

## Policy and strategic implications of Australia's divergent HIV epidemic among gay men

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The importance of this issue of *Sexual Health* has technical, strategic and policy dimensions. Overall Australia continues to have a relatively well-controlled HIV epidemic, contained by and large to gay men. The lack of significant transmission affecting intravenous drug users continues to bear testament to sound public health policies, for which we continue to be the envy of countries that took a different route.

There has, however, been an increasing rate of notifications among gay men in Victoria, Queensland, South Australia and Western Australia and the numbers of such transmissions for Australia as a whole has also increased as a result. This gives rise to the first impetus for this issue of the journal. It provides a timely basis for considering adjustments to our to-date successful prevention strategies.

In New South Wales (NSW), the state hardest hit by the HIV epidemic since its arrival in Australia, the trend has been different, with notifications among gay men falling since a spike in 2001 and flat overall since 1998. Grulich and his colleagues<sup>1</sup> point out that this may make NSW unique among countries where reliable records are kept. This difference gives rise to the second impetus for this issue. What lessons are there to learn from the different trend in NSW?

There is not cause for a panicked knee jerk reconsideration of strategy, although there is reason for immediate analysis and for careful response. The trend increases in notifications among gay men in several states do not mean that we have lost control of the Australian epidemic. On several key indicators, other states could be said simply to have increased from lower rates up to those of NSW, which on some measures have come down. Nonetheless a country with Australia's successful record, resources and epidemic infrastructure should aspire to do better and to be able quickly to act to prevent any more alarming development. Otherwise Australia may be in danger of a different, less-controlled epidemic.

Australia is blessed with internationally envied capacity, in four national HIV research centres and in an HIV community sector, non-government organisations providing services to and advocating for both people with HIV and those from affected communities. The community sectors have been led in each state by AIDS Councils, membership-based non-government organisations set up by the gay community in collaboration with

other affected communities. For the most part Australia has also been advantaged by the strength of relationships between both these sectors, the clinical sector and governments. It is significant that the work reported in this issue started under the auspice of the intersectoral NSW Ministerial Advisory Committee on HIV/AIDS Strategy and draws heavily on collaboration between the national centres, the community sector and a couple of other key groups.

The NSW Ministerial Advisory Committee wanted to know whether the apparent difference between NSW and other states' apparent trends in notifications among gay men was real and what they needed to do to secure that record and avoid an increase in infections.\* This issue of the journal follows a workshop where much of this data was presented, focusing on the difference between NSW, Queensland and Victoria. It shows that the difference is real. NSW is experiencing a different trend and there are lessons to be drawn, not just for the three states examined in the NSW Think Tank but for our national response.

The analysis of the NSW rates among gay men does not point to a single explanation for a lower notification rate, nor a magic bullet to stem the trend elsewhere. It does, however, point to a combination of several factors that need to be understood by policy makers and those active in the epidemic response. Important facets of an explanation lie in surveillance data, in clinical and behavioural trends and in policy, investment and relationship dynamics.

One immediate advance would be the uniform adoption of new 'detuned' testing technology that could be applied nationally at very low cost to all positive HIV tests and allow us to move from a reliance on notification rates to being able to count new infections in our surveillance. This is an immediate priority issue for consideration by the Commonwealth Department of Health and Ageing and would give us much more sensitive and real-time data.

There are several factors that limit increases in infections among gay men. In each of these the trend in NSW is either stable or decreasing whereas in other states some are increasing or stable. Within the surveillance data the effect appears to be cumulative. Facets of an explanation include, for example, the high HIV testing rate among gay men and the high proportion of

\*NSW Ministerial Advisory Committee on HIV/AIDS Strategy *A Think Tank: Why are HIV Notifications Flat in NSW 1998–2006* NSW Health May 2007. This was followed up by a second, national meeting auspiced by the national Ministerial Advisory Council on HIV/AIDS, Hepatitis and Sexual Health.

gay men who do not have casual sex or who disclose their HIV status to casual partners.

There are also factors that tend to increase the infection rate, in relation to which NSW is either stable or declining whereas at least some other states are increasing. The headline indicator here is the proportion of men who have unprotected anal intercourse with casual partners, where NSW has achieved a sustained decrease since a peak in the early years of this decade. Other states have now reached or even passed the NSW rate.

Other factors include, for example, a decline in the proportion of regular relationships that are not known to be between men of different HIV status, offsetting an increase in unprotected sex within relationships. The use of 'party drugs' associated with HIV infection has stabilised in NSW while increasing elsewhere, with the worrying exception of the drug crystal that warrants a public health response for a whole range of health reasons within the gay community.

Australia has always made a practice of combining epidemiological and behavioural surveillance with a detailed understanding of community knowledge and political analysis. This issue of the journal is a strong demonstration of that practice, with the article by Bernard *et al.*<sup>2</sup> building on Prestage's<sup>3,4</sup> important examination of data to estimate population counts and distributions for gay men in different states. The importance of this analysis is that it provides both an explanation of the differences observed in NSW and lessons for practice nationally. Although the surveillance data seem to point to a cumulation of a series of factors, this social and policy analysis points to some important underlying factors that may provide a more unified explanation.

In NSW it appears that not only is the gay community more concentrated geographically but the place of HIV-positive men within it is more integrated, creating a safer environment for positive men to participate as sexual beings within the gay community, rather than identifying primarily within a 'positive community'. This has several possible implications, including supporting both disclosure of HIV status and effective practices for identifying partners of equivalent HIV status.

Over the course of 2007 there has been a policy focus on the issue of disclosure, partly as a result of a small number of cases of people with HIV who have behaved either wilfully or recklessly and endangered sexual partners. The apparent failure of public health authorities to more proactively manage a small number of such cases needed to be addressed but is not helpful in framing an effective response to prevention in the gay community generally.<sup>†</sup>

The analysis in this issue of the journal suggests that a more textured understanding of the dynamics around disclosure and partner selection based on HIV status is needed. In an environment where HIV-positive people are stigmatised and are assigned sole responsibility for prevention, disclosure may be a double-edged sword. The uncertainties surrounding a sexually active man's 'negative' status make partner selection or sexual practice based on disclosure risky.

Men who know their status and seek same-status partners for unprotected sex are at higher risk than those who always use

condoms. On the other hand, it appears that they are less at less risk than those who have unprotected sex without 'knowing' their partners status.<sup>‡</sup> From a policy perspective, we need to avoid creating disincentives for gay men to know their HIV status. Australia has always had a high rate of HIV testing in the gay community, although strong efforts have been made to improve testing rates in the UK and USA.

Gay community and AIDS Councils also have a role in creating an environment enabling of protective behaviour by individuals. The place of positive men in the gay community appears to be reflected in a proactive stance of the NSW organisation for people with HIV (Positive Life NSW) in promoting sexual health among its constituents and playing an active part, with the local AIDS Council, in HIV prevention. The ethic of shared responsibility appears to work better in a shared community. The AIDS Council in NSW (ACON) has also actively defined itself as a gay health organisation since the turn of the century and has since that time sought to communicate to gay men about HIV through the range of their health concerns. Health promotion appears to work better when its practice is integrated with the concerns of the target audience.

ACON has also enjoyed a sustained level of investment from the NSW Health Department, even following the untying of federal HIV funding in 1997. Whereas other states, at least for periods, disinvested in HIV prevention with a concomitant loss in expertise in both community sectors and Health Departments, ACON and NSW Health have actively worked with sexual health providers to make sexual health services accessible and effective with gay men.

Without condoning imperfect risk-reduction strategies, such as 'serosorting' and 'strategic positioning', ACON has defied more conservative public health models to engage actively with the evolving decision-making of gay men through the period of the HIV epidemic since highly active antiretroviral treatments slowly but surely changed the HIV epidemic in the gay capitals of the west. They have done this with greater clarity (certainly with greater resources) than other AIDS Councils, and within a carefully negotiated understanding with NSW Health.

This is difficult work but appears to have paid off. It marks a strategic direction for other states based on encouraging testing, treatment access and honest dialogue with men who engage in risk behaviour and maintaining public policy settings that avoid stigmatisation. An integrated place for positive men as sexual beings within the gay community is clearly important, as is a continued attention to sectoral capacity and building reflective, evidence-based practice.

Informants to Bernard and colleagues' survey<sup>2</sup> of key informants describe widely differing realities within local partnerships, with respect and attention to strategy in NSW and blame allocation and poor communication elsewhere, at least for significant periods.

Bernard *et al.* present an intriguing speculation in their contribution, about the history of microeconomic reform in Victoria and the introduction there in the 1990s of 'compulsory competitive tendering', a policy that required publicly funded

<sup>†</sup>The Australian Health Ministers' Council endorsed a report recommending a nationally uniform approach to managing such cases at its July 2007 meeting.

<sup>‡</sup>A. Grulich, in response to question at MACASH national meeting, based on data from Sero-converters study.

services previously directly provided by government agencies to be 'put out to tender' with a preference for private provision wherever possible.<sup>2</sup>

Bernard *et al.* argue that these wider policy settings have led to a competitive relationship between different players in the Victorian partnership.<sup>2</sup> They argue that this environment has not helped the Health Department and the community sector in that state work together to respond to the challenges there. Discussion has not been based on trust but on blame allocation, which they argue, combined with loss of capacity from disinvestment, has crippled the Victorian response. This may be the first evidence of an important issue in social policy more generally, one that has been raised in other sectors.<sup>5</sup> Although the argument is not conclusive, it is a line of enquiry that warrants further investigation.

There is a tactical issue for the non-government HIV sectors here. Whatever the cause, Bernard and colleagues report that, in most places at least, the much-valued historic notion of partnership has broken down.<sup>2</sup> This is not unique to the HIV and AIDS sector. The sector can decide to agitate for the re-establishment of 'partnership' on its own terms, given the success of that model for most of the epidemic in Australia. Governments do, however, become suspicious of any partnership that (often recently arrived) officials perceive gives *a priori* status to certain partners and precepts. Bernard and colleagues<sup>2</sup> are undoubtedly correct that there has been a potentially disastrous disinvestment in the sector and prevention effort. This has also affected Health Departments and exacerbated the lack of collective memory, in turn reinforcing the official suspicion of the partnership.

The choice facing the sector is whether to argue for the re-establishment of its own model of partnership or to find a new formulation that emphasises to government the sector's commitment to evidence, to change and to dialogue. Indeed the evidence would suggest that Australia needs the relationships between the sectors to work, indeed needs a partnership that is based on privileging the role of those infected and affected by the epidemic. However, there is a pragmatic point here. We need the sector to re-engage governments more than we need any purity in the semantics of partnership and the sector needs to prioritise this objective and find ways forthrightly to engage with the perceptions in governments that create distance where there needs to be closeness.

There are also important implications in all of this for governments. Re-investment and a rebuilding of capacity within Health Departments, in the HIV community sector and in relationship mechanisms would seem to be a high priority in all jurisdictions, probably with the sole exception of NSW. This includes at a national level. It is worth acknowledging injections of \$2 million and \$10 million to the prevention efforts during 2007 by the Victorian and Commonwealth Governments, respectively, and previous corrective action in Queensland.

In addition to this, however, policy makers need to overcome their own suspicion of partnership and actively and forthrightly engage the other sectors on terms that will produce substantive joint effort for the challenges ahead. Policy makers must also respond effectively to issues, such as the management of those who recklessly and wilfully endanger others, which quickly become pressure points for Ministers. They need to do this, as Health Ministers did in relation to that issue, without stigmatising people with HIV generally. Support for AIDS Council responses to the use of the drug crystal in the gay community is also needed.

Finally, there are further research questions. What has been the impact of competitive tendering policy on prevention? What more can we learn about the gay community in different parts of Australia that might provide both better prevalence data and an information platform for further understanding of the social dynamics of the epidemic and its prevention? And if the Commonwealth will fund the implementation of new detuned testing of all positive HIV tests, we will be able to ask what the real rate of new infections is across Australia.

### Conflicts of interest

Robert Griew was CEO of the AIDS Council of NSW from 1998 to 2001 and was a member of the Australian Health Ministers Advisory Council from 2003 to 2006, for a part of which time he chaired the National Public Health Partnership and the Australian Population Health Development Principal Committee. With colleagues, he wrote the report accepted by Ministers in July 2007 on a nationally uniform approach to managing people with HIV who risk infecting others.

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