

AUSTRALIA

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The first case of AIDS in Australia was diagnosed in November 1982, and the first death from AIDS occurred in July 1983. By the mid-1980s, the country was witnessing a rapid increase in the HIV/AIDS caseload. Fortunately, however, cases of new HIV infection subsequently declined significantly and have remained at very low levels for nearly 20 years. The HIV epidemic remained largely contained within groups first affected by HIV and did not take hold in the general population.

This chapter will examine the policies and programs of successive Australian national governments, which have assumed the responsibility for fashioning and funding national HIV/AIDS strategies and in the process have built administrative structures to develop, guide, and implement those strategies. It will discuss the introduction of needle and syringe programs in 1986 and the rapid expansion of methadone treatment programs, through which the spread of HIV into the general heterosexually active community has been greatly contained. The chapter will also look at the creation of critical structures that brought together national and provincial health ministers, parliamentarians, clinicians, and community groups to develop HIV/AIDS policies. These political structures helped to build broad parliamentary and public understanding and acceptance of the need for the sometimes unwelcome and controversial measures necessary to contain HIV/AIDS.

With some occasional difficulties, Australian public and political support for the fight against HIV/AIDS has been sustained for more than two

decades. A critical question facing Australia in the decade ahead, however, is whether this support can continue to be sustained long term, or whether it will succumb to its own success.

HIV/AIDS in Australia: 1982–2005

As mentioned above, the first case of AIDS was diagnosed in Sydney in November 1982, and the first death from AIDS occurred in Melbourne in July 1983. Both of these cases were in gay men. For the nearly 25 years since the virus was first reported in Australia, the HIV/AIDS epidemic has largely been confined to the two communities that were first infected—homosexually active men (men who have sex with men, or MSM), and injecting drug users (IDUs).

In the early years of the epidemic, several cases of HIV transmission were also recorded among hemophiliacs and other recipients of HIV-infected blood products. By the early 1990s, however, the introduction of HIV testing, tighter controls on blood donors, and more stringent treatment of blood products virtually eliminated this vector of new HIV infection.

Geographically, although HIV/AIDS cases have been reported from all Australian states and territories, the eastern, inner suburbs of Sydney remain the epicenter of the epidemic. Between 1983 and 1985, HIV spread rapidly among some 4,500 MSM in that area and, to a lesser extent, in Melbourne, raising concerns that HIV would spread from MSM through IDUs to infect the larger heterosexually active population. As it turned out, this threatened “third wave” of HIV infection did not occur.

Present State and Future Direction of the Spread of HIV/AIDS

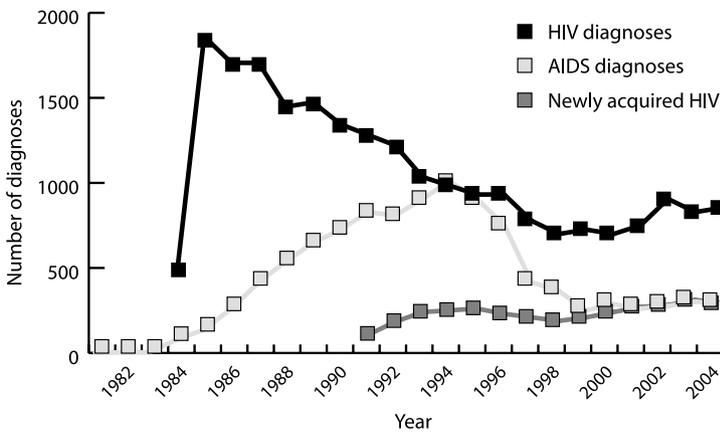
At the end of 2004, after adjustment for reporting delays, it was estimated that the cumulative number of HIV infections that had been diagnosed in Australia was 21,400, and that 14,840 people were living with HIV infection, including around 1,100 adult and adolescent women. It was also determined that there had been 9,500 cumulative AIDS cases and 6,509 deaths following AIDS as of December 31, 2004.

Following a long-term decline, the annual number of new HIV diagnoses in Australia has gradually increased over the past five years, from 656 cases

in 2000 to around 820 in 2004 (818 when adjusted for multiple reporting). Among these new diagnoses, an increasing number are in people who acquired HIV infection within the previous year. An estimated 53% of all people living with HIV infection were receiving antiretroviral (ARV) treatment for HIV infection in 2004—slightly more than the 50% receiving treatment for HIV infection in 2003. The long-term effectiveness of ARV treatment in preventing progression of HIV-related illness, however, remains unknown.

The annual number of AIDS diagnoses in Australia peaked at 952 in 1994, declined to 208 in 2001 and then increased to 239 in 2004 (see fig. 1). The decrease in the number of AIDS diagnoses between 1994 and 2001 was due to the decline in HIV incidence that took place in the mid-1980s and to the use, since around 1996, of effective ARV treatment of HIV infection. This pattern—declining AIDS incidence between 1994 and 2001, followed by relatively stable incidence between 2002 and 2003—is similar to trends reported in most other industrialized countries.

Figure 1. Diagnoses of HIV and AIDS infection in Australia, 1981–2004



Source: National Centre in HIV Epidemiology and Clinical Research (2005).

Table 1 shows some of the key characteristics and trends in HIV cases in Australia over the past decade. These and other characteristics are explained in further detail below.

Mode of Transmission—HIV infection in Australia continued to be transmitted mainly through sexual contact between men, which was reported in more than 80% of cases of newly acquired HIV infection diagnosed between 1999 and 2004. HIV prevalence remained below 1% among people attending needle and syringe programs, prison entrants, men and women seen at sexual health clinics reporting a history of heterosexual contact, and women with a history of sex work.

Indigenous People—Between 1994 and 2004, there were 190 HIV diagnoses and 76 AIDS diagnoses among indigenous people. The per capita rate of HIV and AIDS diagnosis among indigenous people was similar to that among nonindigenous people, but a higher proportion of the HIV diagnoses in indigenous people was among women—33.7% as against 10.1%. Exposure to HIV was attributed to male homosexual contact for the majority of diagnoses among nonindigenous people (67.5%), whereas an almost equal proportion of diagnoses among indigenous people was attributed to male homosexual contact (38%) and heterosexual contact (37%).

Overseas Born—People born in Australia accounted for 66% of domestic AIDS diagnoses in 2000–2004, while 34% were born overseas. AIDS incidence was highest among people born in the countries of sub-Saharan Africa.

Survival After Diagnosis—Survival following AIDS diagnosis in Australia increased from 16.8 months for cases diagnosed prior to 1995, to 32 months for cases diagnosed in 2000.

Geographic Spread—In Australia, HIV/AIDS is still almost exclusively confined to the MSM and IDU communities in Sydney, Melbourne, and other large cities.

Connection to Sexually Transmitted Infection Rates—The recent rise in HIV infection rates appears to be related to a more general increase in the incidence of sexually transmitted infections (STIs) among both homosexually and heterosexually active people. This is a result of a decline in condom use and a higher propensity for risk taking among homosexual

Table 1. Characteristics of newly diagnosed HIV infection

Characteristic	Year of HIV diagnosis										Total ^a	
	to 1995	1996	1997	1998	1999	2000	2001	2002	2003	2004		
Total cases	16,940	900	821	753	714	755	765	848	861	886	890	24,243
Males (%)	93.4	91.9	91.2	89.4	87.0	89.5	89.2	87.8	88.7	88.7	89.0	92.1
Median age (years)												
Males	32	34	34	35	35	35	35	35	37	37	37	33
Females	29	28	30	30	28	30	29	32	31	31	31	30
State/Territory (%)												
Australian Capital Territory	1.2	0.8	1.0	1.1	1.1	1.5	1.0	0.6	0.6	0.9	0.9	1.1
New South Wales	59.8	50.7	52.6	53.1	52.5	48.7	45.0	47.9	49.2	45.7	45.7	56.7
Northern Territory	0.5	0.6	1.3	1.6	0.7	0.4	0.5	0.9	0.6	0.9	0.9	0.6
Queensland	9.2	16.0	13.9	13.8	17.1	15.1	13.6	15.3	14.8	17.5	17.5	11.0
South Australia	3.5	5.1	4.3	4.6	3.2	3.0	5.6	3.5	5.1	5.6	5.6	3.8
Tasmania	0.4	0.3	0.0	0.4	0.4	0.0	0.7	0.6	0.0	0.6	0.6	0.4
Victoria	20.3	20.2	22.0	18.5	19.2	25.2	27.1	25.8	23.7	24.2	24.2	21.1
Western Australia	5.0	6.3	4.9	6.9	5.7	6.1	6.5	5.3	6.0	4.6	4.6	5.2
HIV exposure category (%) ^b												
Male homosexual contact	80.3	75.3	72.9	65.7	65.4	68.3	66.3	70.8	73.6	68.4	68.4	76.9
Male homosexual contact and injecting drug use	4.1	4.2	4.8	4.7	6.5	3.6	5.1	4.1	4.3	3.9	3.9	4.3
Injecting drug use ^c	4.4	2.7	3.1	3.6	5.4	4.3	5.6	2.6	3.8	4.2	4.2	4.2
Heretosexual contact	7.0	16.7	18.2	24.9	21.8	23.3	22.4	22.1	18.1	23.2	23.2	11.6
Partner with/at risk of HIV infection	48.5	70.6	67.6	76.9	70.4	80.9	79.9	68.6	79.2	78.0	78.0	64.1
Not further specified	51.5	29.4	32.4	23.1	29.6	19.1	20.1	31.4	20.8	22.0	22.0	35.9
Hemophilia/coagulation disorder	2.1	0.0	0.0	0.1	0.5	0.0	0.1	0.0	0.0	0.0	0.0	1.4
Receipt of blood/tissue	1.6	0.2	0.1	0.6	0.3	0.0	0.0	0.0	0.0	0.1	0.1	1.1
Mother with/at risk of HIV infection	0.3	0.9	0.9	0.4	0.1	0.4	0.4	0.3	0.2	0.1	0.1	0.4
Health care setting	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Other/undetermined	18.9	9.4	8.1	7.6	9.0	8.1	7.2	9.9	7.7	9.6	9.6	15.8

Source: National Centre in HIV Epidemiology and Clinical Research (2005).

^a Not adjusted for multiple reporting.

^b The "Other/undetermined" category was excluded from the calculation of the percentage of cases attributed to each HIV exposure category.

^c Excludes males who also reported a history of homosexual contact.

men as a result of less effective public education campaigns promoting safer sex practices. There also seems to be a fatigue about HIV and increasing rejection of safer sex practices among older gay men. The recent increase in rates of HIV and STI among young people, on the other hand, seems to reflect the following:

- increased usage and acceptance of a range of licit and illicit drugs conducive to increased sexual activity
- declining coverage of HIV issues in the Australian media
- few recent, government-funded HIV/AIDS awareness campaigns

Prisoners—The low rate of 0.2% HIV prevalence among Australian prisoners reflects the low HIV prevalence rate in the general community. However, in common with prison systems around the world, Australian prisons are potentially important sites for the transmission of blood-borne viruses, including HIV, particularly since IDUs comprise almost half of the inmate population in Australia. Without preventive measures in place, there is a high risk of HIV infection being transmitted in Australia's prisons should general HIV infection rates rise.

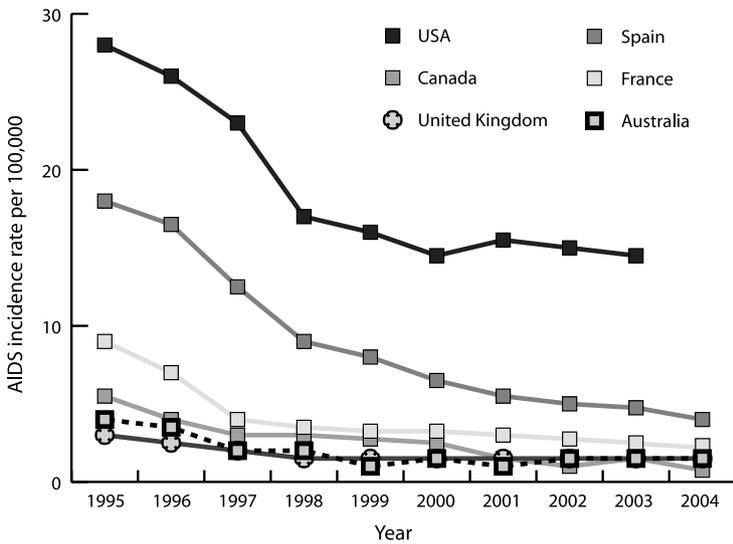
This is an area of serious concern because, despite the demonstrable success of Australia's HIV/AIDS programs, Australian governments have failed to implement the full range of effective prevention measures in the prisons. Additionally, the number of prison inmates has doubled during the last two decades and now approaches 30,000. For a variety of political and industrial reasons, Australian governments have refused or been unable to provide prisoners with access to needle and syringe exchanges. However, condoms are now provided in prisons in five jurisdictions. Unfortunately, it seems unlikely that Australian governments will move on this issue unless and until there is a significant rise in HIV rates among prisoners.

International Comparison

At the end of 2004, Australian HIV prevalence and AIDS incidence were 74 and 1.2 per 100,000 population respectively. The HIV levels were well below those of the United States, France, and Spain, and were comparable with those of Canada and the United Kingdom. As shown in figure 2, AIDS

incidence per 100,000 in Australia was also similar to that recorded in the United Kingdom (1.4) and Canada (0.7), and was substantially lower than in France (2.2) and Spain (4.3). After 25 years of application of its HIV/AIDS control policies, Australia's rate of HIV prevalence and AIDS incidence per 100,000 are roughly one-tenth of those of the United States.

Figure 2. AIDS incidence in selected countries, 1995–2004



Source: National Centre in HIV Epidemiology and Clinical Research (2005).

The Politics of HIV/AIDS: Social and Cultural Environment

The initial Australian response to HIV/AIDS was shaped by the political, social, and cultural environment of the 1980s. Since the 1960s, traditional political party structures had been displaced by the emergence of political groups and movements determined to advance new social agendas. During the 1970s and 1980s, these movements were responsible for significant recognition and improvement of the social and political status of women, homosexuals, indigenous peoples, ethnic minorities, and disabled people.

By the time that HIV/AIDS first appeared in Sydney in 1982, these habits of social awareness, defense of human rights, and political mobilization were deeply ingrained in Australian life. In particular, gay men, lesbians,

and their supporters had organized politically to force governments to recognize basic human rights and to overturn legislation that criminalized gay sex and enshrined discrimination against gay men and lesbians. Many of these activists and the structures that they created were adapted to the objectives of mobilizing against HIV/AIDS.

From the very first months of the HIV/AIDS epidemic, Australian governments were therefore able to deal with organizations that broadly represented the interests of the gay community and that could speak with the authority of many of those most closely affected by HIV/AIDS. Similar groups quickly emerged that could speak knowledgeably and authoritatively on behalf of the other groups first affected by HIV/AIDS—IDUs, sex workers, and hemophiliacs. The emergence of these politically active groups occurred spontaneously and without direction from government. Once these groups emerged, however, Australian governments swiftly saw the good sense of engaging them in HIV/AIDS policy formulation and development.

In 1989, the New South Wales government funded the establishment of the first organization of drug users in Australia. Subsequently, all other states and territories funded similar groups, and the federal government funded the national peak body representing drug users. These consumer groups were therefore funded by governments to represent their communities and to provide education, care, treatment, and other support services to their members and supporters.

In each state and territory, and at the national level, permanent structures were established that represented at-risk communities—gay men, hemophiliacs, IDUs, and sex workers. Over time, many of these community activists were recruited into government departments, where they became senior program administrators and policy developers. The quality and depth of Australia's response to HIV/AIDS were greatly improved as a result.

Australian Governments' Response to HIV/AIDS

Australia has a federal system of government. The Australian constitution allocates functions and responsibilities between the federal government based in Canberra, six states, and two self-governing territories.

Responsibility for funding and service delivery of Australia's public health system—primary care, hospital care, national health insurance, provision of subsidized pharmaceuticals, medical and scientific research—is split between the various levels of government. It is therefore misleading to think of the Australian federal government as being solely responsible for creating and implementing Australia's response to HIV/AIDS. While the Australian federal government accepted that it had a national responsibility to lead, coordinate, and fund the Australian response to HIV/AIDS, responsibility for effective and efficient delivery of HIV/AIDS programs lay with the states and territories.

Most importantly, as described above, the initial impetus for action on HIV/AIDS in the early and mid-1980s came from community groups and individuals first affected by HIV/AIDS—gay men, IDUs, hemophiliacs, clinicians, and researchers. Australia's response was therefore one of "grass-roots" activism pressuring governments first to acknowledge and then to fund the necessary steps to bring HIV infection under control, provide adequate care and treatment for those affected by HIV/AIDS, and over the long term to create administrative and bureaucratic structures that could sustain a multidecade response to HIV.

From 1983, the federal government, through the minister for health, led all Australian governments in a successful multisectoral effort to adopt a common national response to HIV/AIDS. Working closely with community groups, clinicians, and researchers, the Australian government determined to support the following radical measures in Australian public health policy to contain the threat posed by HIV/AIDS:

- peer-based, direct, and explicit preventive education campaigns directed both at high-risk groups and the general public
- widespread introduction of subsidized needle and syringe exchanges
- rapid expansion of methadone maintenance treatment
- access to free, anonymous, and universal HIV testing
- subsidized access to azidothymidine (AZT) and subsequent ARV treatment
- general advocacy of the need to adopt safer sexual practices, especially the use of condoms
- promotion of widespread availability of condoms
- creation of an enabling political environment that encouraged

socially marginalized groups (IDUs, sex workers) to be involved in the national response

- removal of political and legislative barriers to enable effective preventive education and action—e.g., the passage of legislation to prevent discrimination on the grounds of sexual orientation or HIV status
- building of strong scientific and social research capacity and institutions

These policies were based on a number of basic principles:

- the need to minimize risk to the general population
- recognition of the importance to policymaking of empirical research and evidence—especially in the fields of epidemiology, clinical treatment, retrovirology, and the social sciences
- respect for human rights, buttressed as required by legislation
- collaboration and partnership between all stakeholders
- long-term over short-term thinking

As governments gained a greater understanding of the nature of HIV/AIDS, it became clear that responses to the epidemic were required across the whole of government, and not just in the health portfolio. Accordingly, governments and ministers with responsibility for social security and welfare, housing, drug law enforcement, immigration, insurance and superannuation, human rights legislation, scientific research, prisons, and education became involved in developing HIV/AIDS policies in their areas of concern.

Medicare National Health Insurance System

The nature of the Australian response to HIV/AIDS was greatly assisted by the fortunate coincidence of the introduction in 1984 of the Medicare system of national health insurance. Under Medicare, all Australians are entitled to free access to medical and hospital treatment and access to subsidized pharmaceuticals. Medicare provided a structure of administration, funding, and support that was immensely beneficial in delivering care, treatment, and resources where they were most needed.

Through Medicare, those with HIV infection were able to access clinical care free of cost. The federal government also funded the provision of HIV test kits; access to free, universal, and anonymous HIV/AIDS testing; and access to AZT and then subsequent ARV therapies, again without cost to the patient.

In general, Australia has remarkably good health outcomes, although public health spending as a proportion of GDP (6.2% in 2001) is just average for a developed country. Likewise, Australia achieves remarkable health research outputs considering the size of its research investment (1.5% of GDP between 1996 and 2002).

Australian Political Parties and HIV/AIDS

The center-left Australian Labor Party (ALP) formed the national government between 1983 and 1996. Since 1996, the national government has been formed by a center-right coalition of the Liberal and National Parties. The coincidence of the election of the ALP government in March 1983, and the first reported cases of HIV/AIDS in November 1982, had great significance for the shaping of the Australian response to the epidemic. The ALP was philosophically predisposed to a centralization of political initiative at the national level, a nationally coordinated health system, and a strong program of preventive and community health programs.

Since their return to national government in 1996, the center-right parties have endorsed and supported all major elements of the national HIV/AIDS strategy. In particular, over the last decade, the Australian government has greatly strengthened Australia's international and regional response to HIV/AIDS.

At the provincial level, over the 25 or so years since HIV/AIDS emerged on the scene, governments have been formed comprising all shades of political opinion, but all have approached HIV/AIDS with a similar spirit of pragmatism. Furthermore, since the mid-1980s, successive national governments formed by different political parties have broadly agreed on the major elements of the Australian national HIV/AIDS strategy. Innovative, but once-controversial, programs such as needle and syringe exchanges have been maintained and expanded, and governments have accepted the principle of frank, sustained, and effective sex education targeted at young people. Generally, governments have been unwilling to tamper with policies that have produced acceptable outcomes. Australian public opinion accepts the need for continuing investment in effective HIV/AIDS preventive education campaigns, service delivery structures, social and medical research, and needle- and syringe-exchange programs as the price of sustaining the lowest practically achievable level of HIV and AIDS infection.

Since 1982, Australia's major political parties have commendably not exploited HIV/AIDS for partisan political advantage, although from time to time individual politicians have attempted to do so. Australian governments, political parties, and the public can be expected to support the main pillars of the Australian response to HIV/AIDS as long as infection rates are maintained at the current low levels. However, a significant rise in new HIV infection rates would undoubtedly bring renewed focus on the key elements of HIV/AIDS policymaking.

Parliamentary Liaison Groups on AIDS

The emergence of HIV/AIDS in the 1980s was a matter of great public and political concern, transcending traditional political party lines and divisions. As the scale and nature of the epidemic became apparent, relentless and intense media coverage gave rise to interest and concern in all Australian parliaments.

In the mid-1980s, many confusing, contradictory, alarmist, and often simply wrong claims were made about the threat posed by HIV/AIDS. The decisions made by Australian governments to combat HIV/AIDS, while necessary, were radical and controversial.

These public concerns were naturally reflected and debated in Australia's national, state, and territorial parliaments. As public and political concern about HIV/AIDS rose, the Australian government responded in November 1985 by creating a forum in which members of parliament could discuss HIV/AIDS issues in a more structured and useful way, the Parliamentary Liaison Group on AIDS (PLGAIDS).

The PLGAIDS brought together politicians of all parties with an interest in HIV/AIDS policy, who were provided with full briefings on the evolution of the epidemic and policy options likely to be considered by governments. This group also became a valuable conduit through which HIV/AIDS organizations could brief and lobby members of the federal parliament and exchange views and concerns.

At times of unexpected developments that generated controversy and public debate, the work of the PLGAIDS served to create among parliamentarians a very high degree of awareness about HIV/AIDS that led to much better informed public debate about the key issues. Several state and territory parliaments established similar parliamentary liaison groups that for

many years performed a valuable service in educating successive generations of parliamentarians and ministers about HIV-related issues.

National HIV/AIDS Advisory Structures

By the mid-1980s, a partnership had emerged that joined Australian governments, HIV-affected communities, clinicians, and researchers in the fight against HIV/AIDS. The partnership approach continues to be at the heart of Australia's response to HIV/AIDS. It represents an effective, cooperative effort between all levels of government; community organizations; the medical, healthcare, and scientific communities; and people living with or affected by HIV/AIDS, all working together to control the spread of HIV and to minimize the social and personal impacts of the disease. It is based on a commitment to consultation and joint decision making in all aspects of the response.

While initially the involvement of many different interests, governments, and civil society groups might have seemed more likely to confuse and delay an adequate response, the reverse was the case. A wide range of organizations grew up representing those involved in prevention education, service provision, care and treatment, social and medical research, advocacy, charitable works, and fundraising.

In order to coordinate advice and assistance from these groups, in November 1984, the Australian health ministers established two national HIV/AIDS advisory structures—the National Advisory Council on AIDS (NACAIDS) and the AIDS Task Force. NACAIDS was created as the government's peak advisory committee on prevention education; care and treatment of those living with HIV/AIDS; and social policy for the entire Australian population and groups at high risk of acquiring HIV infection. NACAIDS was given effective budget authority to develop and fund HIV/AIDS preventive education programs, and was authorized to negotiate on behalf of the government with civil society organizations and other interest groups.

The AIDS Task Force was created as the peak body bringing together HIV/AIDS clinical and scientific expertise. Its mandate was to make recommendations on the allocation of HIV/AIDS budgets for applied medical, scientific, and social research.

Together, NACAIDS and the AIDS Task Force became the Australian government's major sources of advice on HIV/AIDS policy, and worked

closely with the Australian Department of Health to develop and implement these policies. The creation of these two structures meant that innovative policy advice and ideas could be transmitted very quickly from those at the epidemic's front line to the ministerial decision-making level. And once decisions were made, ministers had confidence that policies would be implemented rapidly and effectively at the local, operational level.

With the adoption of each new HIV/AIDS strategy, the names of these advisory bodies have been changed and some of their functions absorbed into other bodies. However, the Australian minister for health is still advised by a national advisory body on HIV/AIDS and related diseases.

Australian National HIV/AIDS Strategies

With the establishment of NACAIDS, the AIDS Task Force, and various state- and territory-based civil society organizations, the Australian government decided to draw up a comprehensive national HIV/AIDS strategy to guide future HIV/AIDS policy and priorities. Over the 25 years of the HIV/AIDS epidemic, successive national HIV/AIDS strategies have been developed that reflect the changing nature of the Australian epidemic, deepening knowledge about the virus and assessments about the future course of the epidemic in Australia and regionally.

To date, Australian governments' commitment to a nationally coordinated response to HIV/AIDS has found expression in four successive national strategy documents. While far from perfect, these strategies have been exceptionally useful in establishing a shared view of HIV/AIDS among governments and the community, and in recommending how always scarce financial and human resources should be allocated.

Harm Minimization/Needle- and Syringe-Exchange Programs

Perhaps the single most significant contributor to Australia's relative success in sustaining a low HIV infection rate was the adoption in 1985 of "harm minimization" as the central principle underlying national policy on illicit drugs.

In April 1985, the prime minister and leaders of Australia's provincial governments met solely to decide a national approach to the rising usage of illicit drugs. This meeting approved and endorsed "harm minimization" as the basis of Australia's response. Although not defined at the time, this

term meant that reducing the adverse consequences of illicit drug use, and especially controlling HIV among IDUs, was an even higher priority than reducing drug consumption. This enabled far greater policy flexibility than was available when the paramount alternative was considered to be reducing illicit drug consumption.

In November 1986, Australia's first pilot needle and syringe exchange was begun in the inner Sydney suburb of Darlinghurst, in contravention of New South Wales law at that time, but acting in conformity with the harm minimization principles agreed to the previous year by Australia's political leadership. The testing of syringes returned to the Darlinghurst program detected an increase in HIV prevalence, suggesting that HIV was spreading among its clients. The success of this scheme in detecting HIV, managing HIV-infected clients into treatment, and distributing preventive education to IDUs led to its rapid expansion. By 1987, community and public pressure obliged the New South Wales government to amend relevant laws so as to permit such exchanges to operate legally. Other states and territories soon followed the New South Wales example, opening similar exchanges.

In 1987, Australia's health ministers endorsed and adopted needle- and syringe-exchange programs as a central element in the fight against HIV/AIDS and agreed to provide continuing budgetary support for such programs. Australian health ministers agreed that needle and syringe exchanges should be provided at public expense to encourage IDUs not to share equipment that might be infected with HIV and/or other blood-borne diseases. This decision, which was adopted by all Australian governments, implicitly recognized the reality of widespread use of illicit drugs, especially by young Australians.

For nearly 20 years, needle and syringe programs have operated in all Australian states and territories, and under governments of all political persuasions. It is abundantly clear from published research that needle- and syringe-exchange programs have been a crucial factor in containing HIV infection largely within the MSM and IDU communities and in preventing HIV infection from spreading into the community of heterosexually active Australians.

The Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) estimated the cost-effectiveness of needle and syringe

programs in Australia in 1991, using base case (i.e., the most plausible case), best case, and worst case assumptions. According to that study, needle and syringe programs were estimated to have prevented roughly 2,900 HIV infections in 1991, with a range of between 300 (worst case estimate) and more than 10,000 (best case estimate) HIV infections having been prevented (ANCAHRD 2000). In the same year, \$A10 million was spent on needle and syringe programs nationally, which produced savings of \$A266 million. In other words, the savings in treatment costs resulting from the prevention of HIV more than offset the operating costs of the programs. Further, the analysis actually underestimated the likely cost-effectiveness of needle and syringe programs because it did not include savings from prevention of the transmission of hepatitis B and hepatitis C. Had these additional benefits been measured, both the number of years of life saved and the net direct cost savings would have been substantially increased.

In 1999–2000, Australian governments and consumers spent approximately \$A23 million to provide some 32 million needles and syringes to IDUs (see table 2). Almost all of these needles and syringes were returned or disposed of safely in a network of sharps boxes (closed receptacles especially provided for the safe disposal of used needles and syringes) that has been built up around the country.

During the last two decades, compelling evidence has become available that needle and syringe programs are effective in reducing the spread of HIV/AIDS among IDUs. Contrary to claims made before needle and syringe exchanges were introduced, no evidence has emerged in Australia or other countries to suggest a causal link between the availability of clean needles and syringes and any increase in the consumption of illicit drugs.

When the magnitude of the threat of an HIV epidemic among and from IDUs was first fully recognized in Australia in 1985, there were only 2,000 heroin users in methadone maintenance treatment. It was assumed that methadone maintenance treatment would reduce the risk of HIV and this program was therefore rapidly expanded so that by 2005, almost 40,000 Australians were receiving methadone maintenance treatment. During this period, it has been confirmed that methadone maintenance treatment does substantially, indirectly reduce the risk of HIV infection.

Table 2. Expenditures and needles distributed through needle and syringe programs, 1999–2000

	Government expenditure (\$A thousands)	Consumer expenditure (\$A thousands)	Total expenditure (\$A thousands)	Needles distributed (thousands)
Australian Capital Territory	531	8	539	593
New South Wales	9,827	463	10,290	11,566
Northern Territory	n.a.	–	n.a.	604 ^b
Queensland	1,678	–	1,678	5,300
South Australia	787	43	830	3,018
Tasmania	484	138 ^b	622	1,381 ^b
Victoria	4,767	–	4,767	6,177
Western Australia	1,227	2,349 ^b	3,576	3,209
Total ^a	19,673	3,001	22,674	31,848

Source: Health Outcomes International et al. (2002).

^a Data relates to government-auspiced needle and syringe programs only. Excludes expenditure on needle and syringes sold through pharmacies on a commercial basis.

^b Includes figures imputed from data provided by state/territory health authorities.

Civil Society Responses

Domestic Responses

As a robust democracy, Australia has a long history of mobilization and organization from the “grassroots up.” Citizens are accustomed to acting collectively to bring political pressure to bear on regional and national governments to create or change policy settings and to fund new initiatives. While Australians look to government to play a large part in social and political life, they generally do not wait for government to act but move to shape and mold government’s responses.

As has been noted, the emergence of HIV/AIDS brought forth an immediate response from individuals and groups closest to the problem—gay men, IDUs, hemophiliacs, sex workers, clinicians, and researchers. Community activism, largely within the gay communities of Australia’s larger cities, led to the establishment of AIDS Action Committees in key state capitals. These groups responded to public and media interest and concern about HIV/AIDS. They soon began to lobby politicians about the need to respond creatively and flexibly to the rapidly increasing rates of HIV and AIDS infection and caseload.

At the same time, HIV/AIDS community groups rapidly educated their peers about the nature of the emerging threat. These groups moved quickly to acquire substantial specialized knowledge about HIV/AIDS and its impact on the interests they represented. This knowledge was of great value in dealing with their own clients and members and in informing government deliberations and policy formulation.

Using ad hoc funding from existing federal, state, and territorial governments, a range of agencies, health institutions, and community groups mobilized their members around practical HIV/AIDS education and outreach. As the following table demonstrates, those most affected by HIV/AIDS took steps that decisively reduced new HIV infection rates, and gained valuable time until a coordinated national response could be organized and funded.

Table 3. National HIV incidence and Australian federal government funding for HIV/AIDS, 1980–1993

Year	HIV incidence estimates	Federal government funding (\$A millions)
1980	10	–
1981	60	–
1982	540	–
1983	1,930	–
1984	2,890	1.61
1985	2,630	4.29
1986	1,960	7.75
1987	1,260	9.54
1988	870	10.97
1989	740	12.71
1990	710	20.28
1991	680	17.59
1992	580	20.21
1993	450	16.15

Source: Plummer and Irwin (2005).

Note: Incidence estimates were calculated back using projection techniques. Federal funding represents funds earmarked for HIV/AIDS education and prevention for the financial year beginning July 1.

Community group education and action thus brought about a sharp fall in new HIV/AIDS infection rates before large-scale national government funding for prevention could be put in place. Australian governments quickly recognized the crucial role that these civil society organizations

were playing in managing the HIV/AIDS epidemic, and in ensuring that HIV/AIDS public policy was soundly based, practical, and effective. Accordingly, Australian governments decided to wholly or partly fund many of these organizations to assist in their key functions—service delivery, advocacy and representation, information collection and distribution, and participation in the political process. Most of these organizations were established in the early years of the HIV/AIDS epidemic and have now been in existence for the best part of 20 years. In the 1990s, they quickly recognized the global dimension of the epidemic and made the linkages between Australian domestic and international responses.

Together with many Australian-based NGOs and international organizations that were concerned with the impact of HIV in other countries from a humanitarian perspective, they mobilized political support and funding and helped export Australian technical expertise and programming lessons. Many Australians currently engaged in global HIV/AIDS responses through the United Nations (UN) system or global networks such as the Red Cross, first gained their experience in Australia.

Corporate and Union Responses

In general terms, the Australian corporate sector has not contributed greatly to the national response to HIV/AIDS. Australian businesses responded almost purely within the context of occupational health and safety concerns for their workforces and customers. This has been the case particularly in those industries and sectors concerned with food preparation and service, hospitality, nursing, and medical care.

The emergence of HIV/AIDS greatly increased corporate awareness of the risks posed by the spectrum of blood-borne viruses and the need for greatly improved standards of care in the preparation and delivery of goods and services where transmission of such viruses was possible. Individual companies have, of course, chosen to support HIV/AIDS causes, and to associate themselves with a progressive social approach on HIV/AIDS. Apart from those companies with a large gay and lesbian customer base, Australian companies have been averse to associating themselves with the difficult and controversial social questions around HIV/AIDS.

Australian unions, especially those with large memberships in the health and allied professions, hospitality, and leisure sectors have generally adopted progressive and pragmatic policies on HIV/AIDS issues. Businesses and unions have provided education and training for those workers at potential or perceived risk of HIV infection.

Since rates of new HIV infection fell in the 1990s and have stabilized at low levels, however, HIV/AIDS education and information has generally been absorbed within wider occupational health and safety training.

Mass Media Responses

After the first emergence of the HIV virus in Australia in 1982, the way in which issues surrounding HIV/AIDS were reported in the mass media crucially influenced the evolution of policy responses. However, it is inaccurate to speak of a single mass media response to HIV/AIDS. The mass media's function is to create profits and ratings by providing forums for debate, discussion, and argument about the issues of the day.

In Australia, as elsewhere, the quality of reporting in the media generally reflects the quality of the information inputs—the better, more sustained, and accurate the information that is put into the public domain, the better and more informed the debate will be, and the better the quality of public policymaking. In Australia, the mass media reflects all the varied qualities of the Australian public—its fears, prejudices, and concerns, as well as its hopes and aspirations.

In the early days of HIV/AIDS, when there was a rapidly increasing case-load of a disease that seemed fatal and easily transmissible, it was entirely understandable that the Australian mass media would cover and report all developments in the story and provide a forum for all shades of opinion. From 1983 onward, the Australian government and minister responsible for dealing with HIV/AIDS accorded the highest priority to handling the reporting and coverage of HIV/AIDS in the mass media. Faced with a continuing barrage of sensational reporting on HIV/AIDS and commentary that was often based on rumor and speculation rather than evidence or fact, the Australian government and its HIV/AIDS advisory bodies established skilled media units to address the issue. The central principles

of dealing with the mass media on HIV/AIDS were to always be accessible to respond to breaking news developments, and to adhere to the highest standards of truth and honesty in conveying information to the public through the media.

Ministers believed that the greater the quantity of accurate and honest information about HIV/AIDS that appeared in the mass media, the more confidence the public would come to have in the government and its advisers on HIV/AIDS. The greater the public's confidence in HIV/AIDS policymaking, the less likely that the public would be panicked into supporting extreme and counterproductive responses on HIV/AIDS.

During the early years of HIV/AIDS, this careful and intelligent approach to the mass media gradually changed the nature and style of reporting about the epidemic. Fear and irrational panic about HIV/AIDS gave way to a more thoughtful understanding of the ways in which the HIV virus could be transmitted, and a more realistic understanding of the dangers it posed and how these could be avoided.

In the mid-1980s, several cases of appalling discrimination against people with HIV/AIDS were reported fully by the Australian mass media. These cases were thoroughly debated by the Australian community through the mass media. The national government and its expert HIV/AIDS advisory committees fully participated in these debates by providing factual briefings and informed opinion and commentary.

Gradually, a new public consensus about HIV/AIDS formed within the Australian community. Initial fear and panic had led to calls for sanction, isolation, and quarantine of those affected by HIV/AIDS. Very rapidly, these responses were replaced by a reluctant acceptance of the need for frank, honest information to be supplied to those people most at risk of HIV infection, and for action to be taken to provide young people with the necessary means to protect themselves from HIV infection—especially condoms and clean needles and syringes. The mass media both reflected and led this dramatic change in community opinion about HIV/AIDS.

Mass Media Advertising and Educational Campaigns

During the 1980s, a great deal of market research and polling was undertaken to examine public attitudes about HIV/AIDS and specific policy alternatives. This polling was vitally important in shaping the look and

feel of public education campaigns and in assisting ministers and others involved in the public debate about HIV/AIDS to communicate effectively with the Australian public.

Starting in 1987, the national government created and aired a series of graphic and imaginative television and radio commercials about HIV/AIDS. The initial campaign, built around the image of the Grim Reaper, was intentionally controversial and designed to make the maximum impact on public opinion. These commercials were complemented by the publishing of a variety of printed materials about HIV/AIDS and what steps should be taken to prevent transmission of the virus.

This national education campaign was complemented by state and territorial government efforts, working together with HIV/AIDS community groups, to actually deliver condoms, clean needles and syringes, and other materials to venues where unsafe practices were most likely to occur—clubs, bars, brothels, sex-on-premises venues, beats (public places where men obtain casual sex), parks, beaches, and entertainment districts in the major cities.

The mass media not only carried advertising messages but then also reported on HIV/AIDS developments editorially. While there were many lapses in judgment and many unfortunate stories about HIV/AIDS that gave vent to ignorance and prejudice, the Australian mass media's coverage of HIV/AIDS was a crucial factor in shaping public opinion to support enlightened and effective national HIV/AIDS policymaking.

Scientific and Research Community Responses

From a public policy perspective, Australia has placed the highest possible value on the accumulation, assessment, and analysis of factual research data on HIV/AIDS. Australian public policymaking has been based on empirical evidence about the nature of the virus and what works to contain and control its spread. Over two decades, an overwhelmingly convincing body of HIV/AIDS evidence based on factual observation has been accumulated in Australia. The country's HIV/AIDS policies have been based entirely on reasonable interpretation of the evidence accumulated by researchers.

Australia's scientists, clinicians, and researchers responded immediately and imaginatively to the emergence of HIV/AIDS. The pattern of close and active scientific study of HIV/AIDS was set from the earliest possible moment when the New South Wales health authorities funded a cohort study led by Professor Ron Penny following his detection and reporting in November 1982 of what was later identified to be the first HIV/AIDS case. Either by constituting themselves into ad hoc groups or by forming subcommittees within existing institutions, the scientific and clinical communities mobilized rapidly in the early 1980s to define and better understand the emerging epidemic.

The Australian response was notable for the very high degree of interaction between affected communities, researchers, and clinicians from the earliest stages of the epidemic. Affected communities developed great trust and confidence in HIV scientists, clinicians, and researchers, which allowed for very high rates of participation in clinical and epidemiological studies, as well as for highly effective delivery of treatment and care.

As the epidemic progressed, Australian governments funded the establishment of three major institutions especially concerned with HIV/AIDS. They were the National Centre in HIV Epidemiology and Clinical Research (NCHECR), the National Centre in HIV Social Research (NCHSR), and the National Centre for HIV Virology Research. Of these three institutions, the NCHECR and the NCHSR have maintained their autonomy and pursued vigorous research programs for nearly two decades.

Over time, valuable HIV/AIDS research was also undertaken within larger scientific institutions, universities, teaching hospitals, and the country's nine departments of health. Two notable institutions are the Burnet Institute and the Albion Street Centre.

Australian and New Zealand HIV/AIDS clinicians formed the Australasian Society of HIV Medicine (ASHM). This organization played a valuable role in the dissemination of HIV/AIDS information to the health and medical workforce, both in terms of scientific research and occupational health and safety advice. Through ASHM and other institutions, Australian clinical and social scientists and researchers actively contributed to the proceedings of national, regional, and international HIV/AIDS conferences and meetings, and met frequently to disseminate the findings of these meetings.

Close linkages were established between Australian HIV/AIDS researchers and international drug companies and institutions undertaking trials of new therapies and treatments. These linkages furthered general scientific knowledge and greatly benefited those living with HIV/AIDS in Australia.

Current Assessment of and Future Prospects for Regional and International Cooperation

An estimated 38 million people are living with HIV/AIDS in developing countries. The Australian government believes that the HIV/AIDS pandemic represents one of the greatest challenges facing those countries. HIV/AIDS is increasing in the Asia Pacific region, with about 7.4 million people currently infected. The burden falls most heavily on those countries that have the greatest difficulty in meeting this challenge.

HIV/AIDS threatens to reverse decades of hard-won development gains. It attacks people in their most productive years, destroys communities, and disrupts food production. Heavy burdens are placed on already weak health services. The disease cuts into the fabric of society and undermines a country's stability. Australia acted quickly in responding to HIV/AIDS at home, and it has taken a prominent role in the international response to the epidemic as well.

Australia's International Response to HIV/AIDS

Australian governments, institutions, and individuals have a demonstrated record of success in managing the many complexities of the HIV/AIDS epidemic. Their immense experience and practical knowledge are available to countries committed to limiting the spread of HIV/AIDS within their own borders and regionally.

Internationally, Australia has been an active contributor to the World Health Organization's efforts to contain the spread of HIV/AIDS, and to the work of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its predecessor, the Global Program on AIDS; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and other specialized HIV/AIDS organizations. Australia has also been aware of its particular responsibility to its neighbors in the Asia Pacific region.

It has developed substantial bilateral HIV/AIDS programs with several countries in the region, with particular emphasis on Pacific Island countries and territories. In July 2004, the Australian minister for foreign affairs committed the Australian government to spending \$A600 million over six years (until 2010) on its international HIV/AIDS initiative, *Meeting the Challenge*, managed by AusAID (the Australian government's overseas aid program) and the Department of Foreign Affairs and Trade. This initiative complements a wide range of projects developed over two decades between Australian universities; research institutions; governmental and nongovernmental agencies; HIV/AIDS community groups; religious, charitable, and welfare organizations; and individuals wishing to adapt and apply Australia's experience of combating HIV/AIDS to other countries.

The relatively low rates of HIV/AIDS prevalence in most Asia Pacific countries means that there is still an opportunity available to implement structures and programs that might cost-effectively prevent a rapid escalation of HIV infection rates in many Asia Pacific countries.

Global HIV/AIDS Initiative

In July 2000, in recognition of the high priority Australia places on assisting countries to combat HIV/AIDS, the Honorable Alexander Downer, minister for foreign affairs, announced a Global HIV/AIDS initiative of \$A200 million over six years. Additional funds were committed subsequently, and as noted above, at the Second Asia-Pacific Ministerial Meeting on HIV/AIDS in Bangkok, Thailand, on July 11, 2004, Downer announced a significant funding boost of \$A350 million over six years to combat the disease—more than doubling the country's commitment to a total of \$A600 million by 2010.

Australia recognizes the need to tackle HIV/AIDS as more than just a health issue. Political leadership is required to mobilize resources in a coordinated way across a broad range of fields. Partnerships need to extend beyond government to the private sector and community-based organizations to ensure an effective response to the disease and its impact.

The continuing emphasis placed on medical responses to HIV/AIDS means a continued involvement by those with medical and other clinical experience with HIV/AIDS. Thus, Australia is active both in advocacy at the political level and in activities designed to meet local needs and priorities.

After the UN General Assembly Special Session on HIV/AIDS, Australia hosted a Ministerial Meeting on HIV/AIDS for Asia and the Pacific late in 2001, immediately following the 6th International Congress on AIDS in Asia and the Pacific. The meeting concluded with an agreement on a ministerial statement reflecting the commitment of participating countries to strengthening coordination and partnership at every level and to further action and collaboration in tackling the challenges of HIV/AIDS. Stemming from the Ministerial Meeting, Australia worked with UNAIDS to establish the Asia Pacific Leadership Forum on HIV/AIDS and Development to foster continued political leadership and commitment at the highest level in addressing HIV/AIDS.

Issues to Be Addressed through Regional Efforts

Although regional and international cooperation to combat HIV/AIDS has developed reasonably effectively over the past decade or so, it is apparent that much still needs to be done if the Asia Pacific region is to avert a large-scale HIV/AIDS epidemic. Several major areas of concern are described in this section.

Upgrading HIV/AIDS Statistics, Reporting, and Monitoring

The collection of statistical data on HIV/AIDS in Asia Pacific needs substantial improvement. Present data sets for many countries are unreliable and understate the spread of HIV/AIDS. However, the Australian experience demonstrates that HIV testing for the sake of testing is counterproductive. Individuals will only come forward for testing if they do not feel threatened by it and if there is a real prospect of a positive HIV test leading to access to treatments and therapies. Testing without ensuring access to treatment is virtually guaranteed to lead to HIV infection rates being greatly understated, thereby depriving policymakers of accurate information on which to base HIV/AIDS programs.

Prisons

Both globally and regionally within Asia Pacific, HIV infection rates in prisons are increasing at an alarming rate. Existing policies are generating

large numbers of HIV-positive prisoners who will return to the general population at the conclusion of their sentences. Prisoners are overwhelmingly young, sexually active heterosexual males who are exposed in prison to the widespread use of shared needles and syringes and unprotected sex. As is shown in the selection below, a body of research is beginning to demonstrate that the number of HIV-positive prisoners in many countries is becoming overwhelming for the community and prison authorities.

Table 4. Estimated percentage of prison population infected with HIV

Country	Percentage infected
Brazil	16
Estonia	9
Greece	11
Malaysia	6
Portugal	20
South Africa	43
Spain	17
United States	2
Zambia	27

Note: Compiled by author from various sources. Dates of estimates vary.

The connection between drug use and HIV among prisoners is clear. Among Malaysian prisoners who are HIV-positive, the mode of transmission in 94% of the cases was the sharing of contaminated needles and syringes. In Russian prisons, there are an estimated 34,000 HIV-positive prisoners and 95% are IDUs.

Drug Prohibition/Harm Minimization

From the earliest days of HIV/AIDS in Australia, the government and the general public came to understand that the general population was more at risk of a general HIV/AIDS epidemic from IDUs than from MSM. It was also understood that the most serious threat from drug use both for individual drug users and for the community was an uncontrollable epidemic of HIV/AIDS.

Australia did not abandon attempts to restrict drug trafficking but realized the importance of balancing efforts to restrict drug supply with the even more urgent need to control HIV. Needle and syringe programs are examples of harm minimization because they try to reduce HIV infection without trying to stem drug use. Similarly, methadone maintenance treatment is

an example of harm minimization because drug users continue to consume mood-altering drugs but with considerable improvements in their health and well-being, including less risk of HIV infection.

The Australian experience conclusively demonstrates that the widespread availability of clean needles and syringes for those who use illicit drugs is critical to the control and suppression of HIV/AIDS, and to the maintenance of low HIV/AIDS infection rates within the general heterosexually active community. It is erroneous to believe that HIV/AIDS can be confined only to the MSM and IDU communities without eventually crossing over to the general heterosexually active population, but these policies can slow that progression substantially.

Effective harm minimization policies in relation to IDUs implicitly oblige communities and governments to acknowledge that illicit drug use is occurring in their populations but not to endorse it. From two decades' worth of empirical evidence, it is abundantly clear that nations that have criminalized all forms of illicit drug-taking behavior, and have therefore repudiated the introduction of needle- and syringe-exchange programs and related measures, now have an HIV/AIDS caseload that is very large compared with countries that have adopted harm minimization principles.

It is also clear from the Australian experience that the introduction of needle- and syringe-exchange programs did not lead to a significant increase in overall demand for illicit drugs. Indeed, there is evidence that IDUs attracted to needle- and syringe-exchange programs can be enticed to enter drug treatment and rehabilitation with consequent benefits to the individual and to society, including the reduction of crime rates. Harm minimization programs that are coordinated with more effective policing—aimed at the controllers of the illicit drug trade rather than end-users—and with effective preventive education campaigns have worked to reduce both supply and demand of heroin and other similar narcotics.

Priorities for Research and Action

Control and management of HIV/AIDS cannot be left solely to national health authorities, although they must bear the brunt of service delivery, care, and treatment. The vital intersection points for the rapid transmission

of HIV/AIDS into the general community occur in social areas that often involve shame, marginalization, and criminal behaviors—female and male prostitution, consumption of illicit drugs, imprisonment, infidelity, and frequent unprotected sexual encounters. Typically, security, police, and intelligence agencies have high degrees of understanding and involvement in these areas, yet they are very rarely involved in directly considering policies in relation to HIV/AIDS control.

Understandably, religious, cultural, and moral issues relating to the need to modify and alter at-risk behaviors must also be debated before a new social consensus can emerge about HIV/AIDS. In many countries in the Asia Pacific region, there is a need to research social and political attitudes to HIV/AIDS to determine how best to increase knowledge and awareness about the disease. Such research, and the policy implications that flow from it, should be considered not just by health ministries but also by agencies with responsibility for finance, national security, law enforcement, illicit drug control, and national research. If HIV/AIDS is to be brought under control and managed, it is critical that governments continuously work to gain the understanding and consent of religious and social leaders and groups, as well as the involvement of the national and local media.

HIV/AIDS and New Communications Technologies

The rapid expansion of new communications technologies of all kinds—Internet, mobile telephones, third-generation phones, broadband access, podcasting, satellite radio and television, chat rooms, and so on—has dramatically multiplied the channels by which young people receive and process information. This is particularly so in the large cities of Asia Pacific. Governments must consider strategies that use these new communications channels to reach young people at risk of HIV/AIDS infection, and in ways that will appeal to them and bring about sustained behavior change.

The communications strategies and tools that must be adopted for the larger cities are very different from those required among rural and regional populations. However, the consequences of a large-scale HIV/AIDS epidemic in the larger cities are likely to be far more severe and rapidly felt than the spread of HIV/AIDS in rural areas. The rapidly multiplying communications options available to many young people requires a thorough review of accepted marketing techniques, and much closer research,

development, and interaction with artists and those whose business is the development of new content and communications systems.

As with all successful marketing and communications campaigns, there must be comprehensive and insightful market research and opinion polling undertaken that will reflect the nature of community concerns and knowledge about HIV/AIDS, and will suggest how to communicate most effectively with younger people at risk of HIV infection.

While communications campaigns must be adapted to local sensitivities, the core messages about how to prevent HIV infection and to control the epidemic must be those derived from empirical observation and research. The challenge is not to deny the facts and existence of HIV and how it is transmitted, but to shape and send the message so that young people can take effective action to moderate and sustain behavior change.

The Crucial Role of Women

In their many roles as mothers, partners, wives, teachers, and caregivers, women must play a crucial role in educating their families and societies about the facts of HIV transmission and how it can be prevented. The Australian experience has been that women are most easily engaged and convinced about HIV/AIDS issues if they are spoken to by other women who they acknowledge and respect as communicators. It is primarily through women that men will be persuaded and cajoled to take the necessary steps to protect themselves from infection. HIV/AIDS projects and communications must therefore involve women at all stages, from inception to delivery.

Engaging Religious Leaders, Groups, and Organizations

Religious faith and belief play a central role in the lives of the great majority of the world's peoples. It seems likely that the introduction of policies that have been incontrovertibly demonstrated to suppress and control the spread of HIV/AIDS will continue to be questioned, if not opposed, by some of those who speak for religious faiths and beliefs. HIV/AIDS policymaking is just one area in which the clash between the values of science and religion are being contested in the modern world.

If HIV/AIDS policies that have been shown to work are to be introduced successfully in countries where religious beliefs are strong, then ways must be found to engage religious leaders in constructive dialogue about the need

for these policies and the evidence that supports their implementation. In countries as diverse as Iran and China, Australian institutions and groups have successfully engaged local religious leaders in very productive dialogues about HIV/AIDS. Despite the ferocity of the debate, every attempt must be made to respectfully address the concerns and views of religious leaders in developing pragmatic and life-enhancing outcomes for those at risk of HIV infection.

Conclusion

For nearly two decades, Australia has controlled the spread of HIV/AIDS and maintained very low rates of new HIV infection relative to comparable countries. Consequently, many thousands of young Australians have been spared from infection and early death from HIV/AIDS, and Australian governments have been relieved of the financial burdens of treating a much larger HIV caseload.

Australia's relatively successful response to HIV/AIDS came about because the Australian people, civil society organizations, clinicians, researchers, and provincial and national governments fashioned timely, practical, and imaginative responses to the complex challenges posed by the HIV/AIDS epidemic. Australia built its response to HIV/AIDS from the grassroots up, not from the top down. Public concern and mobilization, as well as action by communities first affected by HIV/AIDS, obliged Australia's national and provincial governments to respond quickly, generously, and creatively to the threat posed by this disease.

Out of the tumultuous early years of the Australian response to HIV/AIDS, a partnership evolved among the full range of groups and individuals involved. For nearly 25 years, this partnership has provided a solid framework for development of HIV/AIDS policies encompassing prevention, education, treatment, care, and research. This partnership developed and advocated a range of HIV/AIDS policies that were crucial in the continuing management of HIV/AIDS in Australia.

Empirical and tested evidence clearly indicates which programs and policies have worked in Australia to control the spread of HIV/AIDS infection and to best treat and care for those with HIV/AIDS infection. The greater

the number of cases of HIV/AIDS prevented, the greater the amount of finite resources that can be devoted to treating those who do have HIV and AIDS. Effective HIV/AIDS prevention also spares individuals, their families and loved ones, and the community needless and avoidable suffering.

If HIV/AIDS is to be controlled, the only effective measures that have been demonstrated to work are those tried and tested over 20 years in those countries that were first exposed to HIV/AIDS. Yet such policies can only be applied where there is strong political will and committed leadership to overcome fear, prejudice, intolerance, and inertia.

In Australia, the recent upturn in HIV/AIDS and STI rates demonstrates the paradox of prevention. The more successfully HIV/AIDS infection rates have been kept under control, the fewer dedicated human and financial resources have been directed by governments at HIV/AIDS; resources are instead redirected to other more apparently pressing public health issues. During the 1990s, many Australian governments assumed that the worst of the HIV/AIDS crisis had passed. They chose to "mainstream" HIV/AIDS funding and services within the context of general sexual health programs, the response to other related diseases (including hepatitis C and other STIs), and general expenditure on medical and scientific research. At the national level, the Australian government remained ostensibly committed to renewal of the National HIV/AIDS Strategy. In practice, however, the government has paid progressively less attention to sustaining the partnership among government, clinicians, researchers, and community groups that had been so successful in controlling HIV/AIDS since 1982.

As a consequence of this drift, Australian governments, clinicians, researchers, and HIV community organizations have been slow to develop and implement new education campaigns targeted at both the general and at-risk communities. In 2005, however, there have been encouraging signs of a renewed mobilization of interest and resources by governments and community organizations to address the deteriorating HIV situation in Australia and regionally.

For more than two decades, Australia sustained a pragmatic and workable response to HIV/AIDS that kept its infection rates at low levels. Internationally, however, considerably greater funding and resources have been directed to HIV care and treatment than to effective, sustained popular mobilization around HIV prevention. This unbalanced approach has

resulted in a global toll of HIV infection and deaths from AIDS that was to a great extent avoidable.

The HIV pandemic is now beginning to spread in the countries of the Asia Pacific region. Given its experience, Australia is well placed to make a substantial contribution to building an Asia Pacific coalition of governmental, business, and civil society organizations dedicated to effective HIV prevention. For the foreseeable future, prevention will remain the most effective vaccine against the spread of HIV/AIDS.



This chapter was commissioned by the Lowy Institute for International Policy. In preparing this report, the author interviewed and consulted with many individuals who made crucial and invaluable contributions to the quality and depth of the Australian response to HIV/AIDS. The author is very grateful for their comments and suggestions that immeasurably improved the quality of this report. The views and conclusions expressed in this report, however, are solely those of the author, who assumes total responsibility for this report and the analysis and conclusions it contains.

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