum that ranges from those that focus on individuals' skills and knowledge to those that focus on social determinants such as income and housing (see Appendix A).

The NSW HIV/AIDS health promotion program sits within a social model of health which recognises that while individual factors underlie behaviour they are mediated by broader social factors.

HIV transmission risk is a product of behavioural and biological factors, including susceptibility to infection and infectivity.

The NSW HIV/AIDS health promotion program, unlike those in many comparable jurisdictions, places significant emphasis on medical interventions as a legitimate health promotion strategy.

HIV diagnoses in NSW since the mid-1980s have fallen more than in most other western industrialised jurisdictions for which comparable data are available. Most jurisdictions experienced a plateau of new diagnoses in the late 1990s and more recently an increase. In NSW the increase commenced later and at this stage is of a lesser magnitude.

The lower increase in NSW is probably due to higher levels of engagement with the public health system by the population groups most affected compared to other jurisdictions. In NSW more than 90 per cent of gay men have been tested for HIV, with 68 per cent having been tested in the past year. This is most likely resulting in the higher identification of infection at time of seroconversion (a period of much higher viral load and infectivity) and a greater proportion of people who are HIV-positive being on antiretroviral treatment (thereby reducing viral load and infectivity). Surveys in the United Kingdom, USA and Canada show between 70 per cent and 77 per cent of gay men ever having tested. Testing rates in NSW are also higher than Victoria and Queensland.

STI testing rates are also higher among gay men in NSW than other jurisdictions.

Recent interventions in NSW targeting unprotected anal intercourse among gay men in casual sexual encounters as a risk factor, despite significant effort and some innovative programming, have been neither more nor less effective than those conducted in comparable jurisdictions. Rates of unprotected anal intercourse in this context increased significantly between 1995 and 2001 but have remained steady since. The increase was similar to comparable overseas jurisdictions.

Interventions targeting sexual transmission risk in the context of gay men's relationships appear to have been effective. In the mid-1990s, ACON promoted the concept of negotiated safety in relationships. Behavioural surveys show widespread adoption of this practice and compliance with guidelines promoted. Recent research indicates a decline from around 50 per cent of seroconversions occurring in relationships to around 25 per cent. Antiretroviral treatments may have contributed to this decline.

From 1995 to 2001 it is estimated the frequency of injecting drug use more than doubled in NSW. Over the same period distribution from the needle and syringe program increased even more while actual sharing of needles and syringes declined. Distribution has been falling since 2001, although sharing has not increased significantly indicating a likely reduction in injecting drug use.

Overseas experience demonstrates highly volatile patterns of injecting drug use (eg number of people engaging in injecting drug use, frequency of injecting, types of drugs used). Where programs have been unable to respond to these changes large increases in HIV infection have generally occurred. The jurisdiction in which this has been most intensively investigated is Canada.

The capacity of the NSW needle and syringe program to respond to a large increase in injecting drug use in the later half of the 1990s probably averted an epidemic of HIV infection among injecting drug users and subsequent spread to the wider heterosexual population.

In NSW injecting drug users are also in frequent contact with the public health system through the needle and syringe program. HIV testing rates are also high in this population with about 88 per cent ever having tested and 65 per cent testing in the past year.

Among sex workers and Aboriginal and Torres Strait Islander populations HIV infection has remained low. However, experience in Canada where the rate of AIDS diagnoses among Indigenous populations increased from about 2 per cent in the early 1990s to over 14 per cent in 2002 highlights the need to remain vigilant.

HIV transmission among heterosexuals remains low. This contrasts with Canada and the United Kingdom which have both seen a significant increase in heterosexual transmission over the past ten years. In both countries there is a significant association between heterosexual transmission and either being from a high-prevalence country or having a sex partner from a high-prevalence country.

The experience overseas, as well as local patterns of heterosexual transmission, indicates the need to prioritise strategies to target culturally and linguistically diverse populations from high-prevalence countries.

The NSW program has been underpinned by the principles of:

- partnership between government, community, health professionals and researchers
- non-partisanship
- central involvement of affected communities
- the creation of an enabling environment
- harm minimisation.

The complexity of HIV medicine, the sensitivity of the personal and social issues involved and the rapidly changing medical and social dimensions of the disease create the potential for HIV programs to be riven by conflict, chaos and organisational gridlock. The principles underlying the program are intended to provide a framework through which conflict can be mediated by focussing on common goals, a shared commitment to evidence-based programming and role delineation based on strategic planning. They also facilitate increased program reach and enable changes in environments and policies across sectors and organisations.

The investment in HIV health promotion has been cost effective. Estimates of lifetime treatment costs of HIV range from \$150,000 to \$452,000. A recent study by the Australian Department of Health estimated the net treatment benefit of the needle and syringe program alone as being \$2.277 billion.

## 5.1 Introduction

This section examines the outcomes of the NSW HIV/AIDS Health Promotion Program. For the purpose of this evaluation reference to the NSW HIV/AIDS Health Promotion Program includes the range of health promotion initiatives undertaken since the early/mid-1980s. The focus is on the strategic frameworks and resulting programs implemented through partnership between government, non-government organisations, health practitioners, researchers and other involved agencies.

Section 5.2 describes the program and the inputs. This includes a description of the infrastructure to support HIV/AIDS health promotion (section 5.2.1) and an overview of the types of health promotion interventions targeted at priority population groups (section 5.2.2).

This is followed by an evaluation of the long-term effects of the NSW HIV/AIDS Health Promotion Program. Its primary focus is the prevention of HIV transmission. Some comment is also made on the program's impact on the enhancement and maintenance of the health of HIV infected people and the personal and social impact of HIV infection. However, these matters are also influenced by the wider impact of the NSW HIV/AIDS program which was beyond the ambit of this evaluation.

A health promotion outcomes framework has been used to evaluate the impact of the program (see section 2.1). Where appropriate outcomes are benchmarked against those achieved in programs in other states and overseas jurisdictions. Section 5.3 examines the health promotion and intermediate health outcomes of the HIV health promotion program. Section 5.4 examines the health and social outcomes of the HIV/AIDS health promotion program.

Cost-effectiveness of the NSW HIV/AIDS health promotion program is discussed in section 5.5.

## 5.2 Description of the HIV/AIDS health promotion program

A program can be described as a set of activities designed to fulfil particular strategic goals and targets related to a particular priority. In NSW those strategic goals are:

- minimising the transmission of HIV in NSW
- enhancing and maintaining the health of HIV infected people
- minimising the personal and social impact of HIV infection.

The adoption of a programmatic approach is based on the proposition that the factors contributing to achieving the goals of the program are complex, interrelated and function at a number of levels.

It assumes that several related interventions operating in concert are more likely to be effective than the sum of those interventions delivered independently.<sup>11</sup> This assumption is consistent with an extensive body of research.<sup>11</sup>

The program has been developed over a number of years since the early 1980s and continues to evolve. In describing the program it is recognised that some activities were developed outside formal program structures or prior to any significant government involvement.

The program can be broadly defined as sitting within a social model of health promotion. It recognises that while individual factors such as knowledge, attitudes and skills underlie behaviour they are mediated by broader social factors ranging from socioeconomic status to culture/community values and norms.

Over time the development of the program has been strongly influenced by the approach outlined in the Ottawa Charter for Health Promotion which was adopted by the World Health Organisation in 1986.<sup>12</sup> The Ottawa Charter identifies five key action areas by which individuals, communities and governments act to improve health. They are:

- healthy public policy
- supportive environments
- strengthening community action
- developing personal skills
- reorientation of health services.

Internationally, HIV/AIDS health promotion programs can be viewed as located within a spectrum ranging from highly individualistic to socially determinist (further information regarding such programs is located in the appendix).

Underpinning the NSW HIV/AIDS health promotion program have been the following principles:<sup>13</sup>

- partnership between government, community, health professionals and researchers
- non-partisanship
- the central involvement of affected communities
- the creation of an enabling environment
- harm minimisation.

The complexity of HIV medicine, the sensitivity of the personal and social issues involved and the rapidly changing medical and social dimensions of the disease create the potential for HIV programs to be riven by conflict, chaos and organisational gridlock.

The principle of partnership is intended to provide a framework through which conflict can be mediated by focusing on common goals, a shared commitment to evidence-based programming and role delineation based on strategic planning. It also facilitates increased program reach and enables changes in environments and policies across sectors and organisations.

In this program the partnership is implemented through a range of structures most notable of which is the Ministerial Advisory Committee on AIDS Strategy. This committee, which meets approximately six times a year, advises the Health Minister on all aspects of the HIV/AIDS program. Membership is drawn from specialist HIV clinicians as well as general practitioners with high HIV caseloads, officials from organisations based in communities most affected by HIV as well as those infected with HIV, social researchers and NSW Department of Health officials. Subcommittees address specific areas of strategy (eg health promotion) or specific issues. The NSW Department of Health AIDS/Infectious Diseases Branch provides secretariat support and works in collaboration with CAS on all key program initiatives.

Partnership is also encompassed in program delivery. Social research priorities are determined with input from community organisations and government and often utilise community groups in implementation. Health promotion projects often involve researchers in their planning and development. Many projects are jointly implemented by the NSW Department of Health, Area Health Services and non-government organisations. In addition to the direct provision of health services, NSW Department of Health funds the Australasian Society for HIV Medicine to recruit and train general practitioners to be s100 HIV prescribers.

Non-partisanship allows potentially controversial programs to be implemented with minimal distraction from overt politicisation. In NSW the HIV/AIDS health promotion program has enjoyed the support of both main political parties whether in government or opposition. The early introduction of the needle and syringe program was made possible only by non-partisanship and has had the effect of NSW being among the lowest levels of HIV prevalence in injecting drug users of any comparable jurisdiction in the world.

HIV has primarily affected marginalised and at times stigmatised groups within the broader population. They include gay and other homosexually active men, Aboriginal and Torres Strait Islander people, injecting drug users, and sex workers. Historically the relationship between government and these groups has often been characterised by conflict around public policy issues. However, established public health strategies (eg screening) and contemporary health promotion practice require the active engagement of affected populations.

The benefits of the central involvement of affected communities is reflected in:

- NSW having a higher level of HIV testing among gay and other homosexually active men than any other comparable jurisdiction in the world
- the majority of injecting drug users being in contact with NSW Department of Health services through the needle and syringe program
- extremely low levels of HIV infection among sex workers compared to those elsewhere in the world

- low levels of HIV infection among Aboriginal and Torres Strait Islander people relative to comparable indigenous populations and populations with similar health status elsewhere in the world
- high levels of voluntary involvement in the care and support of people living with HIV – this has both reduced the cost to government and created models that can be extended to other parts of the health sector.

An enabling environment is one in which public policy facilitates program implementation. Examples in NSW include legislation that allows the operation of the needle and syringe program and anti-discrimination measures. Harm minimisation has been a core feature of the NSW HIV/AIDS health promotion program. The fundamental principle of harm minimisation is that policy decisions should be primarily guided by their likely impact on health outcomes. In the area of drug policy it is recognised that while abstinence-based programs are essential because they will assist some people in ceasing drug use other people will continue to inject drugs. International experience demonstrates that in the absence of harm minimisations programs – in particular needle syringe availability – epidemic levels of HIV infection are almost inevitable among this group.

The following section further describes the HIV/AIDS health promotion program by examining the infrastructure to support HIV/AIDS health promotion (section 5.2.1), which includes public health surveillance, governance, roles and responsibilities, funding, workforce development, and by providing an overview of the types of health promotion interventions targeted at priority population groups (section 5.2.2).

## **5.2.1 Infrastructure to support HIV/AIDS health promotion**

### **5.2.1.1 Public health surveillance**

The United States Centers for Disease Control and Prevention defines public health surveillance as the ongoing, systematic collection, analysis, and interpretation of health-related data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control.†

The planning, implementation and evaluation of HIV/AIDS health promotion programs requires information that can be used to:<sup>†</sup>

- estimate magnitude of the problem
- determine geographic distribution of illness
- portray natural history
- detect epidemics/define problem
- generate hypothesis, stimulate research
- evaluate control measures
- monitor changes in infectious agents

- detect changes in health practices
- facilitate planning.

There are five information domains relevant to addressing the above needs. They are:

- epidemiology
- behavioural
- social
- scientific
- evaluation.

**Table 1: Role of information domains in meeting goals of public health surveillance**

	Epidemiology	Behaviour	Social	Scientific	Evaluation
Magnitude of problem	***	*	*	***	
Geographic distribution of illness	***		*		*
Natural history	***			***	
Detect epidemics define problem	***	**	*	***	*
Hypothesis research	***	***	*	**	*
Evaluate control measures	***	***	*	*	***
Monitor changes infectious agents	**	*		***	
Detect changes health practices	*	***	**		***
Facilitate planning	***	***	**	***	**

\*Low \*\* Medium \*\*\*High

### **Epidemiology**

HIV epidemiological surveillance in NSW is primarily the responsibility of the Communicable Diseases Branch of the NSW Department of Health. Under authority of the NSW *Public Health Act 1991*, all HIV diagnoses must be reported. Diagnoses are initially reported by testing laboratories. Following initial reports further demographic information is sought from the doctor who performed the initial HIV test. All surveillance information is stored on a secure database. Entries are coded so that individuals cannot be identified. AIDS diagnoses are reported by doctors.

Additional surveillance is undertaken by the National Centre for HIV Epidemiology and Clinical Research. This includes monitoring of HIV incidence in cohorts of gay and other homosexually active men and sentinel surveillance of other population groups.

HIV testing is performed by general practitioners and through specialist sexual health services. HIV testing levels in NSW are high on a population basis compared to other jurisdictions (see Table 18), and especially high among men who have sex with men (see Table 6) as well as among injecting drug users (see Table 12). In a

<sup>†</sup> Centers for Disease Control and Prevention Epidemiology Program Office. URL: <http://www.cdc.gov/epo/index.htm>. Accessed November 2003.

Sydney-based behavioural survey in 2002 of men who have sex with men, 93.5 per cent had ever been tested while 68 per cent of non HIV-positive men who had been tested had tested in the past year.<sup>15</sup>

Sentinel surveillance facilitates identification of any patterns of infection not revealed through notification data (eg STI clinic testing of sexually active heterosexuals). To date no patterns at variance to those identified through notification data have been identified.

High levels of testing in populations most at risk, as well as other surveillance described above, helps ensure the NSW surveillance system performs well against the criteria described in Table 1. Data is available on a quarterly basis. This allows timely identification of any changes in infection patterns and development of programmatic responses.

### **Social research and behavioural monitoring**

Social research aimed at getting a more detailed understanding of sexual behaviours is extensive among gay and other homosexually active men. Some social research is also conducted among other population groups – particularly injecting drug users. The extent of social research among other population groups is probably sufficient given current levels of HIV transmission risk. There may be a case for more extensive monitoring in the context of other STI risk.

The frequency and quality of behavioural monitoring among men involved in the gay community and injecting drug users is high. The need to monitor behaviour in these two populations is high given the incidence of HIV infection among gay men and the highly dynamic nature of risk among injecting drug users.

The sexual and related behaviours of gay men are monitored every six months through the Sydney Gay Community Periodic Survey. The survey allows any behaviour changes to be identified quickly and responses developed. Two cohort studies Positive Health (HIV-positive men) and Health in Men (HIV-negative men) provide more detailed information including clinical measures.

Surveys which capture a broader population of gay and other homosexually active men (ie including men who are not involved in the Sydney gay community) occur on an ad hoc basis. The most recent was a large national survey (Male Call) conducted in 2000.<sup>16</sup>

An annual survey is conducted of injecting drug users attending needle and syringe program outlets. As part of the survey HIV and hepatitis C testing also occurs.

Among heterosexuals a large national survey was conducted by telephone interview between mid-2001 and mid-2002. Occasional surveys are also conducted among first-year university students. The most recent was in 2002 at the University of NSW.

Among other high priority populations (Aboriginal and Torres Strait Islander people and sex workers) no regular behavioural monitoring occurs. This represents a gap in the program both in terms of planning effective interventions and monitoring outcomes.

### **Evaluation and quality improvement**

There is no ongoing formalised evaluation strategy in the NSW HIV/AIDS health promotion program. However, some of the measures that would be included in such a strategy are available. Specifically there is high-quality, regularly-collected data relevant to health and social outcomes and intermediate health outcomes. However, monitoring of health promotion outcomes is at best ad hoc. Consequently the potential contribution to an ongoing quality improvement program, better quality program monitoring and accountability and replication of effective interventions is not met.

At the local level the extent and quality of evaluation is highly variable. This may reflect a lack of value attached to evaluation within the HIV sector as well as limited opportunities to develop evaluation skills.

However, it is noted that during the period of the current health promotion plan increased attention has been given to evaluation. This is evidenced by the piloting of minimum data sets for HIV health promotion and the emphasis on evaluation of demonstration projects.

### **Scientific research**

Scientific research has made a major contribution to public health surveillance goals in HIV. Identification of HIV as a retrovirus and associated research has contributed to an understanding of the routes of transmission, factors associated with infectivity and susceptibility. This understanding has contributed to estimating the potential magnitude of the HIV epidemic, monitoring natural history, identifying populations most at risk and detecting changes in the infectious agent. Identification of resistance to antiretroviral drugs, the possibility of transmission of antiretroviral resistant virus, viral suppression through antiretroviral treatment and co-factors related to individual susceptibility have profound implications for prevention strategy. Clinical research on antiretroviral treatment has led to the inclusion of post-exposure prophylaxis in HIV prevention and a significant reduction in mother-to-child transmission.

#### **5.2.1.2 Governance**

The Ministerial Advisory Committee on AIDS Strategy has a leadership role in setting directions for the NSW HIV/AIDS program. Since its inception the committee has been chaired by a senior HIV physician. Membership of the committee reflects the principle of partnership underpinning the NSW program and includes HIV medical specialists and high caseload GPs, representatives of affected communities, researchers and senior NSW Department of Health officers. Secretariat support is provided by the NSW Department of Health's AIDS/Infectious Diseases Branch.

The committee has been instrumental in overseeing program implementation and drafting key policy documents. While the NSW Department of Health, under the executive control of the state Minister for Health, is responsible for coordinating program implementation, cooperation with the Ministerial Advisory Committee has always been high.

#### **5.1.1.3 Roles and responsibilities of agencies**

The NSW Department of Health has lead responsibility for program administration and coordination. This function is operationalised by the AIDS/Infectious Diseases Branch. Program implementation is mainly undertaken by Area Health Services and non-government organisations.

Programs targeting gay and other homosexually active men are implemented by Area Health Services and the non-government sector. The AIDS Council of NSW has significant responsibility, subject to Department approval, for developing policies and programs targeting gay men. ACON also runs health promotion programs and services for sex workers through the Sex Worker Outreach Project.

Programs targeting Aboriginal and Torres Strait Islanders are implemented by Area Health Services, ACON and Aboriginal medical services. The AIDS/Infectious Diseases Branch conducts regular meetings between workers employed in both sectors to ensure consistent program implementation and maintains a close working relationship with the Aboriginal Health and Medical Research Council.

Area Health Services have lead responsibility for implementation of the needle and syringe program and the operation of sexual health services. Program delivery occurs in the context of state-wide policies and procedures.

#### **5.2.1.4 Funding**

Table 2 provides a broad outline of the use of HIV prevention funds in NSW. Approximately \$3,854,000 or 15.8 per cent of prevention funds are used to target gay men. It is estimated that 6.8 per cent of Area Health Service prevention funds and 26.9 per cent of non-government organisation funds are used to target gay men. Funding estimates are based on Area Health Service funding plans, non-government organisations funding agreements, and other information provided by the AIDS/Infectious Diseases Branch.

**Table 2: HIV prevention funding**

	AHSs \$(000)	NGOs \$(000)	Total \$(000)	%
Social research		1173	1173	4.8
Workforce development	412		412	1.7
Injecting drug users	6626	3411	10,037	41.3
Aboriginal and Torres Strait Islander people	1643	1166	2809	11.6
Gay and homosexually active men	900	2954	3854	15.8
Sex workers	100	982	1082	4.4
Culturally and linguistically Diverse people	618		618	2.5
Transgender		207	207	0.85
Youth	750	350	1100	4.5
Disabled		150	150	0.6
Prisoners	1246	58	1354	5.6
Heterosexual	635	193	828	3.4
General awareness	635	193	828	3.4
Total	13,330	10,989	24,319	

Specifically in regard to gay men, we estimate that less than \$600,000 is spent on campaigns.

Injecting drug users are the target of the major allocation of funds in the NSW HIV prevention program (41.3 per cent of all funds). The cost of the needle and syringe program is the major component of expenditure in this area (\$8,793,000). However, approximately \$1,234,000 is also allocated for other prevention activities targeting injecting drug users.

**Table 3: Prevention funds targeting injecting drug users**

Activity	Allocation (\$000)
NSP – Area Health Services	6626
NSP – Pharmacy Guild	1770
NSP – ACON	325
NSP – Cabramatta Community Centre	72
NSW Users and AIDS Association	1093
We Help Ourselves	141

### 5.2.1.5 Workforce development

A range of state-wide infrastructure projects exist to support workforce development in NSW. A key component is the Workforce Development Program. The Workforce Development Program, funded by the NSW Department of Health and auspiced by South Eastern Sydney Area Health Service, aims to foster the growth of a skilled and valued workforce through the provision of workforce and management development strategies and projects for workers in hepatitis, HIV and sexual health in NSW. The project works with Area Health Services and non-government organisations.

The program has identified four strategic goals for the coming year:

- enhance access of workers to the range of available training-based activities
- build evidence for and promote innovation in public health and workforce development within the sector
- support NSP workers in developing their knowledge and skills and in enhancing their capacity to implement innovative workforce development activities
- provide infrastructure support to enable greater access and participation among targeted population groups.

The Workforce Development Program includes convening the Annual State-wide NSP Workers' Meeting, auspicing the NSW Workforce Development accredited core training program and the NSW Hepatitis C Workforce Development Project, providing grants to support staff attending workshops and training courses, production and dissemination of a six-monthly training directory, practicum and policy dissemination forums.

Another important initiative is HIV Continuing Medical Education Project, funded by the NSW Department of Health and managed by the Australasian Society for HIV Medicine, that provides training for community-based medical practitioners, including training for those wishing to receive approval to prescribe s100 drugs.

## 5.2.2 Overview of health promotion interventions

As discussed previously, the NSW HIV/AIDS health promotion program is situated within a social model of health promotion. Such a model values interventions across a spectrum from individual behavioural factors (eg knowledge, skills) through social/cultural contexts (eg cultural norms, socio/economic disadvantage, social isolation) to medical interventions (eg post-exposure prophylaxis, viral load). The interaction of these factors was further discussed in section 2.2.

The relative priority of particular points of intervention will vary at different points in time, in different locations and with different population groups. For example in the early and mid-1980s there was a significant gap in knowledge across the population and among population groups most at risk regarding risk behaviours. Interventions to meet that knowledge gap were highly effective in achieving large-scale behaviour change. In 2003 most people are aware of basic risk-behaviour factors and those who are motivated to adopt behaviours on that basis have already done so. (However, there is a need to maintain a level of basic information provision for those who do not have this knowledge).

While the priority given to different points of intervention will vary there is a need to sustain action at all levels. Behaviour is a dynamic process in which individual, social and medical factors interact.

Epidemiological and social research are key influences on determining the relative priority of different levels of intervention. Theoretical models, health promotion research and ultimately evidence of effectiveness and efficiency are used in choosing which interventions to adopt.

### 5.2.2.1 Gay and other homosexually active men

The Australian Study of Health and Relationships is a survey conducted in 2001/02 of the sexual behaviours, attitudes and knowledge of Australian people between the ages of sixteen and fifty-nine. In the survey 1.6 per cent of respondents identified as gay and 0.9 per cent as bisexual. However 8.6 per cent of all men surveyed reported either feelings of attraction to the same sex or some sexual experience with the same sex.

More concentrated populations of gay and other homosexually active men live in the inner suburbs of Sydney. The South East Sydney Area Health Service and Central Sydney Area Health Service, in which these suburbs are located, have much higher rates of HIV than elsewhere in NSW.

HIV health promotion projects targeting gay and other homosexually active men are conducted by non-government organisations and Area Health Services. ACON is the lead agency targeting gay and other homosexually active men in NSW. Most high-profile social marketing campaigns are conducted by ACON.

As discussed elsewhere in this report documentation of health promotion interventions is not sufficiently standardised to provide a detailed description of the HIV/AIDS health promotion program for gay men. Instead we aim to provide a snapshot of the range of projects that constitute the program for gay men in NSW.

Characteristics of the program include:

- segmentation of target audience on the basis of demographic difference, social and cultural factors
- working to address HIV issues in the context of broader sexual health or gay men's health
- utilising a mix of interventions ranging from social marketing to small group work
- interventions that focus on building the capacity of gay men, the gay community and other health service providers.

The table below provides a snapshot of the range of activities, objectives and methodologies that constitute the HIV prevention program for gay men. The information outlined below is taken from the health promotion information reports that were submitted as part of the evaluation of the HIV/AIDS health promotion program.

The information has been grouped under the five areas for action as identified in the Ottawa Charter for Health Promotion.

**Table 4: Snapshot of HIV health promotion activities targeted at gay men**

Health promotion	Objectives	Methodology
<b>Supportive environments</b>	<ul style="list-style-type: none"> <li>• Increase capacity to respond to health issues</li> <li>• Increase peer support</li> <li>• Increase awareness, knowledge and skills</li> <li>• Increase access to means of prevention</li> <li>• Increase community support</li> <li>• Support the development of healthy community norms</li> <li>• Reduce stigma and discrimination</li> <li>• Reduce homophobia and heterosexism</li> <li>• Increase community connectedness</li> </ul>	<ul style="list-style-type: none"> <li>• Community development</li> <li>• Capacity building</li> <li>• Community forums and roundtables</li> <li>• Training</li> <li>• Education resources</li> <li>• Outreach projects</li> <li>• Telephone services</li> <li>• Websites</li> <li>• Social advertising and marketing</li> <li>• Peer support groups</li> <li>• Peer education workshops</li> <li>• Community outreach</li> <li>• Distribution of means of prevention</li> <li>• Stalls</li> <li>• Exhibitions</li> </ul>
<b>Reorienting health services</b>	<ul style="list-style-type: none"> <li>• Increase awareness, knowledge and skills</li> <li>• Improve access to health services</li> <li>• Improve referral processes</li> <li>• Improve coordination of care and support services</li> <li>• Reduce stigma and discrimination</li> <li>• Reduce homophobia and heterosexism</li> <li>• Increase health education and promotion activity</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity building</li> <li>• Training</li> <li>• Forum and planning meetings</li> <li>• Education resources</li> <li>• Enhanced care</li> <li>• Outreach services</li> <li>• Social advertising and marketing</li> <li>• Advocacy</li> </ul>
<b>Developing personal skills</b>	<ul style="list-style-type: none"> <li>• Increase condom use</li> <li>• Increase safe injecting practices</li> <li>• Improve support and emotional wellbeing</li> <li>• Increase access to means of prevention</li> <li>• Increase awareness, knowledge and skills</li> <li>• Increase access and referral to services</li> <li>• Improve self-esteem</li> <li>• Increase social and community connectedness</li> <li>• Minimise personal and social impact</li> <li>• Increase health literacy</li> </ul>	<ul style="list-style-type: none"> <li>• Peer education</li> <li>• Support groups</li> <li>• Workshops</li> <li>• Counselling</li> <li>• Provision of means of protection (eg condom distribution and needle and syringe programs)</li> <li>• Outreach services to individuals</li> <li>• Beats outreach</li> <li>• Venues outreach</li> </ul>
<b>Building healthy public policy</b>	<ul style="list-style-type: none"> <li>• Improve access to health services</li> <li>• Identification of gaps in service provision</li> <li>• Coordination of health services</li> <li>• Reduce stigma and discrimination</li> <li>• Improve quality of services</li> <li>• Increase health equity</li> <li>• Provision of safe and healthy environment</li> <li>• Protect confidentiality</li> <li>• Improve targeting of resources to priority areas</li> </ul>	<ul style="list-style-type: none"> <li>• Policy development</li> <li>• Surveys and reviews</li> <li>• Advocacy</li> <li>• Service policies</li> <li>• Quality assurance processes</li> <li>• Memorandums of understanding</li> <li>• Service agreement</li> <li>• Legislation</li> <li>• Code of practice</li> </ul>

Health promotion	Objectives	Methodology
<b>Strengthen community action</b>	<ul style="list-style-type: none"> <li>• Increase awareness, knowledge and skills</li> <li>• Increase condom use and safe injecting practices</li> <li>• Decrease in risk taking</li> <li>• Increase community involvement and participation</li> <li>• Increase community connectedness</li> <li>• Reduce stigma and discrimination</li> <li>• Reduce barriers to accessing services</li> </ul>	<ul style="list-style-type: none"> <li>• Social advertising and marketing</li> <li>• Community forums</li> <li>• Workshops</li> <li>• Community action groups</li> <li>• Capacity building</li> <li>• Community development</li> <li>• Volunteer and peer training</li> <li>• Community care and support programs</li> <li>• Websites and discussion boards</li> <li>• Media advocacy</li> <li>• Stalls</li> </ul>

Counselling services for which gay and other homosexually active men are a priority target group are provided by most Area Health Services through sexual health services. The largest counselling units are based at Albion Street Clinic, Sydney Sexual Health Service and ACON. Among gay and other homosexually active men, HIV-positive men are the most frequent clients of counselling services.

Provision of peer support groups is a common intervention conducted across NSW. Groups are conducted by non-government organisations and Area Health Services. Sub-populations most frequently targeted are young gay and other homosexually active men and men who are HIV positive. ACON runs peer support groups for a range of sub-populations although young gay men are the most frequently targeted. Other groups include men who have been newly diagnosed with HIV, negative partners of HIV-positive men, mature-age men, Asian men and indigenous men.

In earlier years outreach to beats (public environments where sexual activity takes place) was a common intervention conducted by non-government organisations and Area Health Services. Activity in this area appears to have declined. ACON maintains outreach interventions particularly targeting sex on premises venues, gay bars and gay events. Volunteers are often used for outreach work conducted by ACON in gay bars and at gay events.

A range of community development interventions are conducted across the state. These range from facilitating the establishment of gay and lesbian social groups in rural areas to negotiation and implementation by ACON of a Code of Conduct for gay sex venues.

Some area health services run projects addressing homophobia. Target populations range from health service providers to schools.

A number of area health services maintain websites for gay and other homosexually active men. Interventions targeting established websites are ad hoc.

A significant number of interventions address the broader needs of HIV-positive people, of whom gay and other homosexually active men make up the largest number. Issues addressed include housing, employment and social support services.

Most area health services have procedures to provide access to post-exposure prophylaxis in the event of high risk non-occupational exposure in addition to well established procedures for occupational exposure.

Enhancing the capacity of GPs to meet sexual health needs of the population generally, and gay and other homosexually active men in particular, is becoming an increasing focus of interventions.

### **Key prevention messages**

Key prevention messages, as reflected in social marketing campaigns targeted at gay men, generally tend to:

- differentiate between sexual risk in the context of relationships and sexual risk in casual encounters
- recognise the importance of clinical interventions, such as testing and sexual-health check-ups, in reducing the risk of HIV transmission.

Key prevention messages include:

- reinforcement of condom use as the most effective strategy to reduce the risk of HIV transmission during casual encounters. A parallel message has been to increase understanding about the relative risk of different practices for gay men who do not use condoms all or most of the time
- since 1996, acknowledgment of 'negotiated safety' practices in gay men's relationship via promotion of the Talk, Test, Trust message
- that sexually active gay men need to test regularly for HIV
- promotion of PEP as a last-resort strategy to reduce the risk of infection following a possible exposure to HIV
- promotion of regular STI testing, sexual-health check-ups and information on specific STIs.

### **Responding to the increase in HIV infections**

The increase in HIV infections among gay men has prompted the development of a HIV/AIDS sector action plan. The action plan is a short-term intervention. Longer term strategic priorities are expected to be developed in the next HIV/AIDS health promotion plan.

The action plan aims to reduce new HIV infections among gay and other homosexually active men. The intention of the initiatives outlined in the action plan is to disrupt current transmission patterns by signalling to gay men that the contexts of risk taking have changed and there is an urgent need to reconsider personal risk taking.

The action plan provides the framework for a coordinated response to the increase in HIV notifications, in order to:

- provide gay men with information, skills and equipment to reduce HIV acquisitions/transmission during sex
- increase the rate of consistent safe sex among gay men
- reduce new STI infections and increase diagnosis and treatment of existing STIs
- increase the population of at-risk individuals who have regular HIV and STI tests

- build the capacity of health services and general practice to address HIV prevention with gay and other homosexually active men.

The action plan provides the framework for activities in the following areas:

- communicating with gay men about prevention issues
- supporting GPs and sexual health services to address HIV prevention
- addressing sexually transmitted infections.

An interagency committee has been convened by the NSW Department of Health to implement the action plan. Participants include ACON, PLWHA Inc., CSAHS, SESAHS, NSAHS and ASHM. An evaluation framework is currently being developed.

### **5.2.2.2 Injecting drug users**

In NSW it was estimated in 1995 that the injecting drug user population (those who had injected in the past year) numbered between 32,700 and 65,300.<sup>18</sup> Approximately one third were believed to be regular users (ie daily) and two thirds occasional.

Injecting drug users are at high risk of HIV infection through the sharing of injecting equipment. In many locations throughout the world HIV prevalence among injecting drug users is high and has led to significant levels of HIV transmission in the wider community. However, HIV prevalence among injecting drug users in NSW has remained low. Among those tested in the NSP Attendees Survey in 2002 overall prevalence was 2 per cent. Among heterosexuals tested prevalence was less than 1 per cent.<sup>19</sup>

The primary strategy targeting HIV risk among injecting drug users in NSW is the needle and syringe program. The program operates through pharmacies and public sector outlets. The pharmacy program was established in 1986 and the public sector program commenced in 1988.

There are 436 pharmacies in the program. Clients can purchase needles and syringes in a Fitpack (a container in which used equipment can be disposed) at a cost of \$3 or can obtain a Fitpack for free in exchange for a used Fitpack.

There are 341 public sector outlets in NSW. The public sector program is administered at an Area Health Service level within a state-wide policy framework. The main types of services are as follows:

- primary outlet – a service at a fixed location staffed by specialist NSP workers
- secondary outlet – outlets which offer NSP services as one of a range of other health or community services
- mobile service
- outreach service
- vending machine.

In addition to needle and syringe distribution, the public sector program delivers client education and makes referrals to other services. Education covers topics ranging from infectious disease risk to vein care. Referrals are to services ranging from drug treatment to welfare.

Higher risk is associated with frequency of injecting and type of drug used. Ensuring availability of new equipment is obviously more difficult the higher the frequency. Particular types of drugs (eg psycho stimulants) are associated with more chaotic behaviour.

Overseas experience has demonstrated that changes in drug use patterns, without appropriate program responses, can easily undermine the containment of HIV infection among injecting drug users. In the 1990s there was a significant shift in drug use patterns in Canada from opiate use to psycho stimulant drugs. Severe limits on the availability of equipment and a restricted number of outlets contributed to increased sharing. Over the period from the late 1980s to 1996 HIV prevalence in Vancouver among injecting drug users increased from around 1–2 per cent to 23.6 per cent.<sup>20</sup>

Characteristics of respondents to the Needle And Syringe Program Attendees Survey in 2002 included:<sup>19</sup>

- 64 per cent male, 35 per cent female, 1 per cent transgender
- 76 per cent heterosexual, 11 per cent bisexual, 5 per cent gay/lesbian (8 per cent not reported)
- median age 30
- median age of first injecting 18
- median duration of injecting 10 years

- 10 per cent Aboriginal And Torres Strait Islander origin
- 21 per cent imprisoned in the past year, of whom 38 per cent injected in prison
- 53 per cent inject daily
- 48 per cent injected heroin as last drug injected, 23 per cent amphetamines
- 80 per cent injected in their own home in the last month, 36 per cent at a friend's home, 29 per cent in a street, park or beach, 26 per cent in a car (more than one location could be reported)
- 73 per cent have had some form of treatment/therapy for drug use
- 11 per cent have engaged in sex work in the past month
- 71 per cent of those tested as part of the survey had hepatitis C antibodies (compared with 84 per cent in 1995).

Overall NSW respondents were similar to the national sample in the survey. However, heroin was more frequently the last drug injected (NSW 48 per cent, national 36 per cent). In NSW amphetamines were the last drug injected by 23 per cent of respondents compared with 33 per cent nationally.<sup>19</sup>

The NSW Users and AIDS Association is a peer-based organisation for injecting drug users. It is funded to implement outreach education, produce publications and operate a needle/syringe distribution outlet.

### **5.2.2.3 Aboriginal and Torres Strait Islander people**

The Australian Census 2001 indicates that the Aboriginal and Torres Strait Islander population in NSW increased from 70,019 in 1991 to 135,319 in 2001. This increase gives NSW the largest Aboriginal and Torres Strait Islander population of any state or territory in Australia (29.4 per cent of the total Aboriginal and Torres Strait Islander population).<sup>21</sup> Over 93 per cent of the total Aboriginal and Torres Strait Islander population in NSW is Aboriginal, 3.5 per cent Torres Strait Islander and 2.9 per cent Aboriginal and Torres Strait Islander.

Social factors such as poverty and isolation as well as poor access to services have a major impact on the health of Aboriginal people in NSW. In addition, sexual health and blood-borne viruses further compound the isolation and poor service access due to taboos and shame factors associated with sex and drug use issues.

National and NSW surveillance data on Aboriginal and Torres Strait Islander populations are incomplete. However, anecdotal reports indicate that STIs are a significant source of morbidity in NSW for Aboriginal people.

The NSW Department of Health has funded Aboriginal sexual health projects since 1989/90. The Australian Office for Aboriginal and Torres Strait Islander Health (OATSIH) began contributing Special Funding for this purpose at the start of the National AIDS Strategy 1993/94 to 1995/96. In 2002/03 the Department received \$1,736,000 from OATSIH. The Department exceeded this

allocation by contributing approximate additional funding of \$2,809,268 to Aboriginal sexual health.

NSW has the largest network of Aboriginal and Torres Strait Islander sexual health programs in Australia. This has been achieved through an effective partnership with the Aboriginal Health and Medical Research Council of NSW. Through this partnership, the NSW Department of Health has been able to strategically locate projects based on STI and HIV notification rates and to ensure population and geographic coverage. Projects are based in Area Health Services and non-government organisations.

**Table 5: Location of Aboriginal sexual health workers**

Project	Staff	Project	Staff
Redfern AMS	2 FT	Wellington AMS	1FT
AHMRC-state wide	2FT	MAHS (Dubbo)	1FT
ACON state wide			
IFT male, 1FT female, 1FT sistergirl			
1FT sex worker	4FT	CCAHS (Gosford)	1FT
Awabakal AMS (Newcastle)	1FT	SAHS (Goulburn)	1FT
Biripi AMS (Taree)	1FT	GMAHS (Albury)-nursing	1FT
Bourke AMS	1FT	NEAHS (Tamworth)	2FT
Bulgarr Ngaru AMS (Grafton)	1FT	WSAHS (Westmead)	1FT
Coomealla AMS (Dareton)	1FT	IAHS (Wollongong)	1FT
1PT			
Daruk AMS (Mt Druitt)	1FT	MNCAHS (Coffs Harbour)	
1FT local;1FT state-wide	2FT		
Durri AMS (Kempsey)	1FT	NRAHS (Lismore)	2FT
Katungal AMS (Narooma)	2PT	FWAHS (Broken Hill)	1FT
Pius X AMS (Moree)	1FT	CSAHS (Camperdown)	2FT
South Coast AMS (Nowra)	1FT	MWAHS (Bathurst)	1FT
Tharawal AMS (Campbelltown)	1FT	SEAHS	1FT
Walgett AMS	1FT	SWAHS	1FT

Aboriginal sexual health workers provide a range of individual client services including:

- one on one education, counselling and contact tracing
- clinical services, eg testing particularly non-invasive specimen collection such as urine testing
- referral/support to access sexual health and other services
- other contact including transport to clinics, phone consultations, and mentoring
- youth, women and men's camps
- initiatives targeting gays, lesbians and sistergirls, eg distribution of campaign materials
- community and peer education workshops
- resource development
- staff development.

Aboriginal and Torres Strait Islander people are also a priority target population of sexual health clinics.

Other program initiatives include:

- a statewide support network for the Aboriginal sexual health workers
- network training and development projects
- workforce development
- the distance learning package for a Diploma in Health Science (Aboriginal Sexual Health Studies)
- the NSW Aboriginal and Torres Strait Islander Sexual Health Implementation Advisory Committee.

#### 5.2.2.4 Sex workers

Estimates of the number of sex workers in NSW vary considerably. A report published by the NSW Department of Health in 2000 estimated that in any given week, it is possible that between 200 and 300 female, male and transsexual sex workers solicit their clients on the street. At the time it was generally thought that approximately 10 per cent of sex workers in NSW were street based. On this basis there would be between 2000 and 3000 sex workers in NSW.<sup>22</sup>

Important points of differentiation among sex workers include location of sex work, gender and ethnicity. Generally sex workers are based in brothels, work from their own home or solicit clients on the streets.

Some workers may operate across different locations.

While the majority of sex workers are female there are also significant numbers of male and transgender workers. In Sydney there are many international sex workers, mainly from South East Asia. Many female international sex workers work under contract in highly controlled premises.<sup>22</sup>

The NSW HIV/AIDS health promotion program mainly has contact with sex workers through ACON's Sex Worker Outreach Project (SWOP), sexual health centres and the needle and syringe program. The Gender Centre which provides services for transgender people has significant contact with transgender sex workers. Surveys indicate that a high proportion of transgender people have spent some time working in the sex industry.<sup>22</sup>

The Sex Workers Outreach Project, a project of ACON, has been providing education, support and health promotion services to sex workers throughout NSW since 1990. The project provides a range of services to sex workers including outreach, counselling, advocacy and referral. SWOP works with street-based sex workers, workers with transgender qualities, Aboriginal and Torres Strait Islanders sex workers, male and female sex workers, workers from culturally and linguistically diverse backgrounds, owners and operators of sex industry businesses, and clients of sex workers.

SWOP works closely with other service providers particularly sexual health clinics. All sexual health clinics in NSW have contact with sex workers. In 1997 Sydney Sexual Health Centre had contact with 679 sex workers. Sydney Sexual Health Centre had specific activities to target international sex workers who are thought to be at greater risk of HIV transmission. In 1997, 41.2 per cent of clients required an interpreter.<sup>22</sup>

During the period 1 July 2002 and 30 June 2003 there were a total of 612 attendances at Sydney Sexual Health Centre by international sex workers. Sydney Sexual Health Centre conducts two Thai and one Chinese clinic per week, and Thai and Chinese workers make up the majority of international worker attendances.

Sydney Sexual Health Clinic staff, in conjunction with SWOP staff as well as other area-based workers, conduct outreach to sex industry establishments throughout Sydney. In 2002/03 there were 196 parlour visits to 121 different parlours.

Other activities undertaken with international sex workers include:

- translation of information materials
- facilitation of the sexual health outreach workers network
- research
- cross-cultural training
- liaison with relevant community organisations.

The needle and syringe program has a significant level of contact with sex workers. In the NSP Attendees Survey 11 per cent of respondents had engaged in sex work during the past month.<sup>19</sup> Kirketon Road Centre, based in Kings Cross, had 869 sex workers receive services in 1997. Kirketon Road Centre, in addition to being an NSP, provides a comprehensive range of primary health care services. Of the sex workers receiving services from Kirketon Road, 17.7 per cent identified as street-based workers.

### 5.3 Evaluation of the program – health promotion and intermediate health outcomes

This section evaluates the HIV/AIDS health promotion program on the basis of health promotion outcomes and intermediate health outcomes in relation to priority population groups.

#### 5.3.1 Gay and other homosexually active men

##### *HIV testing*

HIV testing levels are high among gay and other homosexually active men. In 2002 93.5 per cent of Sydney men surveyed reported ever having been tested. This was a significant increase since 1996 when 88.7 per cent had been tested.<sup>15</sup>

There is some evidence to suggest men living outside of Sydney may have lower rates of testing than those noted above. In the year 2000, the Male Call survey included homosexually active men from throughout Australia. Men who were not gay community attached were less likely to have been tested than gay community attached men. Of non-gay community-attached men, 33.9 per cent were unaware of their HIV status compared to 15.4 per cent of gay community-attached men.<sup>16</sup>

Age is not a significant factor in regard to testing. Analysis of data in the February 2003 Sydney Gay Community Periodic Survey showed no difference in testing levels among HIV-negative respondents aged less than 25 compared to those aged 25 and above.<sup>38</sup>

A survey of Sydney gay Asian men shows lower levels of HIV testing. In 2002, 77.2 per cent of respondents to a survey had been tested and of these 62.4 per cent had been tested in the past year (48.2 per cent of the total sample).<sup>23</sup>

Sydney gay men have higher testing rates than those in Melbourne (84.4 per cent ever tested)<sup>24</sup> and Brisbane (86.9 per cent ever tested).<sup>25</sup> Among those who have been tested, less Melbourne men have been tested in the past year.

**Table 6: Testing levels in gay community periodic surveys**

% of respondents in gay community surveys	Sydney <sup>15</sup>	Melbourne <sup>24</sup>	Brisbane <sup>25</sup>
Ever tested	93.5	84.4	86.9
Tested in past year	68.0	61.8	70.0

Note: Test in past year includes only non-HIV-positive men who had ever been tested for HIV.

The level and frequency of HIV testing among Sydney gay and other homosexually active men is much higher than that reported in overseas jurisdictions.

In a survey conducted in London in 1999, 72.9 per cent of men who have sex with men had ever tested. Of those who had tested negative, only 31.8 per cent had tested in the past year.

In the London survey testing levels increased with age. Among those aged 20–24 less than 55 per cent had ever tested.<sup>29</sup>

In a US survey conducted between 1994 to 2000, 77 per cent of men who have sex with men aged 15–29 in six large cities reported ever having tested. However, 76.8 per cent of the men who tested positive as part of the survey reported being unaware of their infection.<sup>44</sup>

A Canadian survey of men who have sex with men undertaken in 1997 showed 71 per cent of respondents had ever been tested.<sup>30</sup>

### **HIV diagnosis and treatment**

Prompt diagnosis of HIV infection and accessibility of antiretroviral treatment maximise the health options available for people with HIV to manage their illness effectively. They are also legitimate health promotion outcomes in that they reduce infectivity. Seroconversion is associated with significantly elevated viral load which increases infectivity. Diagnoses at this stage should be accompanied by counselling and the opportunity to commence antiretroviral treatment. (There is evidence of better health outcomes associated with treatment commencement early in the disease). Antiretroviral treatment results in reduced viral load thereby reducing infectivity.

Median CD4 cell count at the time of HIV diagnosis may give some indication of recency of infection. Over the past six years there has been an upward trend in NSW perhaps indicating earlier diagnoses. Over the three years 2000–2002 average CD4 count was 460 compared with 396 from 1997 to 1999.

Average CD4 count at the time of diagnosis is slightly higher in NSW than Victoria and Queensland. It is much higher than in the United Kingdom. In the UK, in the year 2000, the average CD4 among homosexually active men at the time of diagnoses was 340.<sup>27</sup>

Most men with HIV are on combination therapies (68.1 per cent in 2002). However, since 1997 there has

been a downward trend in the number on combination therapies (74.7 per cent in 1997).<sup>15</sup> Treatment patterns in NSW and Victoria are similar. However in Queensland, the number on combination therapies is lower (48.8 per cent in 2002) and the downward trend greater. Of men on combination antiretroviral treatments 80 per cent report having undetectable viral load compared to 13.2 per cent of those not on combination treatments.<sup>25</sup>

### **Sexual behaviour**

Unprotected anal intercourse between gay and other homosexually active men is the major risk factor contributing to HIV diagnoses in NSW. From the mid-1980s, when risk factors for HIV became relatively well understood, till the mid-1990s, the level of unprotected anal intercourse between gay and other homosexually active men was low. Unprotected anal intercourse between regular and casual partners increased markedly from 1996 to 2001 and has since plateaued.

The increase in unprotected anal intercourse is similar in Sydney to jurisdictions interstate and overseas. There is no significant evidence to suggest health promotion interventions in NSW in recent years, despite significant effort and some innovative programming, have been any more or less effective than elsewhere in addressing sexual risk behaviour in casual sexual encounters. Caution should be used in comparing absolute levels of unprotected anal intercourse because of different survey methodologies and different understandings of terminology.

Rates of unprotected anal intercourse do not vary according to age. This contrast with patterns overseas where younger men engage in higher rates of unprotected anal intercourse. For example, in a survey undertaken in London in 2000 50.3 per cent of men in their 20s compared with 43.9 per cent of men in their 30s had engaged in any unprotected anal intercourse. In the US, the proportion of HIV diagnoses in the 20–29 year age group is significantly higher than in NSW and other Australian states.

The lack of additional risk associated with age among NSW gay and other homosexually active men may be due in part to health promotion programs specifically targeted at younger men. Younger men have been the primary target group of peer support programs conducted by ACON as well as some conducted by other non-government organisations and Area Health Services. They have also been the target of specific social marketing campaigns.

**Table 7: Percentage of respondents having any unprotected anal intercourse**

	96	97	98	99	00	01	02
England <sup>29</sup>					42.3		
London	33	35	39	46	46.4 <sup>29</sup>		
Sydney <sup>15</sup>	35	39.8	41.7	43.1	48.3	51.2	51.3
Melbourne <sup>24</sup>			36.8		42.6	46.8	46.2
Brisbane <sup>25</sup>			38.3	38.8	44.0	44.0	45.1
Montreal		36.3	35.7	40.8	40.9		
Vancouver	41.5	46.2	49.2	45.4	50.8		
Florida (18–29 year olds)						45.0	

### Sex with casual partners

Unprotected anal intercourse between casual partners increased markedly between 1996 and 2001, though recently appears to be plateauing. Again there is little if any evidence to indicate that health promotion campaigns around this issue since 1996 have been effective especially considering the similarity to trends in comparable jurisdictions elsewhere.

**Table 8: Percentage of respondents having unprotected anal intercourse with casual partners and/or partners of unknown status**

	96	97	98	99	00	01	02
Sydney <sup>15</sup>	14	18.3	18.2	18.5	23.0	25.7	24.5
Melbourne <sup>24</sup>			13.4		16.6	17.0	19.1
Brisbane <sup>25</sup>			14.0	14.7	18.4	19.2	22.1
Montreal <sup>30</sup>		15.4	16.1	18.9	18.9		
London <sup>28,29</sup>	20.1	20.3	24.2	26.7	27.4		
Florida <sup>31</sup>						31.0	

Notes: Montreal percentage of respondents having unprotected anal intercourse with a partner of unknown serostatus.

While the research is not conclusive, there is some evidence to suggest that an increase in unprotected anal intercourse is related to the introduction of highly active anti-retroviral treatment (HAART).<sup>32</sup>

In 1996 a new HIV treatment paradigm emerged. Reports from various studies presented at the International AIDS Conference in Vancouver demonstrated the combined use of different classes of antiretroviral drugs could significantly reduce the morbidity of HIV illness, delay HIV related mortality and potentially make HIV a long-term manageable chronic medical condition as opposed to what was a terminal illness.

While it is unclear the extent to which HAART may have directly influenced behaviour, we can identify that the impact of HIV treatments have contributed or resulted in:

- a marked decline in progression to AIDS among those infected with HIV and a significant decline in AIDS deaths leading to a perception that HIV is now a manageable chronic medical condition rather than a terminal illness
- HIV no longer being perceived as a crisis for the gay community and a greater sense of optimism
- undetectable or low viral load provide for a reduced sense of infectivity and are factors that are being considered by some gay men when practising unprotected anal intercourse
- HIV no longer being as visible as it once was as there are less people who are visibly affected by disease.

Apart from HIV treatment, a range of other complex and often interrelated factors impact upon whether gay men have unprotected anal intercourse. These factors include:

- use of drug and alcohol and its impact upon decision-making
- mental health, such as depression
- erectile dysfunction associated with condom use
- assumptions that are made about HIV status
- expectation that gay men with HIV will disclose their HIV status and practice safe sex
- expectation that HIV-negative men will act to protect their own health by practising safe sex
- use of insertive/receptive positions to reduce the risk of HIV transmission.

While these factors are important contributors to unprotected anal intercourse, they have been persistent challenges for HIV prevention programs and are unlikely to have contributed to the increase in unprotected anal intercourse.

While unprotected anal intercourse in casual encounters has steadily increased since 1996 it is likely that HIV diagnoses did not increase until recently due to the impact of HAART on viral load and therefore infectivity.

Social research also indicates:

- most men who have unprotected anal intercourse do so only some of the time
- men who are also in relationships are less likely to have unprotected anal intercourse with casual partners
- younger men are no more likely to have unprotected anal intercourse than their older counterparts
- Asian gay men are less likely to engage in unprotected anal intercourse
- men make judgements about the likely serostatus of their casual partners on the basis of appearance and behaviour
- HIV-negative men expect positive men to disclose their status
- HIV-positive men generally experience sexual rejection when they disclose their serostatus

- HIV-positive men do not usually disclose their status
- gay men often attribute their own unprotected anal intercourse to drug and alcohol use
- some men have difficulty negotiating condom use
- significant numbers of men report erection difficulties associated with condoms in the past six months (36.9 per cent occasionally, 10.2 per cent often)<sup>33</sup>
- men engaging in esoteric sexual practices (eg sadomasochism) are more likely to engage in unprotected anal intercourse<sup>35</sup>
- men who have unprotected anal intercourse with a casual partner do so with approximately 20 per cent of partners (ie with most partners they use a condom).

### **Sex with regular partners**

In the 2002 Sydney Gay Community Periodic Survey, 62.7 per cent of respondents were in a regular relationship. Among HIV-negative men 74.3 per cent were in a relationship with a partner who was also HIV negative, 7.8 per cent were in a relationship with a partner who was HIV positive and 17.9 per cent were in a relationship with a partner whose HIV status they didn't know.<sup>15</sup>

Over the seven years the survey has been conducted there has been little change in the proportion of men who have regular partners. Trend analysis shows that since 1996 there has been a significant downward trend in the proportion of men in regular relationships who also had casual sex (38.4 per cent to 34.6 per cent) and a slight although statistically significant upward trend in the proportion of men in monogamous regular relationships (23.6 per cent to 27.1 per cent). Nearly 70 per cent of men in a regular relationship had been in that relationship for at least one year.<sup>15</sup>

Since 1997 there has been a significant increase in unprotected anal intercourse between regular partners from 45.7 per cent in 1997 to 58.8 per cent in 2002. However, among HIV-negative men this increase has been mainly with HIV-negative partners (1997 – 67.5 per cent; 2002 – 81.3 per cent) or partners of unknown status (1997 – 53.7 per cent; 2002 – 69.2 per cent). The level of unprotected anal intercourse with positive partners has been fairly constant over this period.

**Table 9: HIV-negative men and unprotected anal intercourse<sup>15</sup>**

HIV status of partner	1997	2002
HIV negative	67.5%	81.3%
Status Unknown	53.3%	69.2%
HIV positive	40.0%	39.2%

There is a significant level of HIV transmission in regular relationships. The sero-converters study, in which men recently diagnosed are interviewed about their seroconversion, indicated that over the period 1993–2002 about 40 per cent of seroconversions were believed by men to have occurred within their regular relationships. Although the number interviewed is low this proportion has been declining since the mid-1990s.

There is some evidence that within regular relationships unprotected anal intercourse is negotiated around sero-concordance and agreements to only have safe sex (no anal sex or anal sex only with a condom) outside the relationship.<sup>35</sup> In the 2002 Sydney Gay Periodic Survey, 70.9 per cent of respondents who had a regular partner had an agreement about sex outside the relationship. Most agreements did not permit anal intercourse without a condom.

Agreements about sex outside the relationship are slightly more common in Sydney than Melbourne (67.4 per cent) and Brisbane (65.8 per cent).

**Table 10: Agreements with regular male partners about sex outside the relationship<sup>15</sup>**

Agreement	%
No sexual contact with casual partners is permitted	41.3
No anal intercourse with casual partners is permitted	8.1
Anal intercourse permitted only with a condom	45.0
Anal intercourse without condom is permitted	5.6
Total	100

In the 2002 Sydney Gay Community Periodic Survey, 39.2 per cent of HIV-negative men with positive partners had unprotected anal intercourse with their partner in the previous six months.<sup>15</sup> This proportion has remained relatively constant since 1997 when 40 per cent reported unprotected anal intercourse. There is evidence that serodiscordant partners are adopting strategies to reduce risk related to unprotected anal intercourse.<sup>38</sup> However the efficacy of these strategies (eg withdrawal before ejaculation, the

positive partner adopting the receptive position etc.) are questionable in the context of repeated exposure.

The reduction in seroconversions occurring in relationships, the stable level of unprotected anal intercourse between discordant partners compared with increases elsewhere, and the extent of agreements regarding sex outside the relationship provide evidence that health promotion strategies targeting men in relationships have been effective.

**Sexually transmitted infections**

STIs increase infectivity of people with HIV and susceptibility of HIV-negative people. STI infection has increased significantly among gay and other homosexually active men in Sydney in recent years. Overall gonorrhoea notifications among all men in NSW increased from 1250 in 1998 to 1515 in 2002.<sup>26</sup>

It is believed that a significant proportion of diagnoses are among gay and other homosexually active men. Rectal gonococcal isolates in men in NSW increased from 206 in 2001 to 270 in 2002. A significant increase also occurred in Victoria (2001–50; 2002–96).<sup>26</sup>

Increased levels of STIs are also appearing among gay and other homosexually active men in similar overseas jurisdictions. Reported outbreaks of syphilis have occurred in the United Kingdom, Netherlands, Ireland, France and Norway. Large increases are also being reported in gonorrhoea in France, Netherlands, Sweden, Switzerland and the United Kingdom.<sup>36</sup> In the United Kingdom, notifications of homosexually acquired gonorrhoea increased from 1372 in 1995 to 3509 in 2001.<sup>37</sup>

Increasing rates of STIs, in particular rectal gonorrhoea, indicate higher levels of HIV sexual risk behaviour. However, the effectiveness of their diagnoses and treatment reduces HIV transmission risk.

Most gay men have a basic understanding of risk of STI transmission as evidenced by 80 per cent disagreement with the statement ‘men who always use condoms for anal intercourse don’t need to have regular sexual health check ups’<sup>38</sup> and frequency of STI testing. However, more detailed knowledge of specific infections is mixed (eg around 50 per cent don’t know that gonorrhoea, syphilis, chlamydia, hepatitis A, hepatitis B and hepatitis C can be present without symptoms.)<sup>38</sup>

Sydney gay men have high levels of STI monitoring. Almost 75 per cent of respondents to the Sydney Gay Community Periodic Survey reported having a sexual health check-up in the previous year.<sup>38</sup>

Table eleven shows the range of STI tests respondents to the February 2003 Periodic Survey reported.

**Table 11: Sexual health test in the last twelve months<sup>38</sup>**

Anal Swab	24.5
Penile Swab	26.6
Throat Swab	34.2
Urine Sample	42.6
HIV	64.1
Other Blood	57.5

The percentage having an anal swab is probably indicative of the minimum number having a check-up for gonorrhoea.

Sexual health monitoring appears to be practiced more extensively among Sydney gay men than similar populations overseas. In a London survey 49.2 per cent of respondents reported having a STI check-up in the previous twelve months.<sup>29</sup>

GPs are the most frequent place, amongst respondents to the Sydney Gay Community Periodic Survey, at which gay men have a sexual health check-up (60.4 per cent), followed by a sexual health centre (20.8 per cent). Some of those having an initial check-up from a GP are referred on to a sexual health centre.

### ***Effectiveness and efficiency of prevention interventions***

Gay and other homosexually active men are overwhelmingly aware that condoms are the most effective protection against HIV transmission in anal intercourse. Campaigns have reinforced this knowledge.

Unprotected anal intercourse among gay and other homosexually active men between casual partners has increased significantly since the mid-1990s. Increased rates of unprotected anal intercourse among gay men in the context of casual encounters are similar to other jurisdictions indicating that campaigns in NSW over the past seven years have been no more or less effective.

It is however the case that the majority of gay and other homosexually active men use condoms in casual encounters most of the time. The extent to which this is attributable to interventions implemented prior to 1996 or would have occurred anyway given widespread information available in the public domain is difficult to determine. However, evidence indicates that condom use is much less embedded in US gay communities despite greater disease prevalence. This does indicate that earlier HIV health promotion programs targeting gay and other homosexually active men did contribute to safer behaviours.

Behavioural research shows a decline in HIV transmission in the context of regular relationships. Until 1996 around 50 per cent of recent seroconverters interviewed attributed their infection to risk in the context of a relationship.<sup>35</sup> Over recent years this has declined to less than 25 per cent.<sup>8</sup> The reduction in seroconversions in relationships coincides with the promotion by ACON of negotiated safety as a strategy to reduce risk in relationships.

Furthermore, most men in relationships have a spoken agreement about sex with casual partners. In most cases these agreements are consistent with the guidelines promoted by ACON. Men in relationships are less likely to have unprotected anal intercourse with casual partners than those who are not. The concurrent promotion of HIV testing has provided a context in which this strategy has been feasible.

While unprotected anal intercourse between seroconcordant regular partners has increased since 1997, unprotected anal intercourse between serodiscordant regular partners has remained steady. This indicates that the message of negotiated safety has been effectively targeted.

HIV testing levels are high among gay and other homosexually active men. This has contributed to a high level of diagnosis among those infected and consequent high proportion of those infected on HAART. It has also probably resulted in a significant percentage of people with HIV being diagnosed close to seroconversion – a period of significantly elevated viral load.

STI testing is also high among gay and other homosexually active men with 75 per cent reporting having had a sexual health check-up in the past year. STIs increase HIV infectivity and susceptibility. However, high rates of diagnoses and treatment will have alleviated the impact of increased infection.

HIV testing and risk behaviour patterns among young gay men in NSW are similar to their older counterparts. Most men are diagnosed with HIV in their early 30s.

The trend in HIV diagnoses among gay and other homosexually active men in NSW is similar to that in comparable jurisdictions interstate and overseas. However, the decline until 2001 was generally greater and the recent increase less.

The relatively better performance of NSW is probably attributable to higher levels of engagement with the health sector resulting in earlier diagnosis and higher treatment uptake as well as a reduction of behavioural risk in the context of relationships.

In regard to behavioural risk in the context of casual sex NSW has generally performed no better.

Engagement with the health sector, behavioural risk in relationships and behavioural risk in casual sex have all been a focus of HIV health promotion in NSW. On the basis of evidence reviewed it is reasonable to assume those interventions aimed at health sector engagement and behavioural risk in relationships have been effective while those targeting behavioural risk in casual sex have not.

### 5.3.2 Injecting drug users

#### *HIV testing*

HIV testing levels among IDUs are high but declining. See Table 12. Most injecting drug users have tested for hepatitis C (89 per cent ever in 2002).<sup>19</sup>

**Table 13: Projections of needle use 1995<sup>19</sup>**

Number of people syringe was reused after – last month	% of all people injecting	Number of needles distributed (thousands)	Number of injections per needle (thousands)	Number of injections per needle adjusted (thousands)
0	65	3798	3798	4367(i)
1	24	1403	2806	2806
2	8	467	1401	1401
3 or more	3	175	700	875(ii)
		5843	8705	9449

**Table 12: HIV testing by injecting drug users<sup>19</sup>**

Previous HIV test	1995	2002
In the last year	74%	65%
More than 1 year ago	18%	22%
Never Tested	7%	12%
Not reported	1%	1%

#### *Program reach*

In 1995/96 a review was done of the NSW needle and syringe program. The review reported that in 1994/95 the number of syringes distributed from all sources was 5,843,937. It was estimated that the likely number of injections was between 7 and 9 million. In order to minimise the possibility of an HIV epidemic among injecting drug users a target distribution was set of 7-9 million needles and syringes by 2000/01.

In 2000/01, 12,495,655 needles and syringes were distributed. The increase over the period 94/95 to 00/01 is most likely the result of an increase in drug injecting and improved program reach resulting in a decrease in sharing. In the following year distribution declined to 10,345,095.

#### *Needle and syringe sharing*

Between 1995 and 2001 there was a decrease in reuse of another person's syringe in the past month from 35 per cent to 15 per cent.<sup>19</sup> Reuse increased marginally in 2002 to 19 per cent.

#### *HIV risk*

The vast majority of needles and syringes used by injecting drug users in NSW are acquired through the needle and syringe program. Other potential sources are purchase through pharmacies outside the needle and syringe program and medical supply. Tables thirteen and fourteen provide an estimate of the total number of injections by injecting drug users in 1995 and 2001 based on reported sharing and needle and syringe program distribution.

**Table 14: Projections of needle use 2001<sup>19</sup>**

Number of people syringe was reused after – last month	% of all people injecting	Number of needles distributed (thousands)	Number of injections per needle (thousands)	Number of injections per needle adjusted (thousands)
0	85	10,620	12,213	14,045 <sup>i</sup>
1	9	1124	2248	2248
2	3	375	1125	1125
3 or more	3	375	1500	1875 <sup>ii</sup>
	12,494	17,068	19,293	

Notes:

- i. Number increased by 15% to include reuse by the same injecting drug user.
- ii. Assumption that the average number of people using before was 5.

The above tables indicate that the frequency of injecting more than doubled over the period 1995 to 2001. Had the needle and syringe program been unable to respond to this increase the level of sharing would have been significantly higher. Overseas experience indicates that changes in drug use practices (eg number of users, frequency of injecting, type of drugs used) can occur rapidly. Where programs have been unresponsive HIV incidence among injecting drug users has increased dramatically. Vancouver in Canada is most often reported on in this regard. However, similar experiences have also been reported elsewhere in Canada and more recently in Eastern Europe.

It is highly plausible that the capacity of the NSW needle and syringe program to respond to the increase in injecting averted a major outbreak of HIV among injecting drug users. Assuming a minimum number of regular injecting drug users in NSW of 20,000 and an incidence of 5 per cent (which is lower than that reported in Vancouver)<sup>20</sup>, this would have resulted in an additional 1,000 HIV infections per year.

There was a significant reduction in needles and syringes distributed in 2001/2002 from 12,495,655 the year before to 10,345,095. While reuse increased marginally (from 15 per cent to 19 per cent),<sup>19</sup> it is believed that the decrease most likely reflects a reduction in injecting drug use.

### **Referral to other services**

In 2001/02 injecting drug users received over 6000 referrals to drug treatment and other health and welfare agencies from counsellors and health educators working in the needle and syringe program.

### **5.3.3 Aboriginal and Torres Strait Islander people**

#### **Program reach**

Based on information provided by the AIDS/ Infectious Diseases Branch, over the 12 months from July 1, 2002 to June 30, 2003, 758 educational activities were undertaken specifically by the Aboriginal sexual health projects. There were 17,950 participants in these activities. Of the activities, 90–98 per cent were evaluated as favourable or satisfactory by participants.

A total of 5426 individual one-on-one client interventions occurred over the same period.

**Table 15: Summary of individual client contacts**

# of clients	Service provided
1996	One on one education, counselling and contact tracing
1044	Provision of clinical services ie testing
2028	Referral/support to access sexual health and other services
358	Other contact including transport to clinics, phone consultations, student supervision, mentoring
<b>5426</b>	<b>Total</b>

### 5.3.4 Sex workers

In the early to mid-1980s female sex workers in Sydney experienced high levels of STIs and were at significant risk of HIV infection. At that time female sex workers in Sydney experienced levels of gonorrhoea similar to those found among sex workers in developing countries.<sup>22</sup>

Between 1984 and 1991 there was a significant increase in condom use and STI rates declined significantly. An exception, however, was international

sex workers who had relatively low rates of condom use. However, 1997 research indicated that condom use and STI rates had improved among this group as a result of targeted interventions.<sup>22</sup>

#### Sexual health checks

A survey of street-based sex workers in 1998 indicated that just under 60 per cent had a sexual health check in the past five months, while 52.1 per cent of sex workers attending Sydney Sexual Health Centre in 1997 had a sexual health check in the preceding five months.<sup>22</sup>

**Table 16: Frequency of sexual health checks by sex workers<sup>22</sup>**

	Never	<3 mon	3–5 mon	6–11 mon	12+ mon
Street sample (n=47)	12.8%	19.1%	40.4%	10.6%	17.0%
Sydney Sexual Health Centre sample (n=674)	0	27.9%	24.2%	19.9%	28.0%

#### Condom use

Most sex workers report high levels of condom use by clients.<sup>22</sup>

Among Sydney Sexual Health Centre attendees in 1997, local sex workers reported higher rates of condom use (98.8 per cent) than international workers (80.4 per cent). However, reported use among international sex workers became much higher at follow-up visits.<sup>22</sup>

Among NSP attendees in NSW, 95 per cent of those who engaged in sex work in the past month reported condom use the last time they did sex work. This was higher than in other states, 11 per cent reported having done sex work in the past month.<sup>19</sup>

**Table 17: NSP Attendees – condom use last time did sex work<sup>19</sup>**

NSW	95%
Victoria	89%
Queensland	83%
South Australia	81%
Western Australia	75%

### 5.3.5 General population

#### HIV testing

HIV testing levels are high in NSW compared to similar overseas jurisdictions and higher than Victoria and Queensland. The number of tests conducted in 2002 was the highest on an annual basis in the past ten years. Between 1992 and 1996 number of specimens tested declined from 352,391 to 270,735 then gradually rose to 357,526 in 2002.<sup>26</sup>

**Table 18: HIV testing levels 2002<sup>26</sup>**

Jurisdiction	Number of specimens tested	Number of Specimens as % of population
NSW	357,526	5.67
Victoria	202,682	4.00
Queensland	184,994	5.65

## 5.4 Evaluation of the program – health outcomes

This section evaluates the HIV/AIDS health promotion program in relation to health and social outcomes.

### *HIV/AIDS in NSW*

As at the end of 2002 there have been 12,854 HIV notifications, 5146 AIDS notifications and 3503 AIDS

deaths in NSW. Within Australia 57.2 per cent of HIV diagnoses and 57 per cent of AIDS diagnoses have been from NSW.<sup>26</sup>

HIV diagnoses, after peaking at 1646 in 1987, gradually declined to a low of 342 in 2001. Between 2001 and 2002 reported diagnoses increased to 392 (14.6 per cent increase).

**Table 19: HIV diagnoses NSW<sup>39</sup>**

Pre 87	87	88	89	90	91	92	93	94
2333	1646	1154	992	824	826	701	594	502
95	96	97	98	99	00	01	02	
538	453	425	407	375	356	342	392	

The increase in diagnoses in NSW follows a similar trend to what is happening in Victoria and Queensland as well as comparable overseas jurisdictions. At this stage the increase is not as great but that could change quickly.

In 2002, NSW diagnoses made up 47.1 per cent of all Australian HIV diagnoses. This has declined from 57.9 per cent in 1995.<sup>26</sup>

Unlike comparable jurisdictions overseas the pattern of diagnoses in Australia, and NSW specifically, has not changed significantly over time. Male homosexuals continue to be the largest group diagnosed (75 per cent of all diagnoses in 2002 for which risk behaviour was reported). Diagnoses are concentrated in the age group 30–39 (2002 – 46.4 per cent). South East Sydney Area Health Service and Central Sydney Area Health Services continue to contribute over 50 per cent of all diagnoses.

**Table 20: NSW HIV diagnoses by risk category<sup>39</sup>**

	%
Male homosexual–bisexual	75
Male homosexual–bisexual/IDU	3.7
Injecting Drug Use	2.7
Heterosexual	18.3
Haemophilia–Coagulation Dis	0
Blood–Tissue recipient/NSI	0
Vertical	0.3
Total	100

### *Gay and other homosexually active men*

HIV diagnoses among gay and other homosexually active men declined in NSW from 365 in 1995 to 213 in 2001, and have since increased to 246 in 2002. The pattern is similar to comparable jurisdictions overseas. However, at this stage the rate of increase is lower reflecting lower reported incidence of new HIV infection.

**Table 21: HIV Diagnoses among gay and other homosexually active men**

Location	1995	1996	1997	1998	1999	2000	2001	2002
NSW <sup>39</sup>	365	299	285	249	245	233	213	246
British Columbia <sup>40</sup>		159	146	116	96	129	129	
Ontario <sup>41</sup>	756	564	500	482	431			573
Germany				868	675	640	484	725
United Kingdom	1472	1546	1401	1355	1347	1498	1714	
Switzerland				104	127	116	115	135

Despite HIV prevalence levels in Sydney’s gay community similar to comparable jurisdictions overseas incidence of new infection is generally lower.

**Table 22: Prevalence and incidence among gay and other homosexually active men**

Location	Prevalence %	Incidence %
Sydney 2002 (age see note)	15.5 <sup>15</sup>	0.98 <sup>26</sup>
Florida 2001 (age 18–29) <sup>31</sup>	15.0	6.3
Vancouver 2000 (age see note)	16.0 <sup>42</sup>	3.7 <sup>43</sup>
US 7 cities (1994–2000) age 15–22 <sup>44</sup>	7.2	2.6
US 6 Cities (1994–2000) age 23–29 <sup>44</sup>	13.0	4.4

Notes: Sydney – Prevalence from Sydney Gay Community Periodic Survey 2002; Median age of all respondents 35; Incidence from Health in Men Study median age 36

HIV diagnoses among injecting drug users continues to be low with only nine diagnoses reported in 2002. In most comparable countries injecting drug users make up a significant proportion of diagnoses.

**Table 23: Proportion of all HIV diagnoses attributed to injecting drug use in various jurisdictions**

Jurisdiction	Year	%
NSW <sup>39</sup>	2002	2.7
Canada <sup>45</sup>	2002	23.6
British Columbia <sup>40</sup>	2001	29.8
United Kingdom <sup>37</sup>	2001	2.2
USA <sup>46</sup>	2001	17.8
Switzerland <sup>47</sup>	2002	17.8

Heterosexual transmission has continued at a similar low level for many years. However, within this group infection acquired overseas or through unsafe sex with a person from a high prevalence country is increasing. The relative containment of heterosexual transmission contrasts with increasing infection levels in most comparable countries.

Within Indigenous communities HIV transmission is still low. The per capita rate of HIV and AIDS diagnoses among Indigenous people was similar to that among non-Indigenous people. However, continued social disadvantage and related poorer health status as well as high rates of sexually transmitted infections place this population at higher risk. Population movement between northern Australia and Papua New Guinea, which is in the early stages of an HIV epidemic, are a further concern.

Heterosexual HIV exposure is more common among Indigenous people than the rest of the population and consequently the proportion of females infected is also higher (30.7 per cent).<sup>26</sup>

It is also worth noting the Canadian experience where in 2002 Aboriginal people made up 14.8 per cent of persons diagnosed with AIDS compared with 1.3 per cent before 1992. Age and exposure patterns are broadly consistent with the wider population.<sup>45</sup>

**Table 24: Characteristics of cases of newly diagnosed HIV infection in Indigenous people in Australia 1993–2002<sup>26</sup>**

Exposure Category	%
Male homosexual contact	38.2
Male homosexual/IDU	9.8
IDU	11.6
Heterosexual	38.7
Other	1.7
Total	100

HIV infection among sex workers continues to be rare. The practice of safe sex and regular STI screening within this group appears to account generally for good quality sexual health.

AIDS diagnoses have declined significantly since peaking in 1994 at 552. There were 73 AIDS cases diagnosed in 2002. The decline is attributable in part to the benefits of combination antiretroviral treatment.

**Table 25: AIDS diagnoses and deaths NSW 1995–2002<sup>39</sup>**

	1995	1996	1997	1998	1999	2000	2001	2002
AIDS Diagnoses	472	368	201	173	112	122	77	73
AIDS Deaths	355	272	125	69	64	70	38	25

Deaths from HIV/AIDS have also declined markedly in recent years (1994 – 423 deaths; 2002 – 25 deaths). Again this is attributable in part to improvements in treatment.

While HIV diagnoses declined up till 2002 the actual prevalence (number of people living with HIV) has increased as a result of improved treatment.

Prevalence is a contributing factor to the level of infection.

#### **International comparisons**

Both HIV prevalence and AIDS incidence in 2002 in Australia are relatively low compared to elsewhere in the world.

**Table 26: Estimated HIV prevalence and AIDS incidence – various countries<sup>26</sup>**

Country until 2002	HIV diagnoses per 100,000	HIV Prevalence 2002	AIDS diagnoses 2002	AIDS Prevalence
Australia	13,120	67	246	1.3
Cambodia	169,000	2774	14,000	232
Indonesia	120,000	102	411	Less than 1
Papua New Guinea	16,000	640	–	–
Thailand	671,000	1851	156,309	284
United Kingdom	41,200	117	791	1.3
Canada	39,966	125	351	1.1
USA	506,154	180	43,158	15.4

## **5.5 Evaluation of the program – financial management, funding, and cost-effectiveness**

This section evaluates the HIV/AIDS health promotion program in relation to financial management systems, funding and cost-effectiveness.

### **Financial management**

Currently Area Health Services submits an annual funding plan to the AIDS/Infectious Diseases Branch that outlines proposed funding allocations. There is no standardisation of expenditure categories across Area Health Services and no further documentation is provided.

To enhance accountability and improve program effectiveness funding plans should:

- provide clarity regarding the use of funds
- enable benchmarking of expenditure across Area Health Services
- assist in the evaluation of health promotion outcomes and cost effectiveness.

To achieve these objectives, Area Health Services funding plans should report expenditure against categories outlined in Table 27, and include allocation by salaries, and goods and services.

**Table 27: Recommended expenditure reporting categories for Area Health Services**

Category	Sub-categories	
Medical (clinical service provision)	Inpatient Laboratory	Outpatient Other (specify)
Complex care		
Care and support	Accommodation Other (specify)	Counselling Social support Employment
Surveillance		
Program management		
Prevention	Aboriginal and Torres Strait Islander people Disabled General awareness Needle and syringe program Other injecting drug use Prisoners Social research Workforce development Hepatitis C	Culturally and linguistically diverse Gay and other homosexually active men Heterosexual Other (specify) People with HIV/AIDS Sex workers Transgender Youth

Non-government organisations funded through the AIDS Program are required to comply with operational guidelines governing all NSW Department of Health funded non-government organisations. The requirements are comprehensive in regard to substantiation of proposals as well as funding and performance reporting.

### **Funding of health promotion interventions**

There is strong evidence to suggest (see 5.3.2) the needle and syringe program was effective in preventing an HIV epidemic among injecting drug users in NSW since 1995. Furthermore there has been a major reduction in the unit cost of distribution over the same period. It is unlikely any reduction in expenditure can be made in this area without undermining the capacity of the NSP to contain HIV infection among injecting drug users. While not within the brief of this evaluation the recent reduction in hepatitis C diagnoses among injecting drug users may provide further evidence of the public health benefit of the needle and syringe program.

It is less clear that the current level of expenditure for HIV prevention targeting injecting drug users not allocated to needle and syringe program (NSP) is cost effective.

The third-largest area of prevention expenditure is that targeting Aboriginal and Torres Strait Islander communities. The level of expenditure would appear to be appropriate given high levels of sexually transmitted infections in this population and the experience in Canada where HIV rates increased significantly from a relatively low level in the early 1990s among that countries indigenous population.

The level of funding allocated to targeting youth may be excessive. Youth at highest risk are effectively targeted through programs targeting gay and other homosexually active men, injecting drug users and Aboriginal and Torres Strait Islander people.

Generally the proportion of expenditure allocated to other population groups is not inconsistent with level of risk. However, there may be specific projects that are not cost effective. The adoption of a more rigorous project evaluation framework within the program will facilitate such an assessment being made.

The amount spent on social marketing campaigns targeted at gay men is inadequate. Options to address under expenditure on campaigns include:

- allocation of funds to a central campaign fund from high prevalence Area Health Services
- reallocation of funds from non-government organisations targeting lower priority populations or engaged in activity of limited benefit.

To date funding has been sufficient to ensure NSW has had a higher decline in HIV diagnoses than comparable jurisdictions. There has also been sufficient flexibility to meet additional funding needs in the NSP and sexual health services. That flexibility is in part the result of a strategic decision in the early 1990s to strongly prioritise population groups most at risk of HIV infection.

### **Cost effectiveness**

Studies on cost-effectiveness usually measure benefits on the basis of lifetime treatment costs and Quality Adjusted Life Years saved. The Department of Health in the United Kingdom has recently estimated the lifetime treatment cost of one HIV infection as being between 135,000–181,000 pounds. The monetary value of preventing a single onward transmission is estimated to be between 0.5 and 1.0 million pounds in terms of individual health benefits and treatment costs.<sup>48</sup>

Two studies have been undertaken in recent years in Australia reviewing cost-effectiveness of HIV prevention programs. In June 2003 the Australian Department of Health and Ageing published a report containing a set of return on investment in public health case studies of tobacco consumption, coronary heart disease, HIV/AIDS, measles and road trauma.<sup>49</sup>

The study on HIV/AIDS attributes a net benefit to HIV prevention programs from commencement to the year 2010 of \$2.54 billion. This benefit includes both treatment costs saved and Disability Adjusted Life Years.

The study is primarily focused on gay and other homosexually active men. In regard to treatment cost it concludes that the net benefit is \$180 million. However, if all groups are included there is a net cost of \$191 million. It should be noted that in reaching this conclusion that study does not account for significant reductions in injecting drug use infection attributed to the needle and syringe program and subsequent cost savings. A recent study commissioned by the Australian Department of Health estimated the net treatment benefit of the needle and syringe program as being \$2.277 billion.<sup>50</sup>

The actual lifetime treatment cost assumed (y2000 prices) in the June 2003 study is \$150,975. This is a reasonably conservative estimate which assumes that lifetime survival after HIV infection will be twenty years and antiretroviral treatment will not commence till year eight.

### **Recommendation:**

That Area Health Services funding plans report proposed expenditure against specified categories, as outlined in Table 27.

# 6

## Additional Recommendations for the HIV/AIDS Health Promotion Program

### 6.1 Priority population groups

Patterns of HIV diagnoses in NSW have not changed significantly over time. Male homosexuals continue to be the largest group diagnosed with more than 85 per cent of cases of newly acquired HIV infection diagnosed in 1998–2002 due to sexual contact between men.<sup>26</sup>

Diagnoses among injecting drug users continues to be low.<sup>26</sup> Heterosexual transmission has remained relatively stable over many years, though infections acquired overseas or through unsafe sex with a person from a high prevalence country is increasing. HIV among sex workers continues to be rare. Compared to many countries, Australia's HIV prevalence rate of less than 1 per cent among injecting drug users, women with a history of sex work and prison inmates is exceptionally low.<sup>26</sup>

Among Aboriginal communities, HIV transmission is still low and very similar to that of the whole population, although an almost equal proportion of HIV diagnoses were attributed to heterosexual and male homosexual contact. Additionally, rates of STIs remain substantially higher than compared to the whole population.

On the basis of epidemiology and research, and consistency with the National HIV/AIDS Strategy, priority population groups for health promotion programs should remain gay and other homosexually active men, people with HIV/AIDS, Aboriginal and Torres Strait Islander people, people who inject drugs, and sex workers.

Gay and other homosexually active men remain one of the more vulnerable groups. Given the recent increase in HIV notifications in NSW, which was predominantly concentrated among gay and other homosexually active men, the challenge is to reinvigorate health prevention messages to ensure gay men understand and modify behaviour.

While the prevalence of HIV among other groups remains low, given the experience of overseas jurisdictions, the potential for an increase remains and so these population groups should remain priorities.

People with HIV/AIDS continue to be a priority population group in their own right in terms of their own health needs. There is also an ongoing need to engage people with HIV in terms of the role they can play in reducing HIV transmission.

There is no evidence to suggest young people generally are at any more risk of HIV infection, though it should be noted young people do experience higher rates of STI transmission. This however does not detract from the need to develop programs that may be more appropriate to particular young people within the priority population groups nominated.

#### **Recommendation:**

That the HIV/AIDS health promotion program prioritises the following population groups:

- gay and other homosexually active men
- people with HIV/AIDS
- Aboriginal and Torres Strait Islanders
- people who inject drugs
- sex workers.

### 6.2 People from culturally and linguistically diverse backgrounds

A range of arguments have been put forward on the need to ensure greater focus is given to people from culturally and linguistically diverse backgrounds, particularly those from high HIV prevalence countries, within the HIV/AIDS health promotion program.

A review of epidemiology indicates the following.

- People who speak a language other than English in the home accounted for nearly 18 per cent of new infections during 2001–2002.<sup>39</sup>
- Late HIV presentation (having an AIDS diagnoses within three months of an HIV diagnoses) has disproportionately affected heterosexuals and has been associated with region of birth. A substantially higher percentage of cases of late presentation occurred among people born in Asia and

sub-Saharan Africa and among people born in European countries other than the UK and Ireland.<sup>26</sup>

- HIV data reveals an over-representation of HIV infections in some communities, particularly sub-Saharan African communities and some Asian communities. People born in sub-Saharan Africa accounted for 5.2 per cent and people born in Asia 7.3 per cent of HIV diagnoses in 2002.<sup>51</sup>
- In 1998–2002, 21 per cent of new HIV diagnoses was attributed to heterosexual contact. Among 557 cases attributed to heterosexual contact, for which detailed information on exposure category was available, 36 per cent were in people from countries in sub-Saharan Africa, Cambodia, Myanmar or Thailand, 22 per cent were attributed to heterosexual contact with a partner from a high prevalence country.<sup>26</sup>
- Among heterosexually acquired cases, country of birth of the person was reported as Australia in 39 per cent, South East Asia in 22 per cent and sub-Saharan Africa in 23 per cent.<sup>26</sup>
- High rates of HIV infection exist in some communities drawn from high-prevalence countries of origin.

Another important consideration are patterns of immigration to Australia, with recognition that this significantly impacts upon Sydney as the majority of migrants choose to settle there. Immigration from high HIV prevalence countries, such as sub-Saharan Africa, or countries with emerging epidemics (eg India) is increasing and is likely to continue to do so. The experience of overseas jurisdictions such as the UK, where heterosexual infections acquired largely in Africa have been driving an increase in new diagnoses, provides a valuable lesson to Australia.

Specific projects already exist to address HIV in culturally and linguistically diverse (CALD) communities, such as the Multicultural HIV/AIDS and Hepatitis C Service. The plan recognised the importance of working with people from culturally and linguistically diverse communities by ensuring late HIV diagnoses was a priority area of work. Preventing HIV transmission and late diagnoses among people from CALD backgrounds means working with communities that are generally small in number and addressing heterosexual transmission,

which has generally not been the focus of HIV/AIDS health promotion programs in NSW.

Further investigation needs to occur regarding the extent to which those at risk identify as part of an ethnic community. Many may be on short-term working or education visas and methods to access them may vary from more established strategies.

While the figures do indicate the rate of HIV diagnoses amongst CALD communities are increasing, there is the potential that there is an increasing risk of HIV infection given changing immigration patterns and prevalence of HIV within some CALD communities.

Priority needs to be given to the ongoing development of strategies to address CALD communities who may be at high risk of infection, but also ensuring programs targeting priority population groups better consider how they are meeting culturally and linguistically diverse needs.

#### **Recommendation:**

That the HIV/AIDS health promotion program prioritises:

- the ongoing development of strategies targeted at people from culturally and linguistically diverse backgrounds who come from countries with high prevalence epidemics
- research into more clearly defining sub-populations most at risk and factors that impinge on prevention such as visa status
- strategies that include methods to reach those who don't identify on the basis of their ethnicity
- ensuring existing health promotion projects are able to effectively respond to the culturally and linguistically diverse needs of their target populations.

### 6.3 Strengthening health promotion efforts among gay men

The greatest challenge to the HIV/AIDS health promotion program is reducing HIV transmission among gay and other homosexually active men. We are proposing that the next plan devotes significant priority to the strengthening of prevention messages and health promotion programs targeting gay men.

The evaluation team has reviewed HIV interventions and prevention messages to assess their appropriateness and relevance in the current context of the epidemic.

In the context of HIV prevalence increasing and the increasing practice of structured treatment interruptions or delayed treatment intervention for those who are newly diagnosed, thereby increasing community viral load, HIV infection is only likely to decrease if gay men use condoms more regularly during casual sexual encounters.

#### **Strengthen HIV prevention messages**

Prevention messages need to strengthen the culture and norms of safe-sex practice among gay men. Health promotion initiatives need to recognise that social factors mediate beliefs and may be more important in understanding sexual behaviour than simple belief-behaviour explanations.<sup>52</sup>

Messages need to speak directly to HIV-negative people and recognise that their knowledge and experience of HIV is substantially different to that of HIV-positive people. There needs to be greater emphasis given to the role of HIV-positive people in preventing HIV transmission.

Health promotion initiatives may need to target specific sub-populations, such as 'sexually adventurous' men, or particular demographics, such as men in their late 20s and 30s who have high incidence of HIV infection.

Equally important prevention messages need to be personally relevant.

A review of research indicates some of the key issues that need to be addressed.

- *Differentiated messages for HIV-positive men and HIV-negative men* – Underlying prevention messages addressing unprotected anal intercourse in casual encounters has been an ethic of shared responsibility between HIV-positive and HIV-negative men. As a consequence of this approach messages may have inadequately differentiated between both groups in their targeting. A basic principle of social marketing methodology is that people have needs and wants and that messages are delivered accordingly. In regard to HIV transmission the overriding reason for those who are HIV-negative to use condoms is to protect themselves from HIV infection. Amongst HIV-positive people, the desire to protect your partner may not be as strong, and therefore there may be less motivation to use condoms.
- *Challenge the assumption about HIV status that gay men make* – Prevention messages have addressed erroneous assumptions some gay men make in assessing the likely serostatus of their casual partners (eg by appearance or attendance at particular sex-on-premises venue). There is little evidence to show that less men make these assumptions as a result of these messages. This does not mean campaigns have been ineffective in this regard. Rather data has not been collected over time to make an assessment. Gay men need to be made aware that, in the context of unprotected anal intercourse during casual encounters, partners may make assumptions about HIV status directly opposed to their own assumptions.
- *Challenge discrimination against HIV-positive people who disclose their HIV status* – Researchers report that 80 per cent of HIV-negative men expect an HIV-positive partner to disclose their status. At the same time 84 per cent of HIV-negative men report that they sometimes or always avoided having sex with someone who is HIV-positive.<sup>53</sup> This expectation stands in contrast to the reality of HIV-positive men not disclosing because of fear of rejection. Some HIV-positive men may also assume that a sexual partner wanting to have unprotected anal intercourse indicates shared serostatus.

- *Promote the personal relevance of condom use to HIV-positive gay men* – While there have been some efforts to promote condom use to positive men on the basis of personal benefit, such as HIV superinfection and morbidity associated with STI co-infection, greater effort needs to be made. There needs to also be an emphasis on ensuring positive gay men are educated about the impact STI co-infection and treatment breaks have on viral load and infectivity.
- *Continue to promote strategies to reduce the risk of HIV transmission in relationships* – HIV prevention messages need to continue to promote strategies to reduce the risk of HIV transmission among gay men in relationships who are choosing not to use condoms. In particular, prevention messages may need to consider targeting those entering new relationships and addressing issues that arise when agreements in relationships have been broken.
- *Promote the need for HIV-negative gay men to reconsider personal risk-taking in the current context* – Increasing HIV diagnoses provides an opportunity to engage HIV-negative gay men in reconsidering their personal risk-taking. With a potential increase in community viral load occurring, partially due to new HIV infections but also the increasing tendency for people with HIV to take structured treatment breaks, personal risk during unprotected anal intercourse may have increased. Prevention messages need to be conducted that speak directly to individuals about their personal risk rather than general risk in the gay community.

#### **Recommendation:**

That HIV prevention messages targeted at gay men:

- differentiate messages for HIV-positive men and HIV-negative men
- challenge the assumptions about HIV status that gay men make
- challenge discrimination against HIV-positive people who disclose their HIV status
- promote the personal relevance of condom use to HIV-positive gay men
- continue to promote strategies to reduce the risk of HIV transmission in relationships
- promote the need for HIV-negative gay men to reconsider personal risk-taking in the current context.

#### **Challenge risk-reduction strategies used during casual sex**

It has been well documented that some gay men are adopting risk-reduction strategies with casual partners.<sup>32</sup> These strategies might include insertive/receptive position, withdrawal before ejaculation, assumptions of HIV serostatus, using clinical markers such as viral load testing.

As a result of these practices among some gay men, non-government organisations have adopted a harm-minimisation/risk-reduction model that incorporates unprotected anal intercourse and recognises flexibility as to serostatus and circumstance.

In undertaking the review we found limited support for HIV prevention messages incorporating HIV risk-reduction strategies other than condom use. Indeed, the adoption of a risk-reduction approach has resulted in conflicting and inconsistent messages being provided by different agencies to gay men about the risk of non-condom strategies during casual encounters. This has the potential to undermine the effectiveness of health promotion messages and safe-sex practice by gay men.

There is some disagreement as to whether non-condom risk-reduction strategies during casual sex can be effective. While some of the strategies employed by gay men may be able to reduce risk to some extent, they are often contingent on many unknown factors. Furthermore a reduction in risk does not also mean that HIV transmission won't occur. As an ACON campaign highlighted, while you may reduce your risk of HIV infection from being an insertive partner, one in five gay men who recently got HIV were insertive partners when they had unprotected anal intercourse. No strategy remains as reliable as using condoms.

For HIV infection rates among gay men to decrease there will need to be an increase in gay men regularly using condoms during casual sex. We would argue promoting risk-reduction strategies, apart from condom use, are not appropriate. Such an approach is likely to weaken safe-sex culture and undermine messages that promote condoms as the most reliable strategy. Additionally, such an approach is likely to promote confusion among some gay men. An evaluation undertaken of ACON's resources which have canvassed risk-reduction strategies adds some weight to this view.

While some gay men may continue to engage in such risk-reduction strategies, HIV prevention messages need to address the use of these risk-reduction strategies but do so in the context of highlighting the increased risk these strategies pose as compared to using a condom. Condom use needs to be reinforced as the only reliable means of preventing HIV transmission during casual sex.

**Recommendation:**

That HIV prevention messages targeted at gay men reinforce condom use as the only reliable means of HIV prevention during casual sex.

**Strategic directions in gay men's HIV prevention education**

ACON is recognised as the lead agency targeting gay men in NSW. Developing and implementing health promotion programs for gay men that aim to reduce the risk of HIV transmission remains core work for ACON. ACON has produced many campaigns and other activities over the past few years, and gay men's health promotion has remained an important core component of the organisation's work.

It is important that the goals and strategies of ACON's HIV prevention work with gay men are well articulated and well-communicated, not only to ensure coherence for the programs that ACON implements but to enable the input of stakeholders and community members and to ensure strategic directions are well communicated to stakeholders and community members. The evaluation team recommends that ACON develop a gay men's prevention education strategy that identifies:

- factors contributing to HIV prevalence and incidence
- target audience
- aims and objectives
- key messages
- health promotion interventions planned
- partnerships and collaborations
- evaluation framework.

**Recommendation:**

That ACON undertakes to develop a gay men's HIV prevention strategy, in consultation with community members and stakeholders, that outlines

- factors contributing to HIV prevalence and incidence
- target audience
- aims and objectives
- key messages
- interventions planned
- partnerships and collaborations
- an evaluation framework.

**Strengthen social marketing interventions**

The evaluation team in assessing the overall HIV/AIDS health promotion program has devoted significant attention to social marketing campaigns targeted at gay men. We particularly focus on social marketing as it remains the key mechanism for HIV prevention messages to reach gay men and because of its role in establishing the social and behavioural norms that provide a context for other interventions. This is not to undervalue the important role of other strategies, such as peer education or small group work, but it recognises such strategies often target specific niches and have restricted reach.

Social marketing initiatives targeting gay men have generally been initiated by ACON. Some Area Health Services have worked with ACON to develop and implement social marketing campaigns or developed and implemented their own campaigns.

The evaluation team having examined many of the major social marketing campaigns that have been implemented over the last several years believe there are significant steps that can be taken to strengthen these interventions.

All social marketing campaigns must aim to maximise their reach to the target audience. Ensuring widespread exposure to a campaign message is a prerequisite for a campaign to succeed (although high audience exposure to a message will not guarantee success, a campaign will normally fail without it).

Data is regularly collected and analysed on the reach of campaigns through the Periodic Surveys. This unpublished data was made available to the evaluation team. The recognition rate of campaigns vary significantly, most campaigns generally have a recognition rate of between 40 to 60 per cent. The highest recognition rate was 62 per cent for the ACON *top and bottom* campaign. As noted previously in the report, past social marketing campaigns have been able to achieve recognition rates over 70 per cent.

Overall, we believe the reach of social marketing campaigns is not always adequate to have a significant positive impact upon the population as a whole. Below we outline some steps to strengthen social marketing interventions.

Social marketing is a complex area and our comments are intended to increase the capacity of the health promotion workforce to undertake social marketing, and ensure it is compatible with accepted best practice.

- *Rigorous and independent focus testing* – An evaluation ACON commissioned of its work recommended it should strengthen the research component of resource development. All major social marketing campaigns need to undergo rigorous and independent focus testing during concept and resource development stages with the intended target audience to ensure message receptiveness, clarity, motivational force of messages, attractiveness of resources, as well as any unanticipated outcomes.
- *Utilise broad range of media* – Given the proliferation of new media and the changing nature of gay community, gay newspapers may no longer be as effective at reaching the target audience. A broader range of media, particularly new media, may need to be utilised to reach the target audience.
- *Social marketing needs to incorporate a greater range of strategies* – Social marketing is considered at its most effective when advertising is supported by a range of promotional and marketing strategies and better integrated with other health promotion interventions.
- *Greater degree of reach* – Ensuring widespread exposure to a campaign message is a prerequisite for a campaign to succeed. Saturation advertising needs to be a greater feature of most campaigns. This may need to involve allocation of greater resources or existing resources being directed towards tackling a few key issues with greater intensity.

- *Address new issues* – Gay men are aware of the need to use condoms to protect against HIV. New issues or facts are required to ensure gay men are engaged with the message and consistently reassessing their own personal risk.
- *Monitoring changes in knowledge and attitude* – Knowledge of and attitudes towards issues to be addressed by campaigns need to be measured prior to campaigns being implemented and monitored during and following implementation. There needs to be ongoing monitoring to ensure shifts in knowledge and attitudes have been sustained.

#### **Recommendation:**

That social marketing campaigns targeted at gay men are strengthened by:

- ensuring rigorous and independent focus testing
- utilising a broad range of media
- incorporating a greater range of strategies
- ensuring a greater degree of reach
- addressing new issues
- monitoring changes in knowledge and attitudes.

#### **Expedited approval of social marketing resources**

All social marketing resources produced by AIDS Program funding are required to be submitted to the NSW Department of Health for approval. Concerns were raised by Area Health Services and non-government organisations about delays in receiving approval for resources.

Delays in approval can impact upon the delivery of timely messages to the target audience and as a result the overall impact of the message may be reduced. This is particularly the case when resources have been developed to respond to an outbreak of a particular STI or to capitalise on increased community awareness and interest in a particular issue.

The NSW Department of Health needs to ensure that the approval process for social marketing resources is prompt and timely.

#### **Recommendation:**

That the NSW Department of Health works to ensure that the approval process for social marketing resources are expedited in a timely manner.

## 6.4 Role delineation and partnership

### **Role delineation**

While the plan led to a strengthening of partnerships and collaboration, the issue of role delineation has arisen. The role of Area Health Services and non-government organisations in undertaking HIV/AIDS health promotion is not clearly defined.

Area Health Services and non-government organisations need to build upon their particular strengths. Area Health Services are significantly focused on the provision of clinical services. This provides an opportunity for health promotion within Area Health Services to focus on fostering appropriate links between clinical services, including general practitioners, and health promotion activities. Non-government organisations are generally community-based and have a long tradition in undertaking health promotion with particular affected communities. As an example ACON is a gay and lesbian community-based agency and has accumulated extensive experience and knowledge in developing social marketing and peer education initiatives with the gay community.

Building upon existing strengths provides a basis for clarifying role delineation. Such role delineation may need to differentiate between Area Health Services where there is a significant non-government organisation presence, and those where there are not.

### **Recommendation:**

That the NSW Department of Health facilitates a process to ensure agreement on role delineation between Area Health Services and non-government organisations when undertaking HIV/AIDS health promotion.

### **Partnership**

Partnership has been and continues to be an important feature of Australia's response to HIV. There remains an ongoing need to promote a coordinated approach to the development and implementation of health promotion activities across NSW.

During the evaluation, numerous comments were received on the need for greater partnership between non-government organisations and Area Health Services. While a range of existing partnership mechanisms exist and have been found effective, such as the CAS Health Promotion Sub-Committee, the evaluation team has identified that partnership efforts need to be strengthened in working to address the increase in HIV infections among gay men.

A partnership model that was widely viewed as successful was the NSW PEP Awareness Working Group. It included representatives from a variety of key agencies and worked effectively to develop and implement innovative health promotion programs to promote PEP awareness. Similar models include the STIGMA group and the recent working group that was established to develop an action plan to respond to an increase in HIV infections.

In a climate where resources available to health promotion are unlikely to increase significantly, if at all, there needs to be a greater emphasis on developing and implementing collaborative health promotion projects between key agencies. This enables resources to be pooled and can draw upon the strengths of each of the agencies involved.

Using social marketing techniques to reduce the risk of HIV infection among gay men remains one of the key challenges for the health promotion program. While ACON, as the lead agency targeting gay men, has been responsible for the vast bulk of social marketing campaigns targeted at gay men, the PEP campaign highlights the benefits of an inter-agency approach to campaign development and implementation.

Social marketing is at its most effective when a broad range of strategies can support the advertising and print media component of the campaign. To ensure social marketing campaigns are well resourced, well supported and draw upon multiple education and marketing strategies, we recommend the establishment of an inter-agency working group auspiced by ACON to assist in developing, implementing and evaluating social marketing campaigns targeted at gay men.

The key arguments in favour of such an approach are:

- enables resources to be pooled
- ensures advertising component of campaigns are better supported by other marketing, education and health promotion strategies
- strengthens the links between social marketing campaigns targeted at the community and clinical/health services and health care workers
- ensures social marketing campaigns targeted at gay men are well-implemented and coordinated across Area Health Services.

The interagency's focus should continue to be the high HIV prevalence areas of Sydney, and needs to include representatives of ACON, South-Eastern Sydney Area Health Service, Northern Sydney Area Health Service and Central Sydney Area Health Service. In addition, membership should also be drawn from social researchers and other community groups including PLWHA Inc.

Resourcing for the inter-agency should be provided by contributions from ACON and the three Area Health Services involved. All agencies will need to commit significant human and financial resources to ensure viability. Adequate resourcing is required if campaign reach is to be maximised.

***Recommendation:***

That, as the lead agency, ACON auspice a working group including SESAHS, NSAHS, CSAHS, social researchers and other community groups including PLWHA Inc., to assist in developing and implementing social marketing campaigns targeted at gay men.

# Appendix A: Comparisons with selected western nations

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The evaluation team has reviewed epidemiological trends and program responses in selected western nations to ascertain what lessons may be drawn for the NSW HIV/AIDS health promotion program.

## **Canada key points**

### **Epidemiological trends**

- Infection rates are higher than Australia.
- Patterns of infection are changing.
- HIV diagnoses are now increasing after a long period of decline.
- Diagnoses among young people are stable.
- There is an increasing level of HIV diagnoses among people over 40.
- HIV diagnoses and incidence of infection are increasing among homosexually active men.
- There has been a marked increase in HIV diagnoses among heterosexuals since year 2000.
- Local acquisition of HIV among heterosexuals has been more prominent than in the UK and Australia.
- There has been a major increase in AIDS diagnoses among Aboriginal people indicating increasing levels of HIV transmission.
- HIV diagnoses attributed to injecting drug use are high but gradually declining.

### **Policy and program responses**

- The *Canadian Strategy on HIV/AIDS* focuses on social determinants rather than disease.
- There has been a limited policy focus on emerging patterns of infection.
- The *Canadian Strategy on HIV/AIDS* is moving towards a social justice framework.
- Some Canadian provinces continue to focus on disease.
- Many programs still focus on risk.
- Programs targeting gay and other homosexually active men are community-based but often ad hoc and of limited reach.

- The needle and syringe program has become more responsive and flexible since the mid-1990s.
- Increasing heterosexual transmission is not addressed effectively in national programs.
- Significant effort is being made to address increasing transmission in Aboriginal communities.

## **USA key points**

### **Epidemiological trends**

- Almost one million people have been diagnosed with AIDS in the USA.
- Homosexual men and injecting drug users are the population groups most affected.
- HIV/AIDS has had a disproportionately high impact on black and hispanic populations.
- HIV trends are difficult to assess due to an inadequate surveillance system.
- HIV has had a greater impact on young people compared to Canada, UK and Australia.
- Data from Florida shows a big increase in HIV diagnoses which may indicate trends elsewhere in the USA.
- A Centers for Disease Control and Prevention study shows higher levels than comparable countries of HIV incidence among gay and other homosexually active men.
- There are high rates of unprotected anal intercourse among gay and other homosexually active men.
- There has been a recent increase in HIV diagnoses among injecting drug users from those states where diagnoses are reported.

### **Policy and program responses**

- In 2003, the USA adopted a new prevention policy with HIV-positive people as the highest priority target population.
- A 2001 plan with a wider focus has been largely supplanted.
- Research supporting the new policy is questionable.

- Needle and syringe programs are not supported in national strategy.
- Promotion of abstinence and monogamy are the key strategies for targeting heterosexuals.

### **United Kingdom key points**

#### **Epidemiological trends**

- HIV diagnoses have more than doubled on an annual basis since 1994.
- HIV/AIDS in the UK have been heavily concentrated in London.
- Heterosexual infection acquired outside the UK is driving the increase in new diagnoses.
- After reaching their lowest point in 1999 annual diagnoses of HIV among gay and other homosexually active men have been increasing since.

#### **Policy and program responses**

- The UK adopted its first national HIV strategy in 2001.
- The priorities largely reflect patterns of infection.
- A detailed strategic framework has been adopted for targeting gay and other homosexually active men.
- Prevention programs are largely conducted by community-based organisations.
- Programs targeted at gay and other homosexually active men have strong links with social researchers.
- The needle and syringe program is similar to NSW's in scope and reach.
- Government sexual health clinics are the main site for HIV testing.
- HIV testing rates are much lower among gay men than in NSW.

### **1. Canada**

#### **Background<sup>‡</sup>**

As at the end of 2002 there had been 52,640 positive HIV tests reported in Canada since testing commenced in 1985, 18,469 AIDS cases and 12,563 deaths. On a population basis the proportion of AIDS cases is just under 50 per cent higher than in Australia.

Analysis of AIDS data provides a picture of the changes in infection patterns over time in Canada. Whereas prior to 1993 exposure to HIV through homosexual contact constituted 78.9 per cent of all AIDS cases, this had declined to 39.2 per cent in 2002. AIDS cases attributed to heterosexual transmission have increased from fewer than 10 per cent before 1993 to 35.3 per cent in 2002, while those attributed to injecting drug use have increased from 2.7 per cent to 22.2 per cent. AIDS cases (attributed to all risk categories) among people of Aboriginal origin have increased from 1.3 per cent to 14.8 per cent over the same period.

HIV diagnoses peaked in the 1980s and declined steadily till the year 2000 when 2182 diagnoses were reported. In 2002 there were 2473 HIV diagnoses reported. In 2002 25.4 per cent of all HIV diagnoses were among women. Of all HIV diagnoses, 41.5 per cent were attributed to men who have sex with men, 29.9 per cent heterosexual and 23.6 per cent injecting drug use. Please note actual numbers attributed to risk categories from Health Canada reported surveillance need to be read in the context of between 40 per cent and 50 per cent of diagnoses not including reported risk category.

Both the absolute number and the relative proportion of young people (age 15–29) becoming diagnosed has remained relatively constant since 1997. In this age group there were 549 diagnoses in 1997 (21.6 per cent of notifications) while in 2002 there were 514 diagnoses (20.8 per cent of diagnoses).

While the age group 30–39 continues to have a disproportionately high number of diagnoses there has been a decline in the relative proportion of diagnoses in this age group among men since 1997. Among men the proportion has declined from 45.5 per cent in 1997 to 39.7 per cent in 2002, however, among women the proportion has increased marginally from 38.5 per cent to 39.2 per cent. Of particular note is the increase in the 40–49 year age group. Between 1997 and 2002 the proportion of all diagnoses increased from 30.6 per cent to 38.1 per cent.

Between 1997 and 2001 there was a significant decline in HIV diagnoses among homosexual men (from 487 to 397). However, the number increased markedly from 2001 to 2002 (507). While diagnoses declined

<sup>‡</sup> Unless otherwise indicated, information on Canada epidemiology has been derived from: Health Canada. HIV and AIDS in Canada. Surveillance Report to December 31, 2002. Ottawa: Health Canada, 2003.

between 1997 and 2001, different studies indicate increased incidence of HIV infection. In a Vancouver cohort study of 15 to 30-year-old gay and bisexual men incidence increased from 0.6 per 100 person years in the period 1995–1999 to 3.2 per 100 person years in 2000.<sup>43</sup> In Ontario estimated incidence increased from 0.79 per 100 person years in 1996 to 1.16 per 100 person years in 2000.<sup>55</sup>

The delay between increased incidence of HIV infection and increased reported HIV diagnoses might be attributable to testing levels. Data on testing levels is not widely available but in Montreal the Omega study reports that only 56.7 per cent of respondents had ever tested.<sup>30</sup>

Heterosexual transmission remained relatively constant from 1997 (337 diagnoses) to 2000 (322) then increased markedly over the next two years (446 diagnoses in 2002).

Unlike either the United Kingdom or Australia the extent to which heterosexual transmission is related to either having been acquired in a country with high HIV prevalence or from a partner originating in such a country the proportion of such diagnoses reported nationally in Canada is relatively low (18.2 per cent in 2002). However, the high proportion of diagnoses reported nationally for which no risk category is assigned may mask the true level of HIV infection acquired in high prevalence countries. For example surveillance data reported by public health authorities in Ontario shows 58.4 per cent of heterosexual infection was acquired in a high prevalence country. Nearly 50 per cent of heterosexual transmission reported nationally involves sexual transmission from a person at high risk (eg known to be HIV-positive, IDU, bisexual male).

AIDS diagnoses indicate a significant increase in HIV infection among Canada's Aboriginal peoples over the past ten years. AIDS diagnoses among Aboriginal people increased from 1.3 per cent before 1992 to 14.8 per cent in 2002. Patterns of HIV among Canada's Aboriginal population broadly reflect that of the overall population. However social disadvantage, including poorer health status in general and higher levels of morbidity associated with sexually transmitted infections (eg chlamydia rates seven times that of the general population), contribute to higher risk of more rapid transmission and higher incidence among heterosexuals.

After containing HIV transmission among injecting drug users at relatively low levels (less than 5 per cent of all infections), Canada experienced a rapid increase in the early to mid-1990s. While transmission remains high with 23.6 per cent of diagnoses in 2002, it has gradually declined over recent years from 33.7 per cent of diagnoses in 1997.

### **Policy response**

In 1998 Canada adopted the 'Canadian Strategy on HIV/AIDS'.<sup>56</sup> Previous national HIV/AIDS strategies had been adopted in 1990 and 1993. The strategy is aligned with the broader strategic approach of Health Canada which focuses on the social determinants of health. The implications of this approach is described in the strategy as a shift from a disease oriented approach to one that looks at the root causes, determinants of health and other dimensions of the HIV epidemic.

In the period since 1998, much of the focus in policy and strategic deliberations has been on determining the practical implications of this shift in approach. There has been little effort spent on understanding emerging patterns of infection and identifying more immediate contributing factors. However, to some extent the perceived need to do so is superseded by the view that broader social dynamics determine patterns of infection.

The strategy defines the key policy directions required to prevent HIV and to ameliorate the consequences of living with HIV/AIDS as:

- reduce both absolute and relative poverty, and ensure a more equitable distribution of Canada's wealth
- promote community development efforts that prevent children, youth and adults from being relegated to the social and economic margins of society
- enable those already marginalised by poverty to return to the mainstream
- acknowledge and offset the economic burdens associated with HIV/AIDS and other disabilities.

While at the national level the strategy may be somewhat disengaged from the reality of increasing HIV transmission, some provincial authorities have developed policy frameworks more responsive to current patterns of infection. The government in British Columbia has recently developed a strategy for

the period 2003–2007. While acknowledging the role of broader social determinants, it identifies that much of the capacity and expertise required to address them lies outside the ambit of health authorities. British Columbia's strategy focuses on target populations where infection rates are highest and/or research indicates greater potential risk of infection.

### **Program response**

Canada has a Federal system of government not unlike Australia. While the Federal Department of Health has a broad policy and funding role, service delivery is largely the responsibility of provinces and territories. However, the national HIV/AIDS strategy budget is primarily allocated by the Federal Department centrally or through its state/territory offices.

Despite the broad policy debate around social determinants most prevention activity continues to address risk behaviour and the more immediate personal and social determining factors.

Programs targeting men who have sex with men are primarily conducted by community-based organisations with significant gay membership. Compared to NSW the number of such groups funded in any one city are usually higher. Close relationships appear to exist between social researchers and community-based organisations and issues identified through social research are often the focus of specific projects. However, many projects are ad hoc, of limited reach and not placed within an ongoing program. This may be due to limited funding as claimed by Canadian non-government organisations.

Needle and syringe programs operate throughout Canada. In the early 90s Canada experienced a major increase in HIV transmission among injecting drug users. Contributing factors are believed to be a shift from heroin injecting to cocaine injecting (resulting in much more frequent and chaotic drug use) and a failure in needle and syringe program service delivery to respond to this change (continuation of limited distribution outlets and severe limits on the amount of equipment provided at any one visit). In the period since, program delivery has become more flexible and there has been a reduction in HIV transmission

attributed to sharing of injecting equipment (23.6 per cent of transmissions in 2002 compared to 33.7 per cent in 1997). However, injecting drug use continues to be a risk associated with a high level of HIV transmission.

At the national level there does not appear to be any programmatic approach to addressing the increasing level of heterosexual transmission. National program funding is mainly directed to youth targeted projects even though absolute numbers of younger people being diagnosed are declining.

Significant attention is being given at the national and provincial level to developing programs targeting Aboriginal people.

## **2. United States of America**

### **Background<sup>§</sup>**

At the end of 2001, 807,075 adults and adolescents had been reported as diagnosed with AIDS in the US. On a population basis this is approximately seven times that of Australia. An estimated 362,827 people were reported to be living with AIDS. Of these people 42 per cent were black, 37 per cent white and 20 per cent hispanic. By risk group 57 per cent were homosexual, 8 per cent homosexual and injecting drug users, 24 per cent injecting drug users and 9 per cent heterosexual.

HIV diagnoses are only reported in some states and do not provide a reliable indicator of national diagnoses or trends over time. The Centers for Disease Control estimates that there are currently 40,000 new HIV infections annually in the US.

The impact of HIV on younger people is greater in the US than in comparable countries. In 2001, in those states that report HIV diagnoses, 33 per cent of female cases and 29 per cent of male cases reported were in the 20–29 year age group.

A Centers for Disease Control sponsored survey of homosexual men in seven US cities showed an incidence rate of 4.4 per 100 person years in the period 1998–2000.

In the twenty-five states with HIV reporting, the number of persons who had HIV infection newly

<sup>§</sup> Unless otherwise indicated, information on USA epidemiology has been derived from: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 2001:13(2).

diagnosed increased 14 per cent among homosexual men since 1994 and 10 per cent among heterosexuals between 1999 and 2001.

HIV diagnoses do not necessarily provide a good indication of infection trends. Despite relatively high numbers of people reporting having been tested in surveys, investigation of diagnoses in some states shows those reported are often not recent infections. A recent study in Florida showed that of a sample of HIV diagnoses over the period 1998 to 2001 only 18.8 per cent were recent infections.

Behavioural studies of homosexual men indicate relatively high levels of unprotected anal intercourse compared with similar countries elsewhere in the world. A survey conducted in Boston, Chicago, Denver, New York, San Francisco and Seattle showed that 48 per cent of respondents had engaged in receptive unprotected anal intercourse and 55 per cent in insertive unprotected anal intercourse in the preceding six months.\*

Between 1994 and 2000, HIV diagnoses among injecting drug users in those states with HIV reporting declined by 42 per cent. However, after plateauing in 1999/2000 there was a 22.4 per cent in 2001.

### **Policy**

In 2001 the US adopted a new prevention strategic plan for the period till the end of 2005. The plan was developed after extensive consultation and recognised most effective prevention works at multiple levels simultaneously – at individual, social network and community levels as well as at the structural level – addressing the sometimes hidden societal barriers to effective prevention.<sup>58</sup>

In 2003, the 2001 plan was largely supplanted by *Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States 2003*.<sup>59</sup> In part the new plan was a response to evidence that HIV incidence was increasing but more fundamentally represented a shift towards a more narrowly focused individualised model of HIV prevention. The plan outlines four strategies:

- make HIV testing a routine part of medical care
- implement new models for diagnosing HIV outside medical settings
- prevent new infections by working with persons diagnosed with HIV and their partners
- further decrease perinatal HIV transmission.

The strategy is based on a body of research (generally based on small samples in medical settings often with laws that punish people with HIV that engage in unsafe behaviours) that indicates people newly diagnosed with HIV report that they reduce their HIV-related risk behaviour (at least in the short-term). Other supporting research shows that counselling interventions can enhance this outcome.

The research that the new strategy is based on is contrary to most large scale behavioural surveys which do not show lower levels of unsafe behaviours among those who are HIV infected (many surveys show higher levels of unsafe behaviour among those infected with HIV).<sup>58,15,28</sup> While some studies show efficacy for interventions targeting individuals (eg counselling) or small groups (eg peer support) most health promotion theories and research indicates that sustaining effectiveness will usually be best achieved within a supportive environment (eg wider social and cultural norms supporting safe behaviours).<sup>60</sup>

The US strategy in regard to injecting drug users is based on abstinence. Federal funds are not allowed to be used for providing needle distribution programs.<sup>61</sup> In regard to heterosexual transmission, US policy promotes abstinence among youth and monogamy among adults. However, condom use is generally recognised as a fall-back option.

## **3. United Kingdom**

### **Background††**

At the end of 2002, there had been 19,457 AIDS cases reported of whom 14,854 had died.<sup>62</sup> The total number of HIV diagnoses reported till the end of 2002 was 55,655, and 57 per cent of all diagnoses were recorded in London.

\* URL: 'www.explorestudy.org'. Accessed November 2003.

†† Unless otherwise indicated, information on UK epidemiology has been derived from: PHLS Communicable Diseases Surveillance Centre, ICH (London) SCIEH, HIV and AIDS in the United Kingdom 2001. London: An Update November 2002.

Of all HIV diagnoses reported till the end of 2001 (the last year for relatively complete risk category information), 52.7 per cent of HIV diagnoses had been attributed to gay and other homosexually active men, 32 per cent to heterosexual transmission and 7.1 per cent to injecting drug users. However, since 1999 the number of diagnoses reported annually has been greater among heterosexuals than gay and other homosexually active men. At the end of 2001 it was estimated that approximately 22 per cent of gay and other homosexually active men and 42 per cent of heterosexuals infected with HIV were undiagnosed.

Among gay and other homosexually active men 32 per cent of HIV diagnoses have been in the age group 20-29 and 45.6 per cent in the age group 30-39. Among heterosexuals 18.8 per cent of males and 42.1 per cent of females diagnosed were in the age group 20-29, while 47 per cent of males and 42 per cent of females were in the age group 30-39.<sup>62</sup>

Total HIV infections reported annually have increased every year since 1994 when 2571 diagnoses were reported. In 2002, 5542 diagnoses were reported.<sup>62</sup>

Heterosexual transmission has been the major factor in increased diagnoses since 1994. In that year there were 795 diagnoses attributed to heterosexual transmission while in 2001 there were 2829.

It is estimated that 71 per cent of heterosexual transmissions were acquired in Africa. It is believed that less than 9 per cent of heterosexual transmission occurred in the United Kingdom.<sup>62</sup>

HIV diagnoses among gay and other homosexually active men reached their lowest point in 1999 at 1377. In 2001 there were 1714 diagnoses attributed to homosexual contact – a 24.5 per cent increase.<sup>62</sup> Among gay and other homosexually active men gonorrhoea rates have more than doubled since the mid-1990s and behavioural studies show significantly increased rates of unprotected anal intercourse.

### **Policy**

In July 2001 the United Kingdom adopted its first national strategy for sexual health and HIV. The aims of the strategy are:

- reduce transmission of HIV and STIs
- reduce prevalence of undiagnosed HIV and STIs

- reduce unintended pregnancy rates
- improve health and social care for people living with HIV
- reduce the stigma associated with HIV and STIs.<sup>63</sup>

An additional 47.5 million pounds was to be distributed over the following two years to assist strategy implementation.<sup>63</sup>

Priorities identified included:

- HIV prevention for gay men including endorsement of the Community HIV and Prevention Strategy (CHAPS) and its strategic framework 'Making It Count'
- development of a strategic framework for HIV prevention in African communities
- promoting HIV testing among populations most at risk
- maintaining the sexual health of people with HIV
- improving the diagnosis and treatment of STIs
- assisting people with HIV to deal confidently with disclosure, condom use and safer sex
- maintaining the needle and syringe program
- national campaign targeting young injecting drug users
- continued review of infection control in clinical settings
- harm minimisation information and substance abuse treatment in correctional settings
- general population mass media campaign on preventing STIs (including HIV) and unintended pregnancies
- developing and promoting the evidence for prevention
- collaboration processes
- workforce development
- developing sexual health services
- targeted prevention to young people especially those in or leaving care, black and minority ethnic groups, gay and bisexual men, injecting drug users, people living with HIV, sex workers, and people in prisons and youth offending establishments.<sup>63</sup>

'Making It Count' is a strategy framework developed in partnership by agencies doing HIV prevention work with gay and other homosexually active men. It was first released in 1998 and a revised edition was released in 2000. The framework is used to plan, develop, implement and evaluate HIV prevention programs. It has been used by the CHAPS agencies and other health promoters to develop local planning consortia and prevention programs. It has also provided a commissioning framework for health authorities.

Strategic targets of 'Making It Count' are:

- a reduction in the number of occasions of serodiscordant unprotected anal intercourse
- a reduction in the condom failure rate among all users
- a reduction in the prevalence of gonorrhoea and NSU infections.

The strategy adopts as an ethical starting point the objective of individual empowerment to control the risk of HIV exposure. The agencies collaborating on the framework adopt the view that raising awareness and empowering men through clear, accessible information and facilitating the development of the skills to carry out their choices is the most ethical and sustainable approach to reducing HIV infection.

The document outlines strategic targets and more specific aims, criteria for determining types of interventions and a framework for evaluation.

Within the context of empowerment, evidence of need, effectiveness and efficiency determine the intervention approach adopted. Evaluation is used to identify overall program weaknesses in achieving the aims and to reprioritise program delivery accordingly.<sup>2</sup>

### **Program implementation**

Apart from clinical based interventions and needle availability services, most health promotion programs are delivered by the community-based sector. Government funding is either directly provided nationally or through local Primary Care Trusts. It was intended that Primary Care Trusts either alone or in combination would establish multi-agency groups (including stakeholders) to develop local strategic plans and commission services.

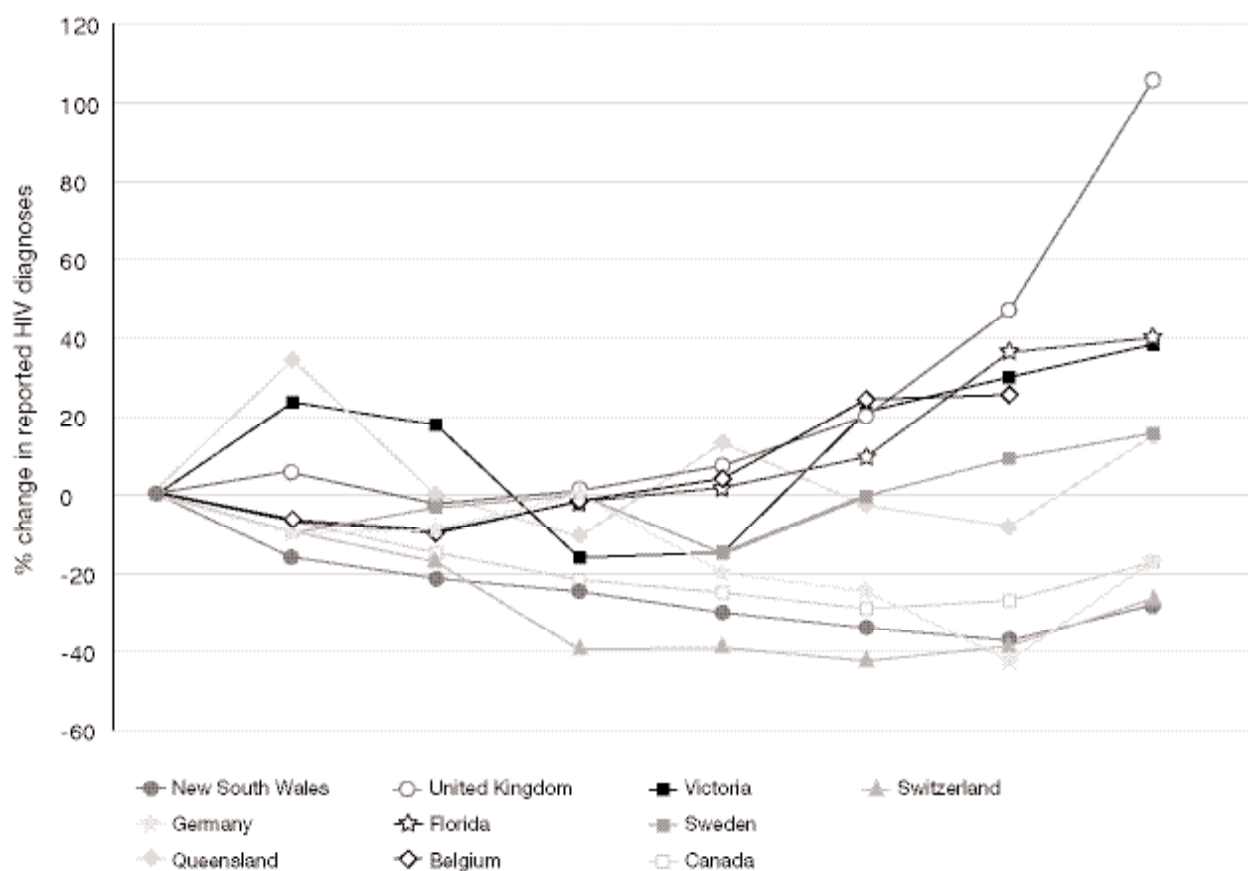
Health promotion programs targeting gay and other homosexually active men generally operate within the framework of 'Making It Count' and involve a partnership across community-based organisations. The Terrence Higgins Trust, which is a major national community-based organisation with a strong presence in the gay community, is often the fundholder for such partnerships.

There is strong relationship between social research organisations and community-based organisations. Surveys of gay men are conducted on a regular basis and findings are well integrated into program planning.

The United Kingdom has an extensive needle availability program.

Sexual health primary health care services including HIV testing are mainly accessed through GUM clinics.

**Figure 3: HIV trends in comparable jurisdictions 1995–2002 (United Kingdom, Florida, Victoria, Sweden, Belgium, Queensland, Canada, Germany, Switzerland, NSW)**



#### 4. Key findings

Perhaps the main finding from examining international developments is how quickly levels of infection can increase and new patterns of infection emerge. Some more specific findings are as follow:

- Maintain a strategic response that addresses both individual factors and the broader social context contributing to risk behaviour.
- Ensure strategies are based on evidence and not driven by ideology.
- Ensure strategies are multi-faceted including interventions ranging from medical to community oriented.
- Maintain a strong partnership between community, medical and government sectors.
- Be responsive to changes in risk behaviour among gay and other homosexually active men.
- Monitor and be vigilant for changes in heterosexual transmission.
- Respond quickly to any indication of increased transmission among injecting drug users.
- Monitor and respond appropriately to the potential impact of population movement between high prevalence countries and Australia.
- Ensure effective program are maintained in Aboriginal communities.

# Appendix B: HIV/AIDS Health Promotion Demonstration Projects Program

The information below, on the status of projects, has been taken from the six-monthly reports that are a requirement of funding. In some cases, it was not possible to determine the status of projects as reports were unavailable.

**Table 28: HIV/AIDS Health Promotion Demonstration Projects Program**

Title	Recipient	\$	Status
<b>3.1 Unprotected anal intercourse among gay and other homosexually active men</b>			
HIV Health Promotion Program for Gay and Other Homosexually Active Men	NEAHS	150,000	In progress
Peer Education Strategy Addressing Sexual Health Among Gay Men and Lesbians	SSHC	23,100	In progress
Peer Education and Community Development Project	HCHA	146,500	In progress
Using New Technologies to Conduct Health Promotion with Gay Men	ARCShS	159,800	In progress
International Strategies in Gay Men's Health Promotion	ACON	6500	Completed
Safe Sex Video for Young Gay Men	ACON	10,000	Completed
<b>3.2 Post-exposure prophylaxis</b>			
Improving Appropriate Access to Non-Occupational PEP	MNCAHS	10,000	Indeterminate
Improving Appropriate Access to Non-Occupational Post-Exposure Prophylaxis	NRAHS	10,000	In progress
Non-Occupational Post-Exposure Prophylaxis Campaign Evaluation	Albion St	7900	In progress
<b>3.3 Serodiscordant relationships</b>			
HIV-positive People and their Partners Project	MNCAHS	25,000	Indeterminate
<b>3.4 Treatments and health issues (for people with HIV/AIDS)</b>			
Heterosexuality and HIV/AIDS Resource Kit	Heterosexual HIV/AIDS Service	35,000	In progress
Heterosexuality and HIV/AIDS Interactive Website	Heterosexual HIV/AIDS Service	25,000	In progress
Evaluation and Modelling of Changes in HIV Infection Risks Among HIV-positive Patients Receiving Medical Treatment	Albion St	45,000	In progress
Developing Therapeutic Models for Addressing Safe Sex with People Living with HIV/AIDS	Albion St	45,000	In progress
Information Packages for General Practitioners Providing HIV Diagnoses	ASHM	55,000	Completed
Health Information Fact Sheets	PLWHA Inc.	30,000	Completed
Positive Sexuality Workshops	PLWHA Inc.	80,300	In progress
Positive Women's Sexuality Campaign	ACON	10,000	Completed
<b>3.5 Aboriginal and Torres Strait Islander Australians sexual health</b>			
Cultural Training	FWAHS	30,000	Completed
Community Development Through Resource Development	SWSAHS	45,000	In progress
Resources on STIs, Blood Borne Viruses and Injecting Drug Use	NRAHS	52,500	In progress
Sexual Health Workshops for Aboriginal Sports Groups	Durri AMS	41,000	In progress
Sexual Health Workshops for Youth Workers	Durri AMS	6000	In progress
Promoting Safe Messages Among Aboriginal People	Redfern AMS	50,000	Indeterminate
Short Course on HIV Medicine for Health Care Workers in the Aboriginal and Torres Strait Islander Community	ASHM	41,000	In progress
Educating Young Aboriginal People About Safe Sex	Darruk AMS	50,000	Indeterminate
<b>3.6 Illicit drug use</b>			
HIV Risk in the Vietnamese Community	CSAHS	170,900	In progress
Needs Assessment Among Vietnamese Injecting Drug Users	CSAHS	40,600	Indeterminate
HIV Education Resources for Homeless People	SESAHS	13,700	Completed
Building Community Support for the Needle Syringe Program	SESAHS	80,000	In progress

Title	Recipient	\$	Status
Aboriginal and Torres Strait Islander Needle and Syringe Program Education Package	NRAHS	15,000	Completed
Building Community Support for the Needle and Syringe Program, Nimbin	NRAHS	171,000	In progress
Illicit Drug Use Database	CCAHS	150,000	In progress
Community Needlestick Education Resources for General Practitioners	Albion St	20,500	In progress
Nutrition for Injecting Drug Users	Albion St	13,600	Completed
Ethnic Media Campaign To Increase Community Support for the Needle and Syringe Program	MHAS	16,100	In progress
HIV Health Promotion in Drug Treatment Facilities	We Help Ourselves	50,400	In progress
Cabramatta Sex Workers Project	ACON	16,400	In progress
<b>3.7 HIV and sexually transmissible diseases</b>			
Sexual Health Promotion for Gay Men	SESAHS	147,700	In progress
<b>3.9 Testing and late diagnosis</b>			
Promoting HIV Testing Among Young Gay Men	WSAHS	150,000	In progress
General Practitioner Liaison Project	NSAHS	98,000	In progress
Non-English Speaking Background Gay Men's Project	MHAS	26,900	In progress
Developing Culturally and Linguistically Appropriate Resources	MHAS	133,500	In progress
<b>Other projects</b>			
Evaluating HIV Knowledge Among Female Asian Sex Workers	SSHC	59,400	In progress
Schools-Based HIV Prevention (Positive Speakers Bureau)	PLWHA INC.	12,000	In progress
Polare Magazine	Gender Centre	45,000	In progress
Training Package for Facilitators Working With Same Sex Attracted Young People	ACON	75,000	In progress
Peer Education Project	YAA	150,300	In progress
<b>Research projects</b>			
Living With HIV and Cultural Diversity	NCHSR	46,781	In progress
Investigation into HIV risk and sexual adventurism among gay men in Sydney	NCHSR	97,946	In progress
A spatial analysis of the needs and lives of HIV/AIDS affected people living in the Hunter Valley	School of the Environment and Life Sciences, Uni. of Newcastle	42,500	In progress
Negotiating ambiguity: making sense of HIV treatments	Centre for Critical Psychology, School of Psychology, Uni. of Western Sydney	69,100	Completed
Demographic and social-economic and behavioural risk factors for AIDS in the HAART era	NCHECR	50,000	In progress
Monitoring Risk Practices Among Asian Gay Men	NCHSR	25,371	Completed
Prevalence incidence and risk factors for sexually transmissible infections among gay men	NCHECR	78,900	Completed
Changing Community, Changing Practice?	NCHSR	83,400	In progress
Pattern of Injecting Drug use, risk behaviours and blood-borne viral incidence following changes in the drug market: a survey of metropolitan and rural injecting drug users.	NDARC	49,843	In progress

# Appendix C: Additional funding to non-government organisations

**Table 29: Additional funding to non-government organisations**

Title	Recipient	\$	Status	Evaluation
Social Marketing to Reduce the Transmission of HIV/AIDS Among Gay Men	ACON	200,300	<ul style="list-style-type: none"> <li>• Nearing completion</li> <li>• Range of resources and campaigns already implemented</li> </ul>	Evaluation report on two campaigns completed
Facilitating Behaviour Change Among Gay Men at Highest Risk	ACON	60,000	<ul style="list-style-type: none"> <li>• Research completed</li> <li>• Interventions currently being trialed</li> </ul>	Research report completed
Strengthening Prevention Efforts Among Gay and Lesbian Injectors	ACON	50,000	<ul style="list-style-type: none"> <li>• Need analysis of alcohol and drugs services completed</li> <li>• Developing interventions</li> </ul>	Needs analysis completed
Strengthening HIV Testing Messages	ACON	40,000	Completed	<ul style="list-style-type: none"> <li>• Process report completed</li> <li>• Impact evaluation will occur in 12 months</li> </ul>
Facilitating Behaviour Change Among Those Accessing PEP	ACON	29,300	<ul style="list-style-type: none"> <li>• Trialed group work intervention</li> <li>• Resource still being developed</li> </ul>	Stakeholder consultation report completed
Strengthening Prevention Efforts Among People with HIV/AIDS	PLWHA Inc.	60,000	<ul style="list-style-type: none"> <li>• Resources awaiting approval</li> </ul>	Project still in progress
Supporting Prevention Efforts in Primary Care Settings	ASHM	60,000	<ul style="list-style-type: none"> <li>• Research component completed</li> <li>• Forum and module developed</li> <li>• Implementation of the forum is in progress</li> </ul>	Research report completed
Clinical Guidelines for STI Management Among Priority Populations	ACSHP	20,000	Completed	

# Appendix D: COAG Illicit Drug Diversion Initiatives

Over the years 2000/01–2002/03, \$1.64 million per annum of funding made available to NSW through the Council of Australian Governments Illicit Drug Diversion Initiatives – Supporting Measures for the Needle and Syringe Program, was allocated directly to Area Health Services. This enabled areas to direct efforts towards increasing education, counselling and referral services and to diversify local programs. Area Health Service projects are outlined below.

**Table 30: COAG Illicit Drug Diversion Initiatives**

Area Health Service	2000–2001 and 2001–2002 Projects	\$	2002–2003 Projects	\$
<b>CCAHS</b>	NSP Extended Services	50,000	NSP Extended Services	50,000
	Illicit drug Use Data Base	30,000	Illicit Drug Use Data Base	120,000
			Case Management Practices	51,725
			Pass the Message Stick	25,050
<b>CSAHS</b>	HIV Multicultural Media	4000	Vietnamese AIDS Risk Assess	113,700
	99/00 Redfern Enhancement	140,914	Vietnamese IDU Needs Assess	40,600
			Multicultural HIV Ethnic Media	12,100
			Mobile Health Clinic	50,000
			Aboriginal Arts project	16,150
<b>FWAHS</b>	00/01 Enhancement	20,000	Study Grants	20,000
			Dareton project	53,300
<b>GMAHS</b>		0		0
<b>HAHS</b>		0	Enhanced NSP Services	137,960
			Coachstop Caravan Park Project	20,000
<b>IAHS</b>		0	Expansion of NSP Services	120,000
<b>MAHS</b>		0	Education Project	19,636
<b>MNCAHS</b>		0	Aboriginal Community Partnership	23,000
			Extended NSP hours	27,000
			Fitpacks	30,000
<b>MWAHS</b>		0		0
<b>NEAHS</b>	Disposal Bins	1,000	Disposal Equipment	3,300
			Harm Reduction Pilot	43,500
<b>NRAHS</b>	Aboriginal and Torres Strait Islander NSP	46,000	Aboriginal Project	92,000
	Extended Services	100,000	Community Support in Nimbin	110,000
	Nimbin Sharps Disposal	20,000	Aboriginal Education Project	10,000
	Nimbin Community Support	29,000	Disposal/Harm Minimisation	132,400
	Aboriginal and Torres Strait Islander Education Package	5,000	Data software	8000
<b>NSAHS</b>	Ryde Relocation	40,000		0

<b>Area Health Service</b>	<b>2000–2001 and 2001–2002 Projects</b>	<b>\$</b>	<b>2002–2003 Projects</b>	<b>\$</b>
<b>SESAHS</b>	Workforce Development	44,000	Workforce Development Centre	88,000
	ASC Education Resource	5,000	ASC Education Resource	15,500
	Community Support for NSP	10,000	Community Support for NSP	40,000
	ASC Nutrition	3,400	Resource for Homeless People	13,700
	00/01 Enhancement	30,000	ASC Nutrition	10,200
			Pharmacy Project	53,700
			Equity of Access Project	74,100
<b>SWSAHS</b>		0		0
<b>SAHS</b>	NSP expansion	20,000	NSP Enhancement	20,000
			Aboriginal Project	10,000
<b>WAHS</b>		0	Greater West Syd Disposal Project	105,478
<b>WSAHS</b>		0	Merrylands CHC NSP	65,000
			Education Project	65,000
			Mt Druitt Mobile NSP	65,000
			Mt Druitt Outreach Bus	50,000

# Acronyms

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ACON	AIDS Council of NSW	MAHS	Macquarie Area Health Service
ACSHP	Australasian College of Sexual Health Physicians	MHAS	Multicultural HIV/AIDS and Hepatitis C Service
AFAO	Australian Federation of AIDS Organisations	MNCAHS	Mid-North Coast Area Health Service
AHMRC	Aboriginal Health and Medical Research Council	MSM	men who have sex with men
AHS	Area Health Services	NCHECR	National Centre in HIV Epidemiological and Clinical Research
AIDB	AIDS/Infectious Diseases Branch	NCHSR	National Centre in HIV Social Research
AIVL	Australian Injecting and Illicit Drug Users League	NDARC	National Drug and Alcohol Research Centre
AMS	Aboriginal medical service	NEAHS	New England Area Health Service
ARCSHS	Australian Research Centre in Sex, Health and Society	NGO	non-government organisation
ASHAC	Aboriginal and Torres Strait Islander Sexual Health Implementation Advisory Committee	NRAHS	Northern Rivers Area Health Service
ASHM	Australasian Society for HIV Medicine	NSAHS	Northern Sydney Area Health Service
CALD	culturally and linguistically diverse backgrounds	NSP	Needle and Syringe Program
CAS	NSW Ministerial Advisory Committee on AIDS Strategy	NUAA	NSW Users and AIDS Association
CCAHS	Central Coast Area Health Service	PEP	post-exposure prophylaxis
CDHA	Commonwealth Department of Health and Ageing	PLWHA Inc.	People Living With HIV/AIDS Incorporated
COAG	Council of Australian Governments	PREP	Pre-exposure prophylaxis
CSAHS	Central Sydney Area Health Service	RPA	Royal Prince Alfred Hospital
FWAHS	Far West Area Health Service	SAHS	Southern Area Health Service
GMAHS	Greater Murray Area Health Service	SESAHS	South Eastern Sydney Area Health Service
GP	general practitioner	SSHC	Sydney Sexual Health Clinic
HAART	highly active anti-retroviral therapy	STDs	sexually transmitted diseases
HAHS	Hunter Area Health Service	STIs	sexually transmitted infections
HCHA	Hunter Centre for Health Advancement	SWOP	Sex Workers Outreach Project
IAHS	Illawarra Area Health Service	SWSAHS	South Western Sydney Area Health Service
IDU	injecting drug user	WAHS	Wentworth Area Health Service
		WDP	Workforce Development Program
		WSAHS	Western Sydney Area Health Service
		YAA	Youth Accommodation Association

# References

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- <sup>1</sup> Nutbeam D. *Health outcomes and health promotion – defining success in health promotion*. H Prom J Aust 1996;6(2):58–60.
- <sup>2</sup> Hickson F, Nutland W, Doyle T, et al. *Making it count. A collaborative planning framework to reduce the incidence of HIV infection during sex between men*. 2nd edition. London: Sigma Research, 2000.
- <sup>3</sup> NSW Department of Health. *NSW sexual health promotion guidelines*. Sydney: NSW Department of Health, 2002.
- <sup>4</sup> Zheng W, Smith D, Kippax S, Grulich A. *Epidemiologically targeted non-occupational post-exposure prophylaxis in Australia 1998–2000*. Paper presented at the Australasian Society for HIV Medicine 14th Annual Conference, Sydney, NSW, October 23–26, 2003.
- <sup>5</sup> Mackie B. *Report and process evaluation of the talk, test, trust...together HIV/AIDS education campaign*. Sydney: ACON, 1996.
- <sup>6</sup> Spina A. *Evaluation of a HIV treatments social marketing campaign*. Sydney: NSW Department of Health, 2001.
- <sup>7</sup> Gorton C, Mackie B, Sparrow V. *PEP Now: NSW HIV post-exposure prophylaxis awareness campaign evaluation report*. Sydney: NSW Department of Health, 2002.
- <sup>8</sup> Jin J, Guerin J, Prestage G, Grulich A, PHAEDRA Study Group. *Behavioural risk factors for HIV seroconversion in homosexual men*. Paper presented at the Australasian Society for HIV Medicine 15th Annual Conference, Cairns, Queensland, October 22–25, 2003.
- <sup>9</sup> Grierson J, Misson S. *HIV Futures 3 Regional reports: NSW, Monograph Series 41*. Melbourne: Australian Research Centre in Sex, Health and Society, 2002.
- <sup>10</sup> Simmet I. *Managing Health promotion. Developing Healthy Organisations and Communities*. London: Wiley, 1995.
- <sup>11</sup> National Health Service. *HIV Prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission*. Evidence Briefing. London: National Health Service, 2003.
- <sup>12</sup> World Health Organisation. *Ottawa Charter*. Geneva: World Health Organisation, 1986.
- <sup>13</sup> NSW Department of Health. *NSW HIV/AIDS Health Promotion Plan 2001–2003*. Sydney: NSW Department of Health, 2001.
- <sup>14</sup> Australian National Council on AIDS Hepatitis C and Related Diseases. *Needle and syringe programs: a review of the evidence*. Canberra: Australian Department of Health and Ageing, 2000.
- <sup>15</sup> Hull P, Van de Ven P, Prestage G, et al. *Gay community periodic study Sydney 1996–2002*. Sydney: National Centre In HIV Social Research, 2003.
- <sup>16</sup> Van De Ven P, Rawstorne P, Crawford J, Kippax S. *Facts and Figures 2000 Male Out Survey*. Sydney: National Centre in HIV Social Research, 2001.
- <sup>17</sup> Australian Research Centre in Sex, Health and Society. *Sex in Australia: summary findings of Australian Study of Health and Relationships*. Melbourne: Australian Research Centre in Sex, Health and Society, n.d.
- <sup>18</sup> NSW Ministerial Advisory Committee on AIDS Strategy. *Review of the NSW Needle and Syringe Exchange Program and Pharmacy Fitpack Scheme*. Sydney: NSW Department of Health, 1996.
- <sup>19</sup> National Centre in HIV Epidemiology and Clinical Research. *Australian NSP Survey. National Data Report 1995–2002*. Sydney: National Centre in HIV Epidemiology and Clinical Research, 2003.
- <sup>20</sup> Strathdee SA, Patrick DM, Currie S, Cornelisse PGA, Rekart ML, et al. *Needle exchange is not enough: lessons from the Vancouver injecting drug use study*. AIDS 11-F59–F65 1997.
- <sup>21</sup> Australian Bureau of Statistics. *Census 2001*.
- <sup>22</sup> Harcourt C, Donovan B. *The health and welfare needs of female and transgender street based sex workers in NSW*. Sydney: NSW Department of Health 2000.
- <sup>23</sup> Mao L, Van De Ven P, Prestage G, et al. *Asian gay community periodic survey Sydney 2002*. Sydney: National Centre in HIV Social Research, 2003.

- <sup>24</sup> Hull P, Van De Ven P, Prestage G, et al. *Gay community periodic survey. Melbourne 2002*. Sydney: National Centre in HIV Social Research, 2002.
- <sup>25</sup> Hull P, Van De Ven P, Prestage G, et al. *Gay community periodic survey. Queensland 2002*. Sydney: National Centre in HIV Social Research, 2002.
- <sup>26</sup> National Centre in HIV Epidemiology and Clinical Research. *HIV/AIDS, viral hepatitis and sexually transmitted infections in Australia*. Annual surveillance report 2003. Sydney: NCHECR, 2003.
- <sup>27</sup> Hickson F, Nutland W, Weatherburn P, et al. *Making it count. A collaborative planning framework to reduce the incidence of HIV infection during sex between men*. 3rd edition. London: Sigma Research, 2003.
- <sup>28</sup> Dodds J, Mercey D. *Monitoring high risk sexual behaviour among gay men in London*. London: Royal Free and University College Medical School, 2000.
- <sup>29</sup> Hickson F, Hartley M, Weatherburn P. London Counts. *HIV prevention needs and interventions among gay and bisexual men in the sixteen London Health Authorities*. London: Sigma Research, 2001.
- <sup>30</sup> Clemon G, Alary R, Otis J, et al. *Increase in unprotected anal intercourse among men having sexual relations with other men participating in the Omega Cohort Study. Has this North American wave finally reached Montreal?* Canadian Journal of Infectious Diseases 2002;13(A):306.
- <sup>31</sup> Webster R, Darrow K, Paul J, et al. *HIV infection and associated risks among young gay men who have sex with men in a Florida resort community*. Journal of Acquired Immune Deficiency Syndrome 2003;33(2):223-31.
- <sup>32</sup> Rosengarten M, Race K, Kippax S. *Touch wood, everything will be OK: gay men's understandings of clinical markers in sexual practice*. Sydney: National Centre in HIV Social Research, 2000.
- <sup>33</sup> Mao L, Van De Ven, Prestage G, et al. *Health in men baseline data*. Sydney: National Centre in HIV Social Research, 2002.
- <sup>34</sup> Kippax S. *The complexity of HIV risk in Australian gay men*. Paper presented at the Australasian Society for HIV Medicine 14th Annual Conference, Sydney, NSW, October 23-26, 2003.
- <sup>35</sup> National Centre in HIV Social Research. *HIV/AIDS, hepatitis C and related diseases in Australia. Annual report of behaviour 2003*. Sydney: National Centre in HIV Social Research, 2003.
- <sup>36</sup> Nicoll A, Homers F. *Are trends in HIV, gonorrhoea and syphilis worsening in Western Europe*. BMJ 2002;324:1324-1327.
- <sup>37</sup> PHLS Communicable Diseases Surveillance Centre, ICH (London) SCIEH, *HIV and AIDS in the United Kingdom 2001*. London: PHLS Communicable Diseases Surveillance Centre, 2002.
- <sup>38</sup> Hull P, Van De Ven P, Prestage G, et al. *Sydney gay community periodic survey: results from the 15th survey*. Sydney: National Centre in HIV Social Research, 2003.
- <sup>39</sup> NDD and HIV/AIDS databases, Communicable Diseases Branch, NSW Department of Health.
- <sup>40</sup> British Columbia Centre for Disease Control. *STD/AIDS control. Annual report 2001*. Vancouver: British Columbia Centre for Disease Control, 2002.
- <sup>41</sup> Remis R, Major C, Calzavara L, et al. *The HIV epidemic among men who have sex with other men: the situation in Ontario in the year 2000*. Toronto: Department of Public Health Services, 2000.
- <sup>42</sup> Low-Beer S, Bartholomew K, Webster A, et al. *A demographic and health profile of gay and bisexual men in a large Canadian urban setting*. AIDS Care 2002; 14(1):111-115.
- <sup>43</sup> Hogg R, Webster A, Chan K, et al. *Increasing incidence of HIV infections among young gay and bisexual men in Vancouver*. AIDS 2001;15(10):1321-1322.
- <sup>44</sup> Center for Disease Control and Prevention. *HIV incidence among young men who have sex with men – seven US cities, 1994-2000*. MMWR 2001;50(21):440-444.
- <sup>45</sup> Health Canada. *HIV and AIDS in Canada. Surveillance report to December 21, 2002*. Ottawa: Health Canada, 2003.
- <sup>46</sup> Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report 2001*;13(2):1-44.
- <sup>47</sup> WHO and UNAIDS Collaborative Centre. *The HIV/AIDS Epidemic in the WHO European Region; Western European Update 31 December 2002* Saint Maurice 2003.

- <sup>48</sup> Department of Health. *Effective commissioning of sexual health and HIV services. A sexual health and HIV commissioning toolkit for primary care trusts and local authorities*. London: Department of Health, 2003.
- <sup>49</sup> Australian Department of Health and Ageing. *Returns on investment in public health: an epidemiological and economic analysis*. Canberra: Australian Department of Health and Ageing, 2003.
- <sup>50</sup> Australian Department of Health and Ageing. *Return on investment in needle and syringe programs in Australia*. Canberra: Australian Department of Health and Ageing, 2002.
- <sup>51</sup> McDonald A. *Birthplace and HIV/AIDS diagnoses in Australia, 1993–2002*. Paper presented at the Australasian Society for HIV Medicine 15th Annual Conference, Cairns, Queensland, October 22–25, 2003.
- <sup>52</sup> Rawstorne P, Crawford J, Van de Ven P, et al. *Beliefs and sex practice associated with risk minimisation strategies in the Health in Men cohort study*. Paper presented at the Australasian Society for HIV Medicine 15th Annual Conference, Cairns, Queensland, October 22–25, 2003.
- <sup>53</sup> Smith G, Van de Ven P. *Reflecting on Practice. Current challenges in gay and other homosexually active men's HIV education*. Sydney: National Centre in HIV Social Research, 2001.
- <sup>54</sup> Murphy D, Aldo S. *All things considered: gay men's education consultation 2002*. Sydney: Australian Federation of AIDS Organisations, 2002.
- <sup>55</sup> Calzavara L, Burchell A, Remis RS, et al. *Increase in HIV incidence among men who have sex with men undergoing repeat diagnostic HIV testing in Ontario, Canada*. *AIDS* 2002;16(12):1655–61.
- <sup>56</sup> Health Canada. *The Canadian strategy on AIDS*. Ottawa: Health Canada, 1998.
- <sup>57</sup> British Columbia Ministry of Health Services. *Priorities for action in managing the epidemics: HIV/AIDS in BC. 2003–2007*. Victoria: British Columbia Ministry of Health Services, 2003.
- <sup>58</sup> Centers for Disease Control and Prevention. *HIV prevention strategic plan through 2005*. Atlanta: Centers for Disease Control and Prevention, 2001.
- <sup>59</sup> Centers for Disease Control and Prevention. *Advancing HIV prevention: new strategies for a changing epidemic*. Atlanta: Centers for Disease Control and Prevention, 2003.
- <sup>60</sup> Bonell C, Hickson F, Hartley M, et al. *By any means necessary. Reflecting on how HIV prevention works and the changes they bring about*. Briefing Paper. London: Sigma Research, 2000.
- <sup>61</sup> Centers for Diseases Control and Prevention. *HIV diagnoses among injection drug users in states with HIV surveillance – 25 States 1994–2000*. *MMWR* 2003;52:636.
- <sup>62</sup> Health Protection Agency. *AIDS HIV quarterly surveillance tables cumulative data to end June 2003*. No 59:03/2 London July 2003.
- <sup>63</sup> NSW Department of Health. *The national strategy for sexual health and HIV. Implementation action plan*. London: Department of Health, 2002.



