

Something borrowed, something new: *Addressing increased rates of HIV and STI transmission among gay men in Victoria*

Action plan
2008–2010



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Disclaimer

This document has been developed in consultation with the Departmental HIV Prevention Taskforce and based on the work of a previous Project Advisory Group tasked to develop a Victorian Gay Men's HIV/STI Action Plan for the Public Health Branch, Department of Human Services. This version was prepared by William Leonard, Australian Research Centre in Sex, Health and Society at La Trobe University.

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Victorian Department of Human Services
March 2008

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1 Introduction

1.1 Background

This action plan provides a framework for addressing increased rates of HIV and STI transmission among gay men in Victoria. It draws on state, national and where appropriate, international epidemiological and behavioural data to understand the multiple factors underpinning these increases. The action plan uses this understanding to develop an integrated policy, program and service response that relies on a renewal of the partnership between government, gay and lesbian community and professional organisations, and the health and academic sectors. It is this partnership which has underpinned Australia's and Victoria's success in containing the spread of HIV and AIDS.¹

At the centre of the framework is a range of initiatives aimed at increasing the capacity of the HIV/AIDS sector to carry out effective gay men's HIV and STI prevention. However, these initiatives *alone* are unlikely to result in sustained changes in gay male cultural norms and sexual behaviours and a long-term reduction in HIV and STI infections. Research shows that many of the health problems and patterns of ill-health specific to gay men are a consequence

of deeply held prejudice and discrimination.^{2,3} While homophobia continues to shape cultural and sexual norms, efforts to improve gay men's health and wellbeing, including efforts to change gay men's sexual practices, will be severely compromised.

In order to maximise the effectiveness of gay men's HIV and STI prevention this action plan argues it must be linked to broader processes of political, legislative and social reform.⁴ The action plan places the development of gay men's HIV and STI prevention in the context of a gay men's health and wellbeing promotion strategy. In turn, this strategy is informed by and contributes to the government's social policy⁵ and human

rights objectives⁶ by promoting sexual diversity, equality and social justice⁷. It also accords with the Ottawa Charter principles⁸ which suggest that it is only within a health promoting and non-discriminatory environment that individuals are able and willing to take responsibility for improving their sexual health and the sexual health of their sexual partners.⁹

1 In its introduction the fifth and latest national HIV/AIDS strategy states "[The earlier strategies] led to the development of what was widely referred to as 'the partnership' between the effected communities, government, service providers and researchers. This allows for a high level of consultation and collaboration between these groups in their work to prevent, manage and treat HIV/AIDS in the community". *National HIV/AIDS Strategy 2005–2008: Revitalising Australia's Response* (2005) Commonwealth of Australia: Canberra, p.1

2 *Health and sexual diversity: A Health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians* (2003) Prepared by W. Leonard on behalf of the Victorian Ministerial Advisory Committee on Gay and Lesbian Health. Victorian Department of Human Services: Melbourne.

3 Pitts, M., Smith, A., Mitchell, A. and Patel, S. (2006) *Private Lives: A report on the health and wellbeing of GLBTI Australians*. Gay and Lesbian Health Victoria and the Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne. This report documents aspects of the health and wellbeing of a large sample of GLBTI people in Australia. It explores the impact of factors such as homophobia, discrimination, family and community connection on health and wellbeing, and investigates aspects of their health service usage.

4 As King argued at the height of the epidemic "The importance of maintaining and building gay esteem, [is] not purely for 'gay political' reasons but [is] a fundamental part of successful safe sex education". King, E. (1993) *Safety in numbers: Safer sex and gay men*. Cassell: London and New York, p.49.

5 *A Fairer Victoria: Creating opportunity and addressing disadvantage* (2005) Department of Premier and Cabinet: Melbourne, Victoria.

6 *Charter of Human Rights and Responsibilities* (2006) Department of Justice: State Government of Victoria

7 *Health and sexual diversity* (2004), op cit.

8 The Ottawa Charter was adopted by the World Health Organisation in 1986 and established a broad social agenda for health promotion. For a detailed discussion of how the Ottawa Charter applies to HIV health promotion see Trussler, T. and Marchand, R. (1997) *Field Guide: Community HIV Health Promotion, Theory, Method, Practice*. Health Canada: Vancouver, British Columbia, pp. 5–9.

9 Leonard, W. and Mitchell, A. (2000) *The Use of Sexually Explicit Materials in HIV/AIDS Initiatives Targeted at Gay Men: A guide for educators*. The Australian National Council on AIDS, Hepatitis C and Related Diseases: Commonwealth Department of Health and Aged Care, Canberra, p.11.

1.2 Development of the action plan

Between 1999 and 2006 Victoria experienced a 99 per cent increase in newly diagnosed HIV infection, from 132 in 1999 to 263 in 2006.¹⁰ The majority of these new diagnoses have been among men who have sex with men (up from 64 per cent of total new HIV diagnoses in 1999 to 78 per cent in 2006).¹¹ Current notification rates among gay men are now at a level not seen since the height of the epidemic in the mid 1990s.¹² Similar increases have been

recorded in other eastern states over the same period.¹³

In March 2006 the Victorian Department of Human Services (DHS) convened a summit of health officials from the eastern states to review the data and consider key issues and new approaches to tackling increasing rates of HIV and STI transmission among gay men. In May of that year DHS hosted a workshop of key stakeholders to revisit Victoria's approach to gay men's HIV and STI prevention in light of the summit's findings and to design and implement policy and programs that are sensitive to the Victorian situation.

One of the outcomes of that meeting was a commitment by Public Health Branch, DHS to develop a Victorian Gay Men's HIV and STI action plan. An expert steering group was convened to provide the Department with advice in the action plan's development (Project Advisory

Group, Victorian Gay Men's HIV/STI Action Plan—Appendix B). In March 2007 the then Victorian Minister for Health, the Hon Bronwyn Pike MP, provided additional funds for projects that focus on reducing rates of HIV and other STIs in Victoria. The DHS HIV Prevention Taskforce was established to advise the DHS and the Minister for Health on the most effective actions to achieve reduced transmission of HIV and STIs in gay men. The Taskforce met for the first time in early May 2007. (Departmental HIV Prevention Taskforce Membership—Appendix C). This action plan is the outcome of these two processes and includes recommendations from both the Steering Group and the Taskforce. It also relies on advice from members of both expert bodies in the development of the action plan's framework.

10 National Centre in HIV Epidemiology and Clinical Research (2006) *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2006*. National Centre in HIV Epidemiology and Clinical Research, the University of New South Wales: Sydney, p.43. The report defines newly diagnosed HIV infection as the "estimated number of HIV diagnoses in each year not reported in previous years". Newly diagnosed HIV infection is to be distinguished from "newly acquired HIV infection" which is defined as "newly diagnosed HIV infection with a negative or indeterminate HIV antibody test result, or a diagnosis of HIV seroconversion illness, within one year of HIV diagnosis", p. 45.

11 Guy, R., McDonald, A. et al. (2007) "HIV diagnoses in Australia: Diverging epidemics within a low-prevalence country". *MJA* 187, p. 2.

12 According to figures presented in the review of Australia's third national HIV/AIDS strategy new diagnoses of HIV among gay men peaked in 1995 at over 190 cases. However, as the review notes this is likely to be an underestimate. See Australian National Council on AIDS and Related Diseases (1999) *Proving Partnership: Review of Third National HIV/AIDS Strategy*. Commonwealth of Australia: Canberra, pp. 12 and 7–9 respectively.

13 National Centre in HIV Epidemiology and Clinical Research (2006), op cit. For state-based data on rates of diagnoses of HIV infection from 1993 to 2006 see Guy, R.J., McDonald, A.M. et al (2007) "HIV diagnoses in Australia: Diverging epidemics within a low-prevalence country". *Medical Journal of Australia* 187, p.2

1.3 Structure and principles

1.3.1 Structure

The action plan is divided into six sections:

Section 1 outlines the purpose and structure of the paper;

Section 2 gives an overview of relevant health and broader social policy;

Section 3 presents current data on rates and modes of HIV and STI transmission among gay men, including a comparative analysis between Melbourne and Sydney;

Section 4 looks briefly at the organisation and resourcing of the HIV/AIDS sector;

Section 5 develops a framework for promoting gay men's sexual health and reducing rates of HIV and other STIs; and

Section 6 lists recommendations for developing gay men's HIV and STI prevention in Victoria, in the broader contexts of gay men's health promotion and whole-of-government social justice and human rights policy and programs.

1.3.2 Principles

This action plan reaffirms the core principles that have informed Victoria and Australia's successful approach to containing the spread of HIV.¹⁴ These include:

- A renewed emphasis on partnerships between government, the health and academic sectors and the gay and lesbian community;
- Acknowledging and extending the role of HIV positive gay men and their representative organisations in gay men's HIV and STI prevention and health promotion; and
- A commitment to research and a sustainable evidence-base on which to develop and assess the effectiveness of HIV/AIDS policy, programs and services.

¹⁴ *Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009* (2006) Victorian Department of Human Services: Melbourne, pp. 5 and 9.

2 Policy context

2.1 International

The action plan's framework is informed by current best practice health promotion principles enshrined in a number of international policy statements, including the Bangkok Declaration¹⁵ and the World Health Organisation's Commission on the Social Determinants of Health¹⁶. These statements adopt a preventative, human rights-driven approach to population health and wellbeing, highlighting the causal relationship between social inequality, discrimination and patterns of ill-health.

2.2 Victoria's social justice and human rights agenda

The government has reaffirmed its commitment to diversity and equality with the development of its social justice and human rights agenda. The implementation of the Victorian *Human Rights Charter*¹⁷ will better protect individuals' rights and strengthen the state's democratic processes. *A Fairer Victoria*¹⁸ is the government's social policy blueprint for the next 10 years. It aims to promote diversity while tackling the disadvantage and discrimination that underpin entrenched population and place-based inequalities.

15 See *Health promotion in a globalized world: Report by the Secretariat* (May 2006) World Health Organisation, Fifty-ninth Health Assembly. http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_21-en.pdf

16 WHO Commission on the Social Determinants of Health accessible at http://www.who.int/social_determinants/en/

17 *Human Rights Charter*, op cit.

18 *A Fairer Victoria*, op cit.

2.3 DHS and broader policy

2.3.1 DHS's mission statement

DHS's mission is to address the needs of the most vulnerable groups within the Victorian community and the social forces underpinning patterns of health inequality.¹⁹ It reflects the government's social policy and human rights objectives and provides both a rationale and opportunity for linking gay men's HIV and STI prevention and health promotion to broader whole-of-government diversity and social justice policy and programs.

2.3.2 HIV and STI health and health promotion policy

The action plan draws on HIV and STI policy development undertaken by DHS over the last two years including:

- The work of the Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections (MACBSTI)
- Key stakeholder workshop "Working together to prevent HIV transmission in men who have sex with men", 27 May 2006
- *Project to Develop an Integrated Service Model for the Provision of HIV Services in Victoria: Consultation Paper*²⁰

19 *Departmental Plan 2007–08: Department of Human Services* (2007) Victorian Government Department of Human Services: Melbourne, Victoria, p. 5.

20 RPR Consulting (June 2007) *Project to Develop an Integrated Service Model for the Provision of HIV Services in Victoria: Consultation Paper*. Prepared by A. Porcino and T. Leach, RPR Consulting: Melbourne.

- *Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009*²¹; and
- *Victorian Sexually Transmissible Infections Strategy 2006–2009*²²

2.3.3 Broader health promotion policy

The plan also identifies opportunities for the inclusion of gay men's health and wellbeing issues in DHS health promotion policy and resource development including:

- *Health Promotion Priority Setting for 2007–2012*; and
- Evidence-based health promotion resources.

2.3.4 Related health and wellbeing policy

The plan builds on and contributes to meeting the objectives of a range of related state and national health and wellbeing strategies including:

- *Health and sexual diversity: A Health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*²³
- *Victorian Drug Strategy 2006–2009*²⁴

21 *Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009* (2006), op cit.

22 *Victorian Sexually Transmissible Infections Strategy 2006–2009* (2006) Victorian Department of Human Services: Melbourne.

23 *Health and sexual diversity* (2003), op cit.

24 *Improving health, reducing harm: Victorian Drug Strategy 2006–2009* (2006) Victorian Department of Human Services: Melbourne.

- *National HIV/AIDS Strategy 2005–2008: Revitalising Australia’s Response*²⁵
- *National Sexually Transmissible Infections Strategy 2005–2008*²⁶; and
- *National Mental Health Strategy*²⁷

²⁵ *National HIV/AIDS Strategy 2005–2008*, op cit.

²⁶ *National Sexually Transmissible Infection Strategy 2005–2008* (2005) Commonwealth of Australia: Canberra.

²⁷ See Department of Health and Ageing (2005) *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia’s Mental Health Services Under the National Mental Health Strategy 1993–2003*. Commonwealth of Australia: Canberra and Department of Health and Ageing (2003) *National Mental Health Action Plan 2003–2008*. Commonwealth of Australia: Canberra.

3 Patterns of HIV and STI transmission

3.1 Population data

3.1.1 Gay men

Prestage of The National Centre in HIV Social Research (NCHSR) has estimated the total number of gay men living in Sydney and Melbourne at 57,000 and 33,000 respectively.²⁸ According to these estimates the number of gay men per capita living in Sydney and Melbourne are comparable, suggesting that population differences alone cannot account for variations in rates of HIV transmission.²⁹

3.1.2 HIV positive gay men

However, Prestage suggests that there are significantly more HIV positive gay men living in Sydney compared to Melbourne and estimates that the numbers of HIV positive gay men living in Sydney and Melbourne at 4,500 and 1,700 respectively.

3.2 Epidemiological data

3.2.1 HIV

Over the last six years gay men living in Melbourne have accounted for 91 per cent of annual new HIV infections among gay men in Victoria. According to 2006 data gay men aged 30–39 years accounted for the majority of these new HIV infections (38 per cent), followed by gay men aged 40–49 years (24 per cent) and gay men aged 20–29 years (20 per cent). The 2006 figures represent a 9 per cent increase in new HIV diagnoses over the previous year. However, this was significantly less than the 17 per cent increase in new HIV infections recorded for 2004–2005.³⁰

The Melbourne data is indicative of national and international trends. In Queensland and South Australia there have been increases of 48 and 34 per cent respectively in new HIV diagnoses between 2000 and 2005.³¹ Rises have also been reported among gay men in Western Europe, North America and

other regions where the epidemic has a similar profile to that in Australia. For example, in the UK in 2005 there were 2356 new HIV diagnoses among men who have sex with men (MSM), the highest on record since the beginning of the epidemic.³²

However, San Francisco and Sydney are notable exceptions. Between 2000 and 2006 both cities experienced a levelling off of new HIV diagnoses. In June 2005, the Centres for Disease Control and Prevention in the United States revised its estimates of the rate of new infection among MSM in San Francisco from 2.2 to 1.2 per cent per year (from approximately 1,100 new infections annually to 550), the lowest rate reported in San Francisco since 1997.³³ In NSW the majority of new HIV diagnoses are among gay men living in Sydney. Between 2000 and 2006 NSW experienced an 8 per cent increase in new HIV diagnoses.³⁴ However, this masks a *decrease* in rates of new diagnoses in 2005/06 which is of primary importance.

28 Data presented by Garrett Prestage at *AFAO Forum on HIV Diagnoses Among Gay and Other MSM* (15 to 16 August 2007), Sydney. The figures were arrived at using national data and estimates of the percentage of the male population that is exclusively homosexual. Prestage stressed that the figures are “guesstimates” and subject to incomplete data and a number of theoretical approximations.

29 This does not exclude the possibility that variations in the population density of gay men living in each city may have an effect on rates of HIV transmission.

30 HIV sentinel surveillance data suggests that increases in HIV prevalence reflect new infections rather than new diagnoses and are not an artefact of testing (see also footnote 9). HIV sentinel surveillance at five sentinel clinics identified a significant increase in HIV prevalence (among those tested for HIV) from 1.3 per cent in 2004 to 2 per cent in 2005. These figures are consistent with the increase in diagnoses reported via passive surveillance over the same period. The number of tests and characteristics of those tested did not change between 2004 and 2005. See Guy, R. and Hellard, M. (2005) *Pilot of a voluntary HIV sentinel surveillance system for men who have sex with men*. Burnet Institute, Melbourne.

31 National Centre in HIV Epidemiology and Clinical Research (2006) *HIV/AIDS*, op cit.

32 UK Collaborative Group for HIV and STI Surveillance (2006) *A complex Picture. HIV and Other Sexually Transmitted Infections in the United Kingdom, 2006*. Health Protection Agency, Centre for Infections: London.

33 Centres for Disease Control and Infection (2005) *HIV Prevalence, Unrecognized Infection, and HIV Testing Among Men Who Have Sex with Men—Five U.S. Cities, June 2004–April 2005*. However, these figures have since been revised by Doctor Willi McFarland of the Department of Public Health San Francisco from 1,084 annual new diagnoses in 2001 to 976 in 2005. See Sabin, Russell (March 31 2006) “San Francisco: Decreasing new HIV infections smaller than expected”. *San Francisco Chronicle*.

34 National Centre in HIV Epidemiology and Clinical Research (2006), op cit.

3.2.2 Other STIs³⁵

Over the last six years in Victoria there has been an increase in STI notifications. Gonorrhoea notifications among men have increased by 46 per cent, from 798 in 2000 to 1166 in 2006. Chlamydia notifications have also increased from 1,335 in 2000 to 4,168 in 2006 (an increase of 212 per cent). The majority of gonorrhoea notifications have been among MSM, with rates and chlamydia also increasing. These patterns and increased rates of gonorrhoea and chlamydia notifications are similar to those of other Australian states and territories including NSW.³⁶

Over the same period there was a large increase in notifications of infectious syphilis, from 6 cases in 2000 to 210 cases in 2006 (an increase of 3,400 per cent). In 2000 MSM accounted for only a third of notifications of infectious syphilis among men. Since 2003 however, MSM have accounted for more than 85 per cent of annual notifications. It is significant that NSW data shows a decrease in rates of infectious syphilis among MSM from the end of 2004.³⁷

Data from the Victorian Infectious Diseases Reference Laboratory investigation in 2004 indicate that 40 per cent of infectious syphilis cases were co-infected with HIV.³⁸ Epidemiological and biomedical research demonstrate an association between transmission of HIV and infection with one or more other STIs. Research suggests that the physiological effects of an STI, including ulceration, may increase the risk of acquiring HIV. There is also evidence that the coexistence of HIV and another untreated STI increases the risk of HIV transmission.³⁹

3.3 Behavioural data

3.3.1 Increasing rates of unprotected anal intercourse (UAI) among gay men

Data from the 2006 *Annual report of trends in behaviour* suggests that between 2001 and 2006 rates of UAI (in the past six months) among gay men in Melbourne have remained relatively stable (46.8 per cent in 2001 to 48.6 per cent in 2006).⁴⁰ During this same period in Sydney rates of UAI have shown a slight decrease from 51.2 per cent in

2001 to 47.3 per cent in 2006⁴¹. However, rates of UAI among gay men vary considerably from sample to sample according to whether respondents are or are not currently in a regular relationship, or whether those in a regular relationship are having UAI with their regular and/or casual partner(s). Rates of UAI also vary considerably between different age groups.⁴²

UAI in regular relationships (UAIR)

Between 1998 and 2006 in Melbourne, the percentage of gay men in a regular relationship who reported having UAI with their regular partner in the past six months increased from 45.3 per cent to 58.8 per cent.⁴³ In Victoria over this period the percentage of gay men aged 30 to 49 years⁴⁴ in serodiscordant and seroconcordant⁴⁵ regular relationships has remained relatively

41 Richters, Juliet (Ed.) (2006), p. 10 op cit. This data is taken from the periodic surveys. The *Annual report* also includes data from a number of other surveys conducted over this period. There are variations in numbers and rates of HIV infection between the different reports depending on sampling methods, sample size, target group etc.

42 Richters, Juliet (2006), p.9 op cit.

43 Hull, P., Prestage, G. et al (2006) *Gay Community Periodic Survey: Melbourne 2006* (GCPS Report 4/2006). National Centre in HIV Social Research, The University of New South Wales: Sydney.

44 The age range that accounts for over 60 per cent of new HIV diagnoses in Melbourne in 2006. See Section 2.2.1.

45 Serodiscordant refers to relationships in which both individuals know their HIV status and one is HIV positive, the other HIV negative. Seroconcordant refers to relationships in which one or both partners does not know their HIV status.

35 Gay men may be over-represented in STI notifications because of sentinel surveillance data and a willingness of high case load practices to collect and report sexual identity data.

36 *National Notifiable Diseases Surveillance System* accessible at <http://health.gov.au/internet/wcms/publishing.nsf/Content/cda-surveil-nndss-nndssintro.htm>.

37 From NSW Notifiable Diseases Database (NDD) and Australian Bureau of Statistics Population Estimates (HOIST), op cit.

38 Guy, R.J., Leslie, D.E. et al. (2005) "A sustained increase in infectious syphilis notifications in Victoria". *Medical Journal of Australia* 183:4, p.218.

39 This is due to increased HIV shedding from genital secretions. See Guy, R. J. (2005) op cit.

40 Richters, Juliet (Ed.) (2006) *HIV/AIDS, hepatitis and sexually transmissible infections in Australia: Annual report of trends in behaviour 2006 (Monograph 3/2006)*. National Centre in HIV Social Research, The University of New South Wales: Sydney, pp. 9 and 10.

stable at about 46 per cent.⁴⁶ In Victoria there has been an increase in UAI in sero-discordant/-nonconcordant regular relationships, from 34 per cent in 1998 to 49 per cent in 2006.⁴⁷ Although there was a similar increase in NSW between 1998 and 2005, between 2005 and 2006 there was a significant decrease from 51.4 per cent to 45.1 per cent.⁴⁸

UAI in casual relationships (UAIC)

There has also been an increase in the proportion of men in Melbourne who reported a casual partner in the past six months and had UAI with the casual partner/s, from 18.6 per cent in 1998 to 29.1 per cent in 2006.⁴⁹ Results from the periodic survey show that for men living in Victoria aged 30 to 49 years rates of UAI with casual partners has increased from 18.6 per cent in 1998 to 30.4 per cent in 2006. In NSW, by contrast, rates of UAI with casual partners for this age group peaked in 2001 at 37.9 per cent and have fallen sharply to about 32.2 per cent in 2006.⁵⁰

UAIC in HIV positive men

In NSW the percentage of HIV positive men aged between 30 and 49 years who had sex with casual partners who reported UAI rose from 37.5 per cent in 1998 to 53.6 per cent in 2006.⁵¹

However, there has been a steady decline since numbers peaked in 2001. In Victoria, by contrast, the percentage of HIV positive men in this age group having casual sex who reported UAI peaked in 2006 at 60.4 per cent. This followed a period of decline in which the percentage dropped from 57.4 per cent in 2002 to 52 per cent in 2005.⁵²

UAIC in HIV negative men

Similar trends in rates of UAI have been noted for HIV negative men and men of unknown HIV status aged 30 to 49 years who have had sex with casual partners. In NSW the percentage of HIV negative/unknown serostatus men in this age group having casual sex who reported UAI peaked in 2001 at 31.5 per cent and has fallen steadily to 27.4 per cent in 2006. In Victoria there have been minor fluctuations over the same period but there has been a small upward trend from 23.2 per cent in 2001 to 25.9 per cent in 2006.⁵³

3.3.2 Disclosure of HIV serostatus

In *HIV Futures 5*, 37 per cent of HIV positive respondents from NSW disclosed their HIV serostatus to their most recent sexual partner.⁵⁴ These compared to Victorian rates of disclosure of HIV positive serostatus of 31 per cent. Data from the 2006 periodic surveys show that the percentage of HIV positive

men who never disclose their HIV serostatus in the context of UAIC has declined in both NSW and Victoria. However, in 2006 the percentage was higher in Victoria, with 25 per cent of HIV positive men compared to 18 per cent in NSW never disclosing their HIV serostatus.

The periodic data show similar rates of non-disclosure of HIV status among HIV negative gay men and gay men of unknown HIV status in the context of UAIC. In 2006, the percentage of men in each of these two categories who never disclosed their HIV status in the context of UAIC was 40 and 46 per cent for NSW and Victoria respectively.

3.3.3 Rates of testing

HIV

The percentage of gay men in Melbourne who have not had an HIV antibody test has remained constant at approximately 16 per cent since 1998.⁵⁵ According to Private Lives data, 62.7 per cent of gay men living in Melbourne have had an HIV antibody test in the last 12 months compared with 70.8 per cent of gay men in Sydney.⁵⁶ This variation in testing levels could be significant as research suggests that one of the contributors to increasing rates of HIV transmission is recently infected individuals who believe they are HIV negative.⁵⁷

46 Although there have been significant annual fluctuations over this 8 year period. Source: NSW, Victoria and Queensland Periodic Surveys 1998–2006; men aged 30 to 49 years. Results presented by Zablotska, I. (May 2007) “A think tank: Why are HIV notifications flat in NSW 1998–2006?” NSW Health.

47 Zablotska, I. (May 2007), op cit.

48 Zablotska, I. (May 2007), op cit.

49 Hull, P., Prestage, G. et al. (2006), p. 24 op cit.

50 Zablotska, I. (May 2007), op cit.

51 Zablotska, I. (May 2007), op cit.

52 Zablotska, I. (May 2007), op cit.

53 Zablotska, I. (May 2007), op cit.

54 Grierson, J., Thorpe, R. and Pitts, M. (2006) *HIV Futures 5: Life as we know it*. Monograph series number 60. The Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne for further figures on treatments’ uptake.

55 *Gay Community Periodic Survey Melbourne 2006*, p. 11 op cit.

56 Pitts, M., Smith, A., Mitchell, A. and Patel, S. (2006) op cit.

57 *HIV/AIDS, hepatitis and sexually transmissible infections in Australia* (2006), op cit.

Other STIs⁵⁸

Private Lives data reveals a marked variation in rates of STI testing between gay men living in Melbourne and Sydney. In Melbourne, 39.5 per cent of respondents had been tested for an STI in the current year compared to 49.9 per cent of respondents in Sydney.⁵⁹

3.3.4 Treatment uptakes Post Exposure Prophylaxis (PEP)

Data from the latest *HIV Futures* study shows that the percentage of HIV positive men in Melbourne taking combination antiretroviral therapy has fallen from almost 83 per cent in 1998 to 59 per cent in 2005.^{60,61} Clinical evidence shows that people on antiviral therapy are more likely to have an undetectable viral load than those not taking therapy (between 60 and 85 per cent compared to between 10 and 25 per cent respectively).⁶² A reduction in the number of HIV positive men taking

antiretroviral therapies is likely to result in an increase in population viral load which is associated with increased rates of HIV transmission.⁶³

Research also shows marked variation in knowledge and usage of PEP between the different states and territories. According to *Private Lives* data 54.3 per cent of gay men in NSW had heard of PEP, compared with between 40 and 50 per cent of gay men in Victoria, the ACT and Queensland. However, among those who had heard of PEP, rates of attempting to access treatment were similar for NSW, Victoria and Queensland, varying between 8.1 and 11.1 per cent.⁶⁴ A lack of awareness and use of PEP by gay men living in Melbourne may result in an increase in population viral load relative to Sydney. This difference may be further compounded by reduced treatments uptake by HIV positive men.

3.3.5 Sexual subcultures

There is a growing body of research that suggests a proportion of new HIV infections are associated with what has been labelled “adventurous sex”.⁶⁵ This includes a number of practices from

barebacking (UAI) and fisting to increased use of sexual prosthetics such as sex toys and performance enhancing drugs.⁶⁶

Hurley and Prestage argue that over the last few years these practices have taken on the characteristics of a subculture, associated with specific groups of gay men and carried out in discrete, identifiable cultural spaces.⁶⁷ They argue that this subculture has developed at the intersection of the gay dance party and more explicit sex scenes. They coined the term “intensive sex partying” to describe this new subculture. According to the terms of their analysis, intensive sex partying reflects changing notions of gay community and identity and changing attitudes toward HIV and AIDS, brought about both by new treatments and increased numbers of well, sexually active and socially engaged HIV positive gay men.

Research suggests that this subculture is subject to serosorting with an over-representation of HIV positive men. This raises complex issues regarding the sexual health of HIV negative men who participate in intensive sex partying. They are at risk of contracting HIV and in the

58 Concerns have been raised about the accuracy of self-reported STI testing among gay men and the belief that being tested for HIV is also a test for STIs. However, it is unlikely that this possible confusion will influence the difference in *rates* of self-reported STI testing among gay men in Sydney versus Melbourne.

59 Unpublished data from *Private Lives* kindly provided by Professor Marian Pitts.

60 Hull, P., et al. (2006) p. 36, op cit. See also Grierson, J., et al. (2006), op cit.

61 These figures need to be interpreted against the backdrop of changes between 1998 and 2005 in clinical guidelines for commencing HIV treatments. People newly diagnosed with HIV are now much less likely to start treatments early in the course of their infection.

62 Richters, Juliet (Ed.) (2006) p. 36 op cit.

63 Presentation by Kippax, S and Zablotska, I “Changes in behaviour of gay men in the context of increases in HIV” given at the *Responding Strategically to HIV Rises on the Eastern Seaboard* summit March 2006.

64 Nonetheless, the most recent Melbourne Gay Periodic Survey shows an increase in the proportion of gay men who knew that PEP was available, from 49 per cent in 2004 to 52 per cent in 2006 (p.36).

65 McInnes, D., Bollen, J. and Race, K. (2002) *Sexual Learning and Adventurous Sex*. Sydney: University of Western Sydney.

66 Kippax offers a list of practices that fall under the umbrella of “adventurous sex”. See Kippax, S., Campbell, D., Van de Ven, P. et al. (1998) “Cultures of sexual adventurism as markers of HIV seroconversion: A case control study in a cohort of Sydney gay men”. *AIDS Care* 18, 942–945.

67 Hurley, M. and Prestage, G. (2007) “Intensive sex partying: Contextual aspects of ‘sexual dysfunction’”. *Journal of HIV Therapy* 12:2, in press.

absence of regular testing of increasing the pool of newly HIV positive men unaware of their HIV status.

3.3.6 Drug use

The 2006 Melbourne Gay Periodic Survey showed frequent use of illicit drugs among gay men; 40 per cent of the respondents had used marijuana and about a third had used amyl nitrate or ecstasy in the six months prior to the survey. The survey also showed increases in illicit drug use. Over the last six years there has been significant increases in the use of crystal methamphetamine, ecstasy, cocaine and erectile dysfunction products or medications (such as Viagra™). For example, in 2000 6.3 per cent of respondents had used crystal methamphetamine; this figure had risen to 15.1 per cent by 2006. Although few men in the sample reported using Special K or GHB, the use of these drugs has more than doubled since 2000. Similar increases have been documented in the general community, with significant increases in the use of crystal methamphetamine, ecstasy, cocaine and GHB.

Similar patterns and rates of illicit drug use among gay men have been recorded in the other state and territory capitals. A number of major research projects have shown a strong association between illicit drug use and increased

rates of HIV transmission.⁶⁸ Recent studies have suggested that this association may be more pronounced for crystal methamphetamine use.⁶⁹ National data shows that crystal methamphetamine use is higher among HIV positive than HIV negative gay men (as is the use of a number of other illicit drugs) and may be a feature of sexual activity.⁷⁰ However, any simple causative relationship is complicated by data showing that although use of crystal methamphetamine continues to increase in Sydney, rates of HIV transmission are falling.

68 For examples see Ruf, M., Lovitt, C. and Imrie, J. (2006) "Recreational drug use and sexual risk practice among men who have sex with men in the United Kingdom". *Sexually Transmitted Infections* 82, 95–97 and Myers, T., Aguinaldo, J. P., et al. (2004) "How drug using men who have sex with men account for substance abuse during sexual behaviours: Questioning assumptions of HIV prevention and research". *Addiction Research and Theory* 12(3), 213–229. Both the *Journal of Substance Abuse* and *Journal of Urban Health* have published special issues looking at the relationship between substance abuse and increased rates of HIV transmission among gay men (*Journal of Substance Abuse* 13 (2001) and the *Journal of Urban Health* (January/February 2005)).

69 For two recent reviews of the research literature on the relationship between methamphetamine use among MSM and HIV transmission see Shoptaw, S. and Reback, C. J. (2007) "Methamphetamine use and infectious disease-related behaviors in men who have sex with men: Implications for interventions". *Addiction* 102 (Suppl.1), 130–135 and Colfax, G. and Guzman, R. (2006) "Club Drugs and HIV Infection: A Review". *Clinical Infectious Diseases* 42, 1463–9.

70 Hurley, M., and Prestage, G. (2007), op cit.

3.3.7 Gay community attachment

In the *Private Lives* survey (2007) more gay men in NSW than Victoria reported that "Most of their friends were gay and lesbian" (46 per cent and 40 per cent respectively).⁷¹ This data is consistent with the findings of the 2006 Melbourne Periodic Survey which show a small decrease in the number of respondents reporting that they spent "A lot" of time with gay men, from 45.1 per cent in 2000 to 41.7 per cent in 2006. Gay men in NSW also reported being more connected to the gay community than their Victorian counterparts (32 per cent and 26 per cent respectively)⁷².

According to *Private Lives* data, 66.8 per cent of gay men living in Sydney know at least one person who is HIV positive compared to 62.4 per cent of gay men living in Melbourne.⁷³

71 Unpublished data from *Private Lives* provided by Professor Marian Pitts.

72 This percentage figure was arrived at by adding the responses to "very attached" and "mostly attached".

73 Unpublished data from *Private Lives* provided by Professor Marian Pitts.

4 HIV/AIDS sector

4.1 Organisation

Australia's effective response to HIV and AIDS has been characterised by strong partnerships between government, gay and lesbian community organisations and the academic sector.⁷⁴ The shape and level of support for those partnerships has varied significantly over time and between different jurisdictions.

In NSW, the concentration of gay men and the visibility of gay culture in inner Sydney has facilitated the growth and development of a strong gay and lesbian community sector. This has meant that gay and lesbian community representatives have had a degree of political influence, particularly in health policy, not achieved in other states and territories. The NSW AIDS Council (ACON) has worked closely with NSW Health in the development and delivery of HIV/AIDS prevention, education and training, and of services to people living with HIV and AIDS (PLWHA) through area health services.

Historically, the number and concentration of gay men living in Victoria has been less than in NSW. As a consequence, the gay and lesbian community health sector in Victoria is smaller than in NSW with reduced infrastructure and capacity. Nonetheless, the Victorian AIDS Council (VAC) and later VAC in partnership with PLWHA Victoria have produced some of the country's most innovative and

effective HIV/AIDS education and prevention campaigns.⁷⁵ State government support and funding has been vital to the work and success of both organisations. Recent research suggests that the size of the gay community in Sydney and Melbourne is now approaching each other.⁷⁶

4.2 Capacity

In NSW the HIV/AIDS sector is diverse and comparatively well resourced. It provides a range of professional development and career opportunities and as a consequence, has generated and maintained a skilled and relatively large workforce. The sector has also attracted a disproportionate number of gay men, consolidating links and the flow of information between government and the gay and lesbian community.

The Victorian Government has recently provided additional funds to consolidate and enhance the capacity of the HIV/AIDS sector in Victoria and in particular, the partnerships between government, the gay and lesbian community, and academic organisations. This enhanced capacity will ensure that Victoria continues to respond effectively to the epidemic while being able to respond rapidly and appropriately to new and emerging issues. Ongoing investment will be required if the partnership is to achieve the long-term objective of sustained reduction in HIV and STI transmissions in Victoria.

74 Commonwealth Department of Health and Aged Care (2000) *National HIV/AIDS Strategy 1999–2000 to 2003–2004: Changes and Challenges*. Canberra: Commonwealth Department of Health and Aged Care, p.2.

75 Leonard, W. and Mitchell, A. (2000), op cit.

76 Garrett Prestage—see footnote 28.

5 A comprehensive gay men’s HIV and STI prevention strategy

5.1 Introduction

Epidemiological and behavioural data suggest that increased rates of HIV and STI transmission among gay men in Melbourne are the result of interactions among a number of factors including:

- Improvements in treatments and knowledge of their side effects
- Improvements in the health and wellbeing of HIV positive gay men
- Increased rates of UAI in casual and regular relationships;
- Increased prevalence of STIs; and
- The emergence and divergence of gay subcultures.

These have been compounded by generational shifts within the gay community and age-related variations in people’s experience and understanding of HIV and its effects.⁷⁷

At the same time, comparative analyses between Victoria and NSW of epidemiological and behavioural data, of gay community attachment and of the HIV/AIDS sector, point to differences at the local or state level which may have an impact on rates and patterns of HIV and STI transmission among gay men.

These include:

- Larger numbers of HIV positive men living in Sydney
- Higher (and increasing) rates of condom use by gay men with casual partners in NSW
- Higher rates of HIV testing and disclosure of HIV status among gay men in NSW
- Stronger gay community attachment among gay men in NSW
- Greater HIV/AIDS sector capacity within NSW; and
- Higher levels of funding and support for the HIV/AIDS sector in NSW.

5.2 Framework

This evidence base has been used to develop a framework for reducing rates of HIV and STI transmission among gay men in Victoria (**Figure 1**). The framework is divided into three discrete but interrelated levels. Although interventions can focus on any one level, the overall aims of promoting gay men’s health and wellbeing and achieving a long-term reduction in rates of HIV and STIs depend on a coordinated effort across all three.

5.2.1 Gay men’s HIV and STI prevention

Level one focuses on interventions within the gay community and the HIV/AIDS sector. It includes short to longer-term initiatives aimed at:

- Reducing rates of UAIC among gay men;

- Promoting increased condom use in UAIC and increased rates of HIV testing;
- Increasing the capacity of the HIV/AIDS sector to deliver programs and services that meet these goals; and
- Providing an evidence base for the ongoing development of effective gay men’s sexual health, programs and services through funded research and evaluation.

Overarching principles to achieving the above desired outcomes include:

- Build more connected and informed gay community networks;
- Provide gay men with the information, skills and resources necessary to protect their own health, and the health of their partners;
- Enhance networks and build capacity of health services, including drug and alcohol and mental health services;
- Work with other areas of government and the general community to ensure that they are aware of issues relating to gay men’s health and wellbeing;
- Enhance the role of, and support the involvement of, commercial gay venues; and
- Promote a culture of testing.

Table 1 lists these initiatives in detail.

⁷⁷ See Allan, B. and Leonard, W. (2005) “Asserting a positive role: HIV-Positive people in prevention”. In Egan, John P. (ed.) HIV/AIDS Education for Adults. *New Directions for Adult and Continuing Education* 105, 55–64.

5.2.2 Gay men’s health and wellbeing promotion

Level two advocates for the development of a coordinated and comprehensive response to gay men’s health and wellbeing that accommodates gay men’s sexual health and HIV and STI prevention. An approach to HIV and STI prevention that focuses solely on gay men’s sexual practices ignores the reality that these practices only gain meaning and importance as part of gay men’s lives as a whole.

Level two also includes potential areas for action aimed at promoting HIV positive gay men’s health and wellbeing. They centre on the development of an integrated model of HIV care and support.⁷⁸ This model not only promises to improve HIV positive gay men’s health and wellbeing but also to increase their willingness and ability to participate in gay men’s HIV and STI prevention and health promotion.⁷⁹

Section 6.2 lists these potential areas for action in more detail.

5.2.3 Human rights and sexual diversity

Level three locates gay men’s health and wellbeing promotion in the broader context of the government’s social justice and human rights agenda, and whole-of-government policy and programs that support sexual diversity.

These include:

- Ongoing same sex legislative and social reform;
- The inclusion of anti-homophobia initiatives in whole-of-government anti-discrimination and social justice policies and programs; and
- The promotion of sexual diversity as part of the implementation of the government’s charter of human rights.

⁷⁸ RPR Consulting (June 2007), op cit.

⁷⁹ As research shows, the success of gay men’s HIV and STI prevention and health promotion depends on the active participation of HIV positive gay men. Allan, B. and Leonard, W. (2005), op cit.

6 Recommendations

6.1 HIV and STI prevention programs and services

Table 1 lists initiatives that directly address rising rates of HIV and STI among gay men in Victoria. They are divided into three interrelated action areas and aim to provide increased HIV/AIDS sector capacity, and promote an ethics of shared sexual responsibility among gay men.

ACTION AREA		
Gay community	HIV/AIDS sector	Research
1. OUTCOME: Reducing rates of UAIC		
<p>1.1.1 Broad-based campaigns</p> <ul style="list-style-type: none"> • High impact campaign focussing on increases in transmission • Positive and negative advertisements focussing on strategies following a risk event, subsequent testing and dealing with a diagnosis • Banner advertisements on HIV and STI issues <p>1.1.2 Targeted campaigns</p> <ul style="list-style-type: none"> • Sexual subcultures • Party and dance scene • Sex on premises venues • Other settings or groups identified in the mapping of the gay community—see 3.2.1 <p>1.1.3 UAIC prevention & condom promotion strategies</p> <p>Multifaceted UAIC and condom promotion campaign and strategy</p>	<p>1.2.1 Consolidate links between the HIV/AIDS and sexual health sector and the drug and alcohol and mental health sectors</p> <p>1.2.2 Resource development and training for health care workers on behaviours which place gay men at increased risk of HIV and STI transmission</p>	<p>1.3.1 Evaluation of campaigns & strategies</p>

Gay community	HIV/AIDS sector	Research
2. OUTCOME: Promoting a culture of HIV & STI testing		
<p>2.1.1 HIV & STI testing campaign</p> <ul style="list-style-type: none"> • Health promotion campaign which addresses barriers to, and encourages, testing 	<p>2.2.1 Pre and post test HIV support</p> <ul style="list-style-type: none"> • Increase capacity of community agencies including on line HIV, Hep C and sexual health telephone support and referral, and support and counselling for men testing positive • Increase capacity of high case load clinics to provide pre and post test counselling <p>2.2.2 Increase access to HIV and STI testing</p> <ul style="list-style-type: none"> • Clinical reference group to advise Public Health, DHS and the Taskforce on issues around HIV & STI testing • Options paper on ways of encouraging GPs to increase HIV & STI testing where appropriate • Increase capacity of high case load clinics to provide HIV/STI testing • Increased community-based testing 	<p>2.3.1 Evaluation of campaigns</p> <p>2.3.2 Collection and analysis of phone line data</p>

Gay community	HIV/AIDS sector	Research
3. OUTCOME: Increasing system capacity		
<p>3.1.1 Review peer education & outreach initiatives</p> <ul style="list-style-type: none"> • Build partnerships to enhance peer education, outreach and community engagement capacity of sector agencies <p>3.1.2 Workforce development</p> <ul style="list-style-type: none"> • Increase the sector’s health promotion capacity <p>3.1.3 Community awareness campaign to increase knowledge of, and access to, PEP as an HIV prevention strategy</p>	<p>3.2.1 Review partnerships</p> <ul style="list-style-type: none"> • Ensure DHS capacity to implement, support and monitor gay men’s HIV/STI prevention strategy • Stakeholder forums <p>3.2.2 DHS to work with and support partner agencies to promote PEP:</p> <ul style="list-style-type: none"> • PEP providers • Gay men’s organisations • PLWHA organisations <p>3.2.3 Workforce development</p> <ul style="list-style-type: none"> • Increase the sector’s health promotion capacity • Increase involvement of HIV positive people in prevention 	<p>3.3.1 Mapping gay community study</p> <ul style="list-style-type: none"> • Completion of stage 1 of study • Recruitment of Victorian cohort <p>3.3.2 Ongoing data analysis</p> <ul style="list-style-type: none"> • Evaluation of data from the implementation of the gay men’s HIV/STI prevention strategy • Evaluation of relevant periodic and other data sources • Victorian NPEP Service Data Report

6.2 Gay men's health and wellbeing promotion

This section provides a list of potential areas for action that would result in a more coordinated and comprehensive response to gay men's health and wellbeing that accommodates gay men's sexual health and HIV and STI prevention, and also addresses issues for HIV positive gay men.

Achieving the desired outcomes will rely on developing links between existing departmental structures and processes and in particular, on using the expertise of GLBTI-related ministerial advisory bodies such as the recently formed Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (MACGLBTIHW) and the proposed Ministerial Advisory Committee on Blood Borne Viruses, Sexual and Reproductive Health (MACBVSRH).

Potential areas of action:

1. Inclusion of sexual orientation and gender identity in generic DHS policies and data collection
2. Development of gay men's health promotion policies and resources
3. Increase cross divisional gay men's HIV and STI health promotion activities
4. Development of gay men's mental health and drug and alcohol health promotion policies, programs and resources
5. Development of an integrated model of HIV care and support

6. Consolidate and extend links between DHS and the research/academic and HIV/AIDS sectors
7. Work with relevant bodies to develop a set of core competencies for health educators

6.3 Whole-of-government policy and programs

Potential areas of action under this section locate gay men's health and wellbeing promotion in the broader context of the government's social justice and human rights agenda and whole-of-government policy and programs that support sexual diversity. It is envisaged that advice on how best to achieve these outcomes will be provided by the GLBTI-related ministerial advisory bodies, including the Attorney General's (AG's) Committee on GLBTI Issues, the MACGLBTIHW and the MACBVSRH.

Potential areas of action:

1. Promotion of sexual and gender identity diversity in the ongoing development and implementation of social justice policy and the Charter of Human Rights
2. Same sex legislative reform
3. Reducing homophobia and promoting sexual and gender identity health and wellbeing
4. School-based sexuality and gender identity policy and programs

Appendix A—Glossary

ACON	AIDS Council of New South Wales
AIDS	Acquired Immune Deficiency Syndrome
ARCSHS	Australian Research Centre in Sex, Health and Society
ASHM	Australasian Society for HIV Medicine
DHS	Department of Human Services (Victoria)
GLHV	Gay and Lesbian Health Victoria
GPDV	General Practice Divisions Victoria
HIV	Human Immunodeficiency Virus
MACBVSRH	Ministerial Advisory Committee on Blood-borne Viruses, Sexual and Reproductive Health (previously the Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections)
MACGLBTIHW	Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (previously know as the Ministerial Advisory Committee on Gay and Lesbian Health)
MSHC	Melbourne Sexual Health Centre
MSM	Men who have sex with men
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCHSR	National Centre in HIV Social Research
PEP	Post exposure prophylaxis
PLWHA	People Living with HIV and AIDS
RACGP	Royal Australian College of General Practitioners
STI	Sexually transmissible infection
UAI	Unprotected anal intercourse
VAC	Victorian AIDS Council
VINES	Victorian Networks Study

Appendix B—Membership of the Project Advisory Group, Victorian Gay Men’s HIV/STI Action Plan

Name	Organisation
Mr Colin Batrouney	VAC/GMHC
Mr Mark Camilleri	Action Centre for Young People, Family Planning Victoria
Mr Philip Clift (Chair)	BBV/STI Program, DHS
Dr Danny Csutoros	BBV/STI Program, DHS
Dr Jeffrey Grierson	ARCSHS, La Trobe University
Ms Rebecca Guy	Centre for Epidemiology and Population Health Research, Burnet Institute
Mr Mike Kennedy	VAC/GMHC
Mr William Leonard	Social Policy Branch, DHS
A/Prof Bernie Marshall	School of Health and Social Development, Deakin University
Mr Roger Nixon	BBV/STI Program, DHS
Mr Brian Price	Infectious Diseases Unit, The Alfred Hospital
Dr Tim Read	Melbourne Sexual Health Centre
Mr Jim Sotiropoulos	BBV/STI Program, DHS
Mr David Voon	Association for Prevention of Harm Reduction Programs (ANEX)
Mr David Wain	PLWHA, Victoria
Mr Sonny Williams	PLWHA Victoria

Appendix C—Departmental HIV Prevention Taskforce membership

Name	Position/Organisation
Dr Jim Hyde	Director, Public Health (Chair)
Dr Rosemary Lester	Assistant Director, Communicable Disease Control Unit, DHS
Prof Andrew Grulich	National Centre in HIV Epidemiology and Clinical Research
Mr Todd Harper	CEO, VicHealth
Dr Margaret Hellard	Burnet Institute
Mr Tony Keenan	CEO, Hanover Welfare Services
Mr Mike Kennedy	Executive Director, Victorian AIDS Council/Gay Men’s Health Centre
A/Prof Anne Mitchell	Director, Gay and Lesbian Health Victoria
Ms Lyn Morgain	CEO, ALSO
Prof Marian Pitts	Director, ARCSHS, La Trobe University
Mr John Ryan	CEO, Anex
Mr Sonny Williams	Executive Officer, PLWHA Victoria
Darryl Kosch	Secretariat—Blood Borne Viruses/Sexual Transmission Infections Program, DHS

