

Responding to the challenges of HIV prevention in NSW

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Human immunodeficiency virus (HIV), the virus that causes acquired immune deficiency syndrome (AIDS), represents one of the greatest public health challenges of our time. Despite a global shift towards generalised epidemics, a rapid and sustained response has been effective in containing the New South Wales (NSW) epidemic to low levels of infection largely within identifiable at-risk populations.¹ Some of the reasons for this success are thought to include: effective partnerships between government, community, researchers and clinicians responding to HIV; use of an evidence-based policy platform; integration of behavioural, clinical and epidemiological data to better understand HIV trends and to develop responses; sustained investment in HIV prevention programs; and maintenance of a skilled workforce.¹

Trends in HIV surveillance in NSW

The first Australian case of AIDS was diagnosed in NSW in 1982.² At the end of 2007, there were 14 803 new HIV notifications in NSW residents, with 404 in 2007 alone. Males account for at least 92% of notifications, with the highest proportion in the age group 30–39 years. The greatest risk factor for transmission in NSW continues to be sexual contact between men who have sex with men (MSM).³

Since 2000, the World Health Organization (WHO) and the United Nations Joint Programme on HIV/AIDS (UNAIDS) have promoted the use of second generation HIV surveillance.⁴ This strategy focuses on examining biological and behavioural data (including evaluation data from prevention, treatment and care programs) concurrently to explain observed disease trends. This form of expanded surveillance is intended to provide better information for action and to guide timely and evolving HIV prevention responses.

Recent trends in the rates of newly diagnosed HIV have differed between Australian jurisdictions. From 2002 to 2006, NSW observed a stable rate of approximately

6.1/100 000 population (5.9/100 000 in 2006), whereas Queensland, South Australia, Victoria and Western Australia all observed increasing rates, from 3.5, 2.0, 4.5 and 2.4/100 000 in 2002 to 4.0, 4.1, 5.6 and 3.5/100 000 population, respectively, in 2006.⁵ A NSW HIV Think Tank, held in mid 2007, brought experts in HIV epidemiology, clinical and behavioural research together with leaders from the HIV community response, clinicians and NSW Health agencies to investigate the reasons for the differences in these state trends.¹ The Think Tank used a second generation surveillance approach to compare trends in Queensland and Victoria with NSW. These jurisdictions showed the most marked differences and had the most comprehensive behavioural and clinical data available for comparison.

A stabilisation and subsequent decline in reported rates of unprotected anal intercourse with casual partners among MSM (including HIV-positive men) from 2001 to 2006, was identified as the single most important, but not the only, explanation for the observed NSW trend.¹ This trend was not observed in Queensland or Victoria. Other trends in sexual practice, disclosure of HIV status and frequency of HIV and sexually transmissible infection (STI) testing among MSM may have also contributed to differences in HIV notifications in eastern Australian states.

The HIV response in NSW

The partnership approach to HIV in NSW has ensured collaboration between government, affected communities, researchers and clinicians. The NSW HIV/AIDS Strategy 2006–2009 provides the government framework for HIV health promotion; treatment and care; and infrastructure and support in NSW.⁶ It identifies the current priority populations as gay and other homosexually active men; people living with HIV/AIDS; people from culturally and linguistically diverse backgrounds; Aboriginal people; people who inject drugs; and sex workers.

Area health services and community-based organisations within NSW work collaboratively to provide a comprehensive range of HIV prevention and care services. Area health services have HIV/AIDS and Related Program Units, which provide HIV and sexual health promotion; Aboriginal sexual health worker positions; and harm reduction strategies, such as needle and syringe exchange programs. Community-based organisations, including the AIDS Council of NSW, are also funded by government to provide HIV prevention, education and health promotion, treatment, care and support, policy, advocacy and community mobilisation.

An example of collaborative practice in NSW is the STIs in Gay Men Action Group (STIGMA), which brings together general practitioners, researchers, area surveillance, health promotion officers and community organisations to plan and implement prevention, testing and treatment programs. Among other initiatives, STIGMA has developed well-accepted STI testing guidelines for general practitioners, social marketing programs to remind MSM about STI testing, and innovative online mechanisms to encourage contact tracing by those who have been diagnosed with an STI.

Many of the findings related to the NSW HIV Think Tank have now been published in a special edition of *Sexual Health* titled 'HIV in Australia'.⁷

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