Building on success 1

a review of gay and other homosexually active men's HIV/AIDS education in Australia

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Executive summary

The HIV epidemic in Australia has had its greatest impact on gay men. Of those who have died from AIDS more than 89 per cent were gay or other homosexually active men. Of those who have been diagnosed with AIDS more than 88 per cent are gay or other homosexually active men. Of those who have tested positive to the virus (where exposure category is known), more than 80 per cent are gay or other homosexually active men.[1]

Although there has been a dramatic decline in the incidence of HIV infection from the peak rate in 1984 to a comparatively low rate of infection over the last decade it remains of concern that new HIV infections continue to occur in Australia. Each year since 1993 approximately 600 new diagnoses of HIV infection amongst gay and other homosexually active men have been reported.[2] There have also been approximately 200 diagnoses of newly acquired HIV infection.[3]

Altogether, since the first case of HIV was diagnosed in 1983, there have been 16,030 diagnoses (following adjustment for multiple reporting) of HIV infection in Australia to 31 December 1997. There have been 5,540 deaths following AIDS.[4] It is estimated that are currently more than 10,000 people living with HIV in Australia.[5]

Maintain the effort

Overall the Review of gay and other homosexually active men's education found that Australia has been remarkably successful in containing the spread of the epidemic. In comparison with a range of other countries Australia has achieved (and maintained for a decade) a remarkably low HIV/AIDS incidence rate per head of population.

There has been significant adoption of safe sex practice amongst gay men, and there have been significant increases in the knowledge of the means of transmission of HIV and of preventing its spread.

It is possible to conclude that education has been a significant and effective component of the overall response to the epidemic. However education has been only one of the strategies used to control the epidemic and it remains difficult to identify information that would allow the measurement of the contribution of education alone to the control of the epidemic. Attention needs to be given to improve not only the quality and effectiveness of health promotion programs, but also understanding of what works.

Despite this success to date there is a need to ensure ongoing effort to further reduce the incidence of HIV. In a changing environment, and as the sense of crisis wanes for many, there will be a need to ensure that safe sex and safe injecting behaviours are maintained. New combination treatments, too, will have an impact on the health and well being of gay men living with HIV. This means that education programs (in particular) and other health promotion strategies will need to adjust to the implications of HIV/AIDS becoming a chronic, manageable disease.

Available evidence indicates an increase in unprotected anal intercourse in casual encounters. While there has yet to be a corresponding increase in HIV infections this increase in unprotected anal intercourse remains a source of concern and highlights the need to ensure ongoing efforts to sustain (and improve on) what has been achieved to date.

Build evidence of effectiveness

To improve the quality and effectiveness of education interventions greater attention needs to be given to developing evidence of what works in what circumstances, with which groups?

- **Need to describe inputs**

There is a need for much more detailed information about the inputs to the educational response. This includes descriptions of expected outcomes, target groups, methods used, and the resources used to develop and implement the program. It is impossible, for example, to measure cost effectiveness without first having the information on costs.

- **Need for process evaluation**

Even for the many educational programs that were identified by the Review very few had reported evaluation results of any kind. This means that it is impossible to comment on the whether programs were of sufficient quality that it would be reasonable to expect them to achieve their intended health promotion or intermediate outcomes.

The information about the programs included in the Review revealed the need for much more extensive process evaluation to enable assessment of program integrity, and of program delivery including modes of delivery, reach, and the response of the proposed audience.

- **Need for impact and outcome evaluation**

The Review found almost no documented examples of impact or outcome evaluation for individual programs or for campaigns. It is essential that a much more systematic approach is taken to evaluation at process, impact, and outcome levels, measuring, as appropriate, health promotion, intermediate, and health outcomes.

Improve the quality and effectiveness of health promotion programs

There needs to be an ongoing and systematic effort to improve the quality and effectiveness of programs.

Method

- Australia's success in HIV/AIDS education confirms the need to continue to actively involve gay men in all aspects of program planning and delivery. Efforts also need to continue to ensure the inclusion of gay men living with HIV in education initiatives.

- The mix of methods needs to be sustained. However better evaluation needs to occur to ensure ongoing adjustment of the mix of methods, to ensure that effective interventions are well documented, and that current best practice is systematically introduced across the country. The use of theory to guide program development needs to be further encouraged, and an appropriate level of innovation should be included in the range of programs offered by the agencies responsible for program delivery.

- The comprehensive mix of educational methods used to date has contributed to the population-wide achievement of improved health literacy. While it will be important to preserve a comprehensive mix in the future, it will be necessary to develop more evidence on the effectiveness of different methods with different target groups, and in different contexts. It will also be important to develop more sustained, consistent programs that use a comprehensive set of health promotion strategies.

Target groups

- Gay men should continue to be the principal focus of the educational efforts. However further epidemiological research is needed to understand the risk posed to other homosexually active men (i.e. current levels of HIV infection).
- National initiatives for programs targeting non-gay identified homosexually active men need to be developed and systems established to improve communication and cohesiveness amongst various state-based programs.
- Aboriginal and Torres Strait Islander gay men should also remain a priority and newly established programs targeting these groups need to be sustained and systematically evaluated.
- Prioritisation of target groups or health issues needs to occur using transparent criteria.
- Greater attention needs to be given to the accessibility of programs for people from culturally and linguistically diverse backgrounds. There is a need for research to assist in ensuring that health promotion programs (including education) are developed with a view to ensuring equity – not only equity of access to educational activities, and but also to the achievement of equitable outcomes.
- Young people in general, and young gay men in particular, constitute target groups that will require particular attention in view of their developing sexual identities and the likelihood of sexual experimentation during adolescence and young adulthood.

Content

- Multiple messages are appropriate given the changing environment and different ways that gay and other homosexually active men are responding to the epidemic. However programs to encourage people who are newly sexually active to adopt and maintain safe sex behaviours need to be maintained.
- These programs should be embedded in wider programs that encourage the development of healthy sexuality more generally.
- The combination of well-executed, timely research and the active involvement of gay men in the development and delivery of education has been very effective in ensuring that the content of the education has been relevant and up-to-date, particularly in the large, urban centres.

Agencies

- The roles and responsibilities of the different agencies involved in HIV/AIDS health education for gay and other homosexually active men will require continuous scrutiny and refinement by all members of the ‘partnership’.
- Partnerships are a key component of the infrastructure needed to develop effective programs, to ensure efficient use of resources, and to enhance the likelihood of achieving positive outcomes. The range of agencies among whom partnerships will be needed is likely to expand as the focus of education expands, more complex issues that are arising are addressed, and in order to include the wider range of strategies that will also be needed to prevent the spread of HIV and to ameliorate its effects.
- The national and State/Territory systems that have been developed to engage key agencies in developing programs that are effectively responding to the changing environment need to be sustained and further developed.

Ensure continuing national leadership and direction

The leadership and direction for HIV/AIDS education for gay men and other sexually active men that have been provided by the National HIV/AIDS Strategies needs to be preserved in the new environment created by the Public Health Outcome Funding Agreements. There will be a need to ensure that:

- the Public Health Funding Outcome Agreements reflect the central importance of health promotion (including education), particularly for gay and other homosexually active men, to the HIV/AIDS outcomes.
- the coordinated national approach to HIV/AIDS health promotion is preserved under the bilateral Public Health Outcome Funding Agreements.
- the further development of performance indicators that are valid, reliable and relevant measures of the outcome of the health promotion programs for gay and other homosexually active men. This will require the active engagement of community-based organisations as well as the State/ Territory and Commonwealth health authorities. *(See Appendix 5 for examples of the types of performance indicators that could be developed)*
- a strong body of evidence of effectiveness upon which to base arguments for resources.
- opportunities for working more flexibly with a wider range of partners within and beyond the health sector to promote the sexual health of gay and other homosexually active men will need to be identified.

Strengthen the infrastructure

The Review confirmed the findings of the evaluation of the second National HIV/AIDS Strategy that the development of an effective infrastructure to design, deliver and evaluate the range of interventions required to control and combat the HIV/AIDS epidemic has been a major contribution to the success of Australia's initiatives. Research and evaluation, workforce development, and program delivery structures were three areas where particular effort is needed.

In the area of research and evaluation there is a need to:

- Improve communication between researchers and practitioners
- Collaborate on research policies, practices and innovation
- Collaborate to conduct research projects
- Extend research priorities to include solution generation and maintenance
- Further develop the systems established to disseminate and ensure use of research findings
- Change organisational cultures to support evaluation
- Ensure adequate financial resources for research and evaluation
- Define roles and responsibilities for evaluation
- Develop the knowledge and skills of educators

In order to develop the professional skills of the workforce some of the activities that need to occur are:

- Accreditation of educator experience
- Promoting access to existing university courses in relevant disciplines
- Development of systematic national training on priority content specific issues
- Expansion of the national Gay Educators Conferences to ensure incorporation of additional training opportunities
- Systematic and formalised learning opportunities within the workplace (including an increased focus on critical reflection)

To strengthen cohesive national and State/Territory approaches to program development and delivery:

- A national approach to program delivery is needed to ensure that the most effective health promotion programs are delivered consistently and systematically, over time, across the whole of the gay and other homosexually active men's populations (which also take account of local differences).
- The roles and responsibilities of State/Territory health authorities and community based organisations need to be clarified to ensure that there is coordination of goals, resources and program implementation.
- The partnership between government and community based organisations at national level will require particular fostering under the Public Health Outcome Funding Agreements.

Chapter 1

Introduction

1.1 Background

The third National HIV/AIDS Strategy announced that a national Gay Men's Education Strategy would be developed following a national assessment of the effectiveness of education programs for gay men.[6]

The Commonwealth Department of Health and Family Services established an Advisory Committee late in 1997 to develop the terms of reference for such a review and to advise consultants on the Review process. In November 1997 the National Centre for Health Promotion at the University of Sydney was contracted to conduct the review and develop a national strategy.

1.2 Terms of reference

The terms of reference for the review were to:

- identify the scope, efficiency and effectiveness of current health promotion activities by partners in the Third National HIV/AIDS Strategy in targeting gay and other homosexually active men in relation to HIV/AIDS and related diseases, and awareness of related risk factors and risk behaviours; and
- report to the Commonwealth Minister for Health and Family Services, and advise partners in the Third National HIV/AIDS Strategy, including the Australian National Council on AIDS and Related Diseases, on an effective and workable strategic framework to develop and implement targeted education and awareness programs and activities for gay and other homosexually active men during the period of the Third National HIV/AIDS Strategy, and capable of being applied beyond that period.

The terms of reference also included a further series of specific issues that were to be addressed in the review (see Appendix 1).

1.3 Scope

The terms of reference required that this review cover the period since the onset of the HIV epidemic in Australia. However during that period there have been two previous comprehensive reviews of the implementation and effectiveness of the first and second national strategies.[7] [8] Rather than repeat previous work this review builds on these reviews giving greatest emphasis to the period since the completion of the evaluation of the second National HIV/AIDS Strategy in 1995.[9]

The population groups that are the focus of the Review are:

- gay–identified men, including those who are HIV positive, HIV negative, and those who are living with AIDS;
- non–gay identified homosexually active men, including those who are HIV positive, HIV negative, and those who are living with AIDS.

This Review has attempted not to repeat the reviews and strategies recently undertaken in relation to specific population groups. The Aboriginal and Torres Strait Islander project,[10] the Positive Information and Education Strategic Plan,[11] the report on HIV/AIDS Education Programs for Homosexually active men,[12] and the HIV/AIDS Education Strategy for People from Diverse Cultural and Linguistic Backgrounds[13] have been used to assist in formulating the recommended strategy options arising from this Review.

1.4 Methodology

The Review was carried out between November 1997 and April 1998. The report has been developed using information and advice from a variety of sources.

1. Literature review

a) Critical examination of published and accessible unpublished literature (international and Australian) on gay men's HIV/AIDS education to:

- identify factors affecting the effectiveness of education as a strategy;
- identify current 'best practice' in the field;
- identify gaps in the literature in relation to current practice.

Unpublished literature was sought at key stakeholder interviews and consultation meetings.

b) Critical examination of the literature on effectiveness and best practice in health promotion in general, and health education in particular, to identify key factors influencing success or failure.

2. Key stakeholder interviews

Interviews were conducted with Commonwealth, State, Territory governments and community based organisations, with educators, researchers, managers, policy officers, health care practitioners, and community organisation office bearers.

3. Dissemination of a Discussion Paper

A Discussion Paper was published midway through the Review to canvass issues and ideas, and to allow a wide range of individuals and organisations to contribute to the Review. Approximately 470 copies of the Discussion Paper were distributed to agencies and individuals.

4. Stakeholder consultation

A consultation meeting was held in the capital city of each State and Territory to which stakeholders from health authorities, AIDS Councils and other key organisations were invited. The Discussion Paper was used as a prompt for the exchange of ideas and views at these meetings. See Appendix 2 for a list of attendees.

5. Public consultation

A public consultation meeting was held in the capital city of each State and Territory. Meetings were publicised through advertisements in local gay newspapers and newsletters and through the distribution of fliers by community-based organisations. Invitations were also sent to community groups and individuals. Again the Discussion Paper was used as a prompt for these meetings. See Appendix 2 for a list of attendees.

6. Written submissions

Written submissions were invited throughout the consultation process, and encouraged from those unable to attend the scheduled consultation meetings. See Appendix 3 for a list of written submissions received.

The consultation process took account of the inability or unavailability of all stakeholders and community members to attend consultation meetings held in each capital city, particularly for people located in rural and geographically remote areas. Input was encouraged through broad distribution of the Discussion Paper, encouragement of written submissions, and individual meetings with the reviewers.

Chapter 2

The current context

2.1 Brief history of the epidemic and response

AIDS first began appearing amongst gay men in San Fransciso and New York in 1980-81. Soon after the first published reports of AIDS occurred in the USA medical press in June 1981. AIDS related stories soon began appearing in both the gay and mainstream press in Australia. The first cases of acquired immune deficiency syndrome (AIDS) in Australia were reported in 1982-83. The virus that causes AIDS was identified in 1983 and was officially named the human immunodeficiency virus (HIV), in 1984. Testing for antibodies to the virus became available in 1985.

As it became clear to gay men in Australia that a serious threat to their health (and to their civil liberties) was beginning to emerge they began to organise a response. From 1983 gay men formed action committees to respond to the emerging epidemic. These committees later became the State-based AIDS Councils. The committees were significant because before this time gay men had been marginalised and stigmatised. There was a long history of suspicion of government and government agencies. In 1985 the Australian Federation of AIDS Organisations (AFAO) was established as an umbrella body representing community organisations at national level. The representation of the gay community at a national level was established.

In 1984 the Commonwealth Government established the National AIDS Task Force, a medical advisory body, and the National Advisory Committee on AIDS, an educational advisory body, which included representatives from the gay community. Funds were allocated for AIDS-specific services and by 1985 funding was being provided to the State/ Territory AIDS Councils to support their education and health care programs.

The National Health Strategy on AIDS Control was endorsed by the Commonwealth Government in 1985. It provided national leadership and a framework for action. Significantly, it pointed out that, in the absence of any cure for AIDS, and with only limited treatment options available, the most appropriate approach to controlling the virus would be one focussing on the whole population a public health approach. Furthermore, the strategies most likely to succeed were from the fields of disease prevention and health promotion.

In 1986 a drug known as AZT was identified as being an effective treatment for some people with AIDS. It was the first sign that science might be able to develop effective treatments to slow the progression of HIV.

1987 saw the development of a National Preventive Education Strategy for gay and bisexual men.[14] It was developed through a national workshop sponsored by the Gay and Bisexual Men's Working Group of the National Australian Committee on AIDS and organised by the Australian Federation of AIDS Organisations for researchers and educators. The Strategy recognised the need to significantly expand and upgrade the preventive education directed to gay and bisexual men. Its goal was to prevent the transmission of HIV by men who have sex with men.

The bi-partisan response by Australian government was consolidated with the release of the first National HIV/AIDS Strategy in 1989. For the first time AIDS organisations were guaranteed funding over a four year period. The first National HIV/AIDS Strategy recognised that HIV may impinge on the lives of all Australians and the Strategy therefore aimed to:[15]

- eliminate transmission of the virus; and
- to minimise the personal and social impact of HIV infection.

Four Programs were established to guide the development of structures, interventions, and the investment of resources to address the epidemic. The four program areas were:

- Education and Prevention
- Treatment and Care
- Research
- International Assistance and Co-operation

The Strategy also recognised that the effectiveness of Australia's response to HIV/AIDS depended upon co-operation among a wide range of sectors of Australian society: across the three levels of government, between government and non-government sectors; between union and employers; and between all these parties and those infected with the virus.

In the absence of medical or pharmacological treatments to prevent the spread of HIV, or to treat or arrest the affects of AIDS, the education and prevention program was a cornerstone of the effort to limit the spread and impact of HIV/AIDS.[16] Homosexual and bisexual men were identified as key priority target groups.

Since the first National HIV/AIDS Strategy two more strategies have been developed. The second National HIV/AIDS Strategy was for the period 1993-96, and the third National HIV/AIDS Strategy is for the period 1996-99. The second National HIV/AIDS Strategy was evaluated in 1995.[17]

2.2 The third National HIV/AIDS Strategy

The third National HIV/AIDS Strategy is for the period 1996-97 to 1998-99 and is framed in the context of sexual health and related communicable diseases.

It has the same aims as the first and second Strategies but nominates five priority areas to guide implementation:[18]

- education and prevention
- treatment and care

- research
- international assistance and cooperation
- legal and ethical matters

The Strategy also acknowledges three elements that have been vital in the success of Australia's response to HIV/AIDS:

HIV/AIDS is both a health and a social issue

- HIV/AIDS has been regarded as primarily a public health and medical problem and has been responded to using both these approaches, but its social impact has always been accorded high priority in public policy;

Partnerships are essential for an effective response

- The principal partnership has been between governments, community-based organisations, affected communities, health professionals and researchers. But other partnerships have also been crucial to our national effort and success. These have been partnerships between governments at all levels; between governments and various community organisations; between medical and non-medical groups; between a multiplicity of voluntary and community-based organisations; and between educational authorities and the media and so on;

National non-partisan political consensus has provided a strong platform for action

- Non-partisan political support has been given to HIV/AIDS efforts and consensus had underpinned the development of appropriate public policies. This has allowed those policies to provide national leadership and to be innovative.

The Strategy, on the basis of epidemiological evidence continues to identify homosexually active men as a priority for education and prevention programs. It also gives priority to Aboriginal and Torres Strait Islander people, people who inject drugs, sex workers, prisoners.

2.2.1 Sexual health and related communicable diseases

The third National HIV/AIDS Strategy is also framed in the context of sexual health and communicable diseases. This is because it has become clear in recent years that the management and control of communicable diseases cannot be done in isolation. For example the Strategy notes that there has been much overlap between public health responses to HIV/AIDS and hepatitis C in relation to the relevance and success of Australia's needle and syringe exchange program.

It also notes that in the primary care setting, programs designed to limit the spread of sexually transmissible diseases have been developed alongside those targeted more specifically at HIV/AIDS, and that greater integration of a range of public health policies is not intended to detract from the focus that should be accorded to HIV/AIDS.

2.2.2 Roles and responsibilities

The third National HIV/AIDS Strategy is based on valuing and developing the partnership among government, community based organisations, affected communities, health professionals and researchers. Australia's success in combating HIV/AIDS has been largely attributed to the partnerships that have formed the basis of the response to the epidemic.[19] The roles and responsibilities of the various partners have been refined and developed over time. These roles have been summarised below.

- The third National HIV/AIDS Strategy states that the Commonwealth Government will need to continue to provide leadership and coordination for national education programs, for research and for monitoring and surveillance, as it has throughout the epidemic. Since 1991 there has been a shift by the Commonwealth Government away from direct service delivery for gay and other homosexually active men and towards a more strategic leadership role in education.[20] The Commonwealth works closely with a range of community and health care bodies and provides funding to national community and professional organisations. Research and development projects have also been commissioned from academic bodies and private organisations.
- State and Territory Governments are responsible for providing leadership at their level of jurisdiction. This includes establishing the policy framework. It also includes developing, delivering and evaluating a range of services, including education. State and Territory governments primarily fund community organisations to develop and deliver education programs for gay and other homosexually active men. However some health authorities do provide education programs directly to gay and other homosexually active men. Together with non-government organisations the States and Territories operate needle and syringe exchange programs.
- AIDS Councils are community based organisations that are responsible in most States and Territories for the majority of education programs for gay and other homosexually active men. However a range of other HIV/AIDS specific, gay and lesbian, and general health and youth organisations also receive some funding for HIV/AIDS education. AIDS Councils primarily focus on three areas of work education and prevention, care and support for people living with HIV, and advocacy and policy.
- The Australian Federation of AIDS Organisations (AFAO) is the peak organisation representing State and Territory AIDS councils, the National Association of People with HIV/AIDS, the Australian Intravenous League and the Scarlet Alliance. It plays a central role in representing those affected by HIV, coordinating the efforts of non-government organisations, contributing to the development of national policies, programs and strategies and development of a number of education initiatives. AFAO has, through the establishment of the Gay Education Strategies (GES) project in 1994, played an increased role in developing education resources and in enhancing the capacity of its member organisations to respond to the epidemic.

2.2.3 Public Health Partnership and Public Health Agreements

Government is the major provider of public health services in Australia. Historically, most core public health functions have been the responsibility of the eight States and Territories. However, the Federal government plays a significant role in the funding of a range of national public health strategies, supporting health research, regulating pharmaceutical and therapeutic goods, ensuring access to health services, and in quarantine and immigration screening. Local government plays a central role in food inspection, environmental health and a range of community services, while a range of non-government organisations plays a critical role in disease prevention, health promotion and related activities of education and research.

Efforts to achieve public health goals reflect the contribution of this range of participants in the health sector as well as others outside the health arena. This breadth of players and activities in Australia demands improved coordination and collaboration for public health across jurisdictional boundaries, and ultimately, across the government and non-government sectors.[21]

In October 1996, Australian Health Ministers from all jurisdictions agreed to the establishment of a National Public Health Partnership. Its broad objectives, formalised through the signing of a joint Memorandum of Understanding, are, to:[22]

- improve collaboration between stakeholders in the national public health effort;
- achieve better coordination and sustainability of public health strategies; and
- strengthen public health infrastructure and activity.

The overall goals of this cooperative approach are to improve the health status of all Australians, and in particular, the health status of those population groups considered at risk.

A National Public Health Partnership Group (the Partnership Group), comprising the Chief Health Officers and/or Directors of Public Health of each State and Territory, representatives of the National Health and Medical Research Council and the Australian Institute of Health and Welfare, is the implementation mechanism for the Partnership.

Under the auspice of the National Public Health Partnership, a new set of bilateral agreements (Public Health Outcome Funding Agreements) are being signed by the Commonwealth with each of the States and Territories. They will, from 1998, establish the outcomes (performance indicators) that must be achieved by each of the States and Territories in relation to HIV/AIDS (and the other national program areas that are to be included in the new Agreements). The new Agreements, therefore, point to a growing focus on the achievement of, in this case, public health outcomes in relation to HIV/AIDS. There is much less focus on the methods or processes through which the outcomes are to be achieved.

Each of the Agreements will include a set of performance indicators as outcomes to be achieved by the States and Territories in relation to HIV/AIDS. The National Public Health Partnership and the Australian National Council on AIDS Related Diseases (ANCARD) have been nominated as the agencies responsible for monitoring the performance of the States and Territories.

Under the Agreements funding will no longer be provided through Special Purpose Payments by the Commonwealth to the States/Territories. Instead, funding will be 'broadbanded' with States and Territories being free to allocate resources across the range of program areas that are being brought together under the Agreements. This means, in effect, that there will be no 'ring-fenced' funding for the HIV/AIDS Program in general, or for HIV/AIDS education in particular.

Although the Partnership and the Agreements are separate mechanisms, the National Public Health Partnership provides the multilateral policy framework for the development of broad banded bilateral Public Health Outcome Funding Agreements.

Through the Public Health Outcome Funding Agreements the Commonwealth and each of the States and Territories have agreed on:[23]

- the range of program funding * that is to be broad banded;
- outcomes or proxy outcome measures to be achieved by each of the States and Territories in the program areas that are subject to the new broad banded funding arrangements;
- replacement of input controls which inhibit flexibility to apply funds in any way appropriate to achieve objectives;
- key principles, values or processes to be upheld in the operation of the Agreements;
- measurement of performance in relation to outcomes; and,
- incentives and sanctions relating to performance.

The Public Health Outcome Funding Agreements do not replace the third National HIV/AIDS Strategy. The PHOFAs will continue to see the Commonwealth and State and Territory Governments commit to these existing national strategies and policies. However, as a consequence of the Agreements three issues of concern arise for the education program for gay and other homosexually active men.

1. the need to ensure that health promotion (including education) remains a central component of the nation's programs to combat HIV/AIDS;
2. the need for more and higher quality of evidence of the effectiveness of education programs and health promotion programs;
3. there is potential for the efficiencies and effectiveness offered by a national approach to gay and other homosexually active men's education to be undermined as States and Territories adopt different mechanisms to achieve their outcomes.

* The eight program areas that are to be 'broad banded' under the first Public Health Outcome Funding Agreements are the HIV/AIDS Matched Funding Program, the National Women's Health Program, the National Drug Strategy, Alternative Birthing Program, National Education Program on Female Genital Mutilation, BreastScreen Australia, National Cervical Screening Program, National Childhood Immunisation Program.

2.3 Links to other strategies and projects

Several other strategies and projects are being developed that overlap with the current review. This review process has undertaken not to cover the same terrain so as to avoid duplication of effort.

Positive Information and Education Project

The Positive Information and Education Project (PIE) was funded by the Commonwealth Department of Health and Family Services in 1996 to examine the information and education needs of people living with HIV/AIDS in Australia. The Project is jointly managed by the Australian Federation of AIDS Organisations and National Association of People with AIDS.

The project has engaged in national consultation to determine the priority education issues for people living with HIV/AIDS and has recently released a report on the findings of the consultation phase.[24] The consultation also reviewed existing education efforts and identified overall strengths and weaknesses in current approaches. The second phase of the PIE project is the development of a National Positive Information and Education strategy which is due for release in 1998.

The overlap between the PIE project and this review have been examined further in Chapter 6.

Aboriginal and Torres Strait Islander Gay and Transgendered Project

The Aboriginal and Torres Strait Islander Gay and Transgendered Project was funded by the Commonwealth Department of Health and Family Services in 1996. It has been undertaking an extensive national consultation to establish the needs of Aboriginal and Torres Strait Islander gay and transgendered people for education about the prevention of HIV/AIDS.

A report that includes recommendations for future actions will be released in 1998. A national strategy for Aboriginal and Torres Strait Islander Gay and Transgendered people will also be released in 1998. Following the release of the Aboriginal and Torres Strait Islander Strategy, its relationship to the Strategy for gay and other homosexually active men will need to be explored and opportunities for joint programs will need to be identified.

Education needs of people from diverse cultural and linguistic backgrounds

Since 1995 a series of initiatives have been undertaken to review and develop a more coordinated approach to HIV/AIDS information and services for people from diverse cultural and linguistic backgrounds. A report on the education needs of these groups has been prepared for the Commonwealth Department of Health and Family Services and is expected to be released early in 1998.[25] Again, upon release of this report, exploration of its relationship to the strategy being developed as part of this review will need to occur.

2.4 Education programs responding to a changing epidemic

Since the beginning of the epidemic, there have been significant changes in the knowledge about HIV/AIDS in the rates of transmission of HIV, and in the educational responses required.

The availability of new treatments, and the number of gay men living with AIDS, have also had an impact on the educational response.

Living in a world with HIV

In the early 1980s there was a general climate of uncertainty about HIV and its transmission. This uncertainty combined with an increasing number of deaths and illness and growing media hysteria about homosexuals and AIDS, led to a sense of crisis and fear among gay men.[26]

It was in these circumstances that the first education activities began. These efforts took place in the belief that a dramatic change in behaviour by gay men would be needed for only a short period. The seemingly rapid advances in understanding of both HIV and the immune system gave rise to a belief that a cure would be found quickly. The success of AZT in treating HIV infection in the late 1980s further promoted this belief. However by the early 1990s there was growing recognition that AZT was not as effective as first hoped. There were few treatments on the horizon that might lead to HIV infection becoming a chronic manageable illness

As it became evident that there was not going to be a miracle cure, gay men have slowly learned to live with HIV. The sense of crisis has largely disappeared. This does not mean that gay men are no longer concerned about HIV and its impact on their community, or have stopped viewing it as a serious health threat, or believe AIDS is over. However it does mean that HIV no longer engulfs most gay men's lives as it once did.[27]

The waning of the sense of crisis has resulted in an audience no longer as receptive or necessarily ready to heed health education.

Changing responses to HIV/AIDS and safe sex

Throughout the 1980s the 'condoms every time' message was the underlying message of health education programs. This was based on the assumption that it was impossible to be certain of the sero-status of sexual partners. Therefore it was safer to assume that everyone might be HIV positive and therefore, to use a condom. However by the 1990s the vast majority of gay men had been tested for HIV and knew their HIV antibody status. Research found that many gay men in regular relationships were ignoring the 'condoms every time' message.

In short, gay men's responses to HIV have changed. Gay men are no longer adopting a single strategy to deal with HIV and negotiating safe sex.[28] Instead, they have been adopting increasingly sophisticated safer sex practices, often termed 'negotiated safety'. The term 'negotiated safety' was coined in 1993 to describe the practice by gay men in regular relationships who had negotiated not to use condoms in their relationships. This was occurring when both had tested HIV negative, were aware of each other's status, and had negotiated a clear and unambiguous agreement about the nature of their sexual practice both within and outside of the relationship, such that any sexual practice outside their relationship was safe.[29]

However, subsequent research found that 'poor' negotiation of unprotected anal intercourse within regular relationships was a significant factor amongst those gay men who had recently sero-converted.[30] Many men who were attempting to negotiate safe sexual practice with their partners did not have the negotiation skills required and were possibly placing themselves or their partner at risk.

As a result safe sex was redefined to include not using condoms in particular contexts and education programs changed to assist men to develop the skills needed to minimise the risk posed to their health and that of others.[31]

Impact of new combination treatments

Advances in knowledge of effective treatments for people who have been infected with HIV have also influenced gay men's responses to the epidemic.

Combination anti-retrovirals are proving to be beneficial for many people living with HIV, and there has been a dramatic increase in their use.[32] HIV-positive people now need education programs that provide them with accessible, up-to-date information on combination treatments and that support them in complying with the stringent treatment regimes. The success of new treatments has led to increasing speculation that HIV is becoming a chronic, manageable illness.[33]

There is considerable debate about the potential impact of new combination treatments on gay men's safe sex behaviour.[34 35] It will be necessary for researchers and educators to identify and adapt to this impact, with particular emphasis on improving the health and quality of life of men living with HIV/AIDS.

Gay men living with HIV/AIDS

The early national response to HIV/AIDS saw the development of four Programs to combat the epidemic. These were the Education and Prevention Program, the Treatment and Care Program, the Research Program, and the International Assistance and Co-operation Program. The Education and Prevention Program aimed to raise awareness of HIV/AIDS across the whole population, and to promote the development of new community norms (in relation to safe sex) within populations at risk.[36] Many agencies responsible for education and prevention established structures and programs that reflected the priorities. As a consequence, the needs of gay and other homosexually active men living with HIV AIDS have not been given adequate attention, partially as a result of the organisational structures that were established to manage the earlier phases of the epidemic.

The new treatments, and the fact that many gay men and other homosexually active men living with HIV are now living longer means that it is essential that health promotion programs be developed to improve their health and quality of life. It will be essential to involve gay and other homosexually active men with HIV/AIDS in all aspects of prevention education program design, delivery and implementation.

Summary

- Although the early sense of crisis has waned, HIV/AIDS remains a serious and ongoing health threat for gay and other homosexually active men.
- There is widespread knowledge of HIV/AIDS and means of transmission among gay men. However, this knowledge is not automatically followed by behaviour change.

- Gay men are responding to the need to adopt long-term behaviours to reduce their risk of HIV infection (or that of others) using an increasingly diverse range of ‘safe sex’ behaviours.
- New combination treatments will continue to have a significant impact upon the health of gay and other homosexually active men living with HIV/AIDS and potentially on the commitment to safe sex by gay and other homosexually active men.
- Increasing recognition of the specific needs of gay and other homosexually active men living with HIV/AIDS

The implications for HIV/AIDS health promotion programs are that:

- Target audiences are no longer as receptive to simple messages such as ‘condoms every time’.
- Provision of basic information on routes of transmission, while still important for the newly sexually active, cannot be the sole focus of education programs. Other factors that influence the adoption and maintenance of safe sex behaviours must be addressed.
- Programs will need to include a variety of objectives and use a combination of strategies.
- Programs will need to be flexible and responsive to the changing environment, and will have to operate in a climate of uncertainty.
- Programs will need to address the specific needs of gay and other homosexually active men living with HIV/AIDS.

Chapter 3

A framework for the Review

3.1 A framework for health promotion

The terms of reference required the Review to focus on the scope, efficiency, and effectiveness of current health promotion activities by partners in the third National HIV/AIDS Strategy. However the title and the second terms of reference refer to "education and awareness" programs and activities. The Review has confirmed the need for clarification of the meaning of the two terms.

The distinction between health promotion and health education is important because the outcomes achieved by each are significantly different. Education contributes to the achievement of some, but not all, health promotion outcomes (see model below). It is important, in other words, to assess the effectiveness of health education programs in terms of the outcomes they are capable of achieving. Education is a necessary, but not sufficient, strategy to bring about improvements in health outcomes, represented in this review as reduced incidence of HIV infection and reduced numbers of deaths from AIDS.

Health promotion is the combination of education and environmental supports for actions and conditions of living which are conducive to health.[37] Health promotion, as outlined in the Ottawa Charter, is the process of enabling people to increase control over and to improve their health.[38] The Charter identifies five key actions by which individuals, communities and governments act to improve their health:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- reorient health services.

Thus health promotion includes ensuring legislative change to protect the confidentiality of people living with HIV and working with local councils to ensure policy support for outreach education programs to public locations where men may meet other men for sex.

Health promotion includes a range of strategies, which, used in combination, contribute to the achievement of a wide range of outcomes described below.

Health education is defined as any combination of learning experiences which are designed to facilitate voluntary actions conducive to health.[39] Examples of such activities range from one-on-one peer education to print media campaigns.

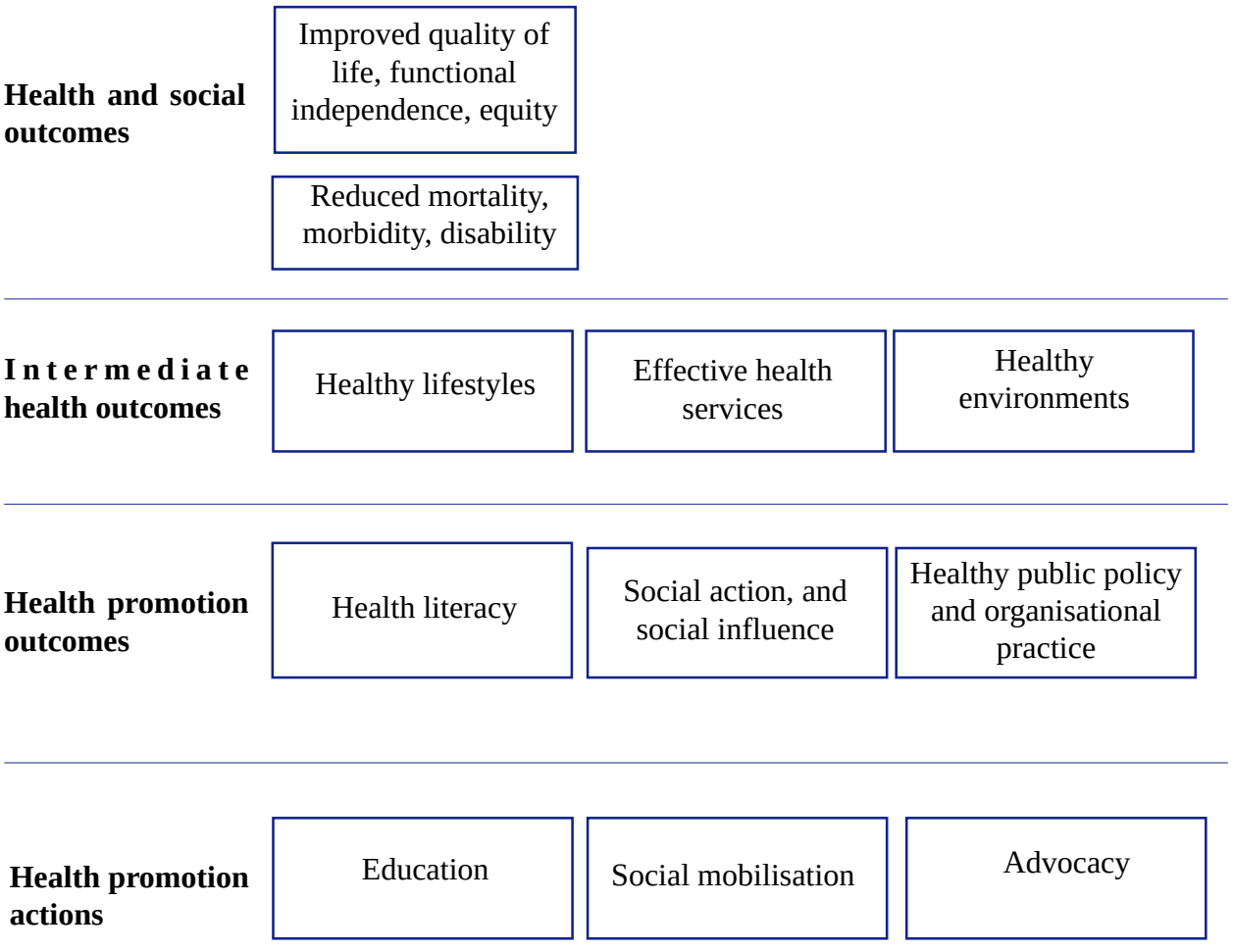
The Review has focused, largely, on the educational activities and programs that have been addressed to gay and other homosexually active men.

3.2 Health promotion and health outcomes

The terms of reference for this review ask that effectiveness be measured in terms of a reduction in HIV incidence rates and/or risk behaviours. This implies that education programs result in changes in the health of an individual or community.[40] This is a rather simplistic reductionist model of the relationship between educational programs and health outcomes and has long been discredited in mainstream health promotion.

Figure 1 illustrates one framework that links health promotion activities with outcomes.[41] It places education within the wider range of actions that are used in health promotion and highlights the fact that the outcomes of education activities are measured most directly by their effect on the health literacy of individuals and communities.

Figure 1 A conceptual model for health promotion and health outcomes[42]



Three *health promotion actions* are represented by the model.

- *Education*, in the context of the model, is the creation of learning opportunities which are intended to improve personal health literacy, and thereby the capacity of individuals and communities to act to improve and protect their health;
- *Social mobilisation* is action taken in partnership with individuals and social groups to mobilise human and material resources for health;
- *Advocacy* is action taken on behalf of individuals and/or communities to overcome structural barriers to the achievement of health.

Through these activities a range of outcomes is achieved.

- *Health promotion outcomes* are the most immediate changes resulting from health promotion activity. They are changes in the personal, social and environmental factors that can be modified to influence the determinants of the health of populations and individuals.
- *Health literacy* is the most direct outcome of education activities. Health literacy reflects the knowledge and skills of individuals and populations, and their attitudes and beliefs in relation to different issues and behaviours. The outcomes of education might be measured in terms of changes to knowledge and skills, motivation and self confidence. Improved health literacy could also be measured in terms of a community's capacity to identify health problems, and to arrive at and implement solutions.[43 44 45 46] Thus health literacy means more than being able to read pamphlets and make health service appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.[47 48]

One example of outcomes achieved by education interventions is the high level of knowledge among gay men of the factors associated with the spread of HIV and of preventive actions. This represents an improvement in health literacy. Another example of an outcome resulting from health education is the enhanced capacity of the gay men's community to advocate to achieve high levels of public support for funding for education and health services to gay men in relation to HIV/AIDS.

- *Intermediate health outcomes* represent the determinants of health and social outcomes. They are, often, the result of the achievement of health promotion outcomes. For example, the gay men's community organisations were able to mobilise support and resources to provide education programs and diagnostic and treatment services that, in turn, influenced the lifestyles of gay men and health services available to them. Another example of a change in public policy that, in turn, influenced the environment in which homosexually active men lived and worked was the introduction of the Disability and Discrimination Act 1992. This influenced the likelihood of gay men seeking and then acting on new knowledge and skills they may have received through educational interventions.
- *Health and social outcomes* are measured by changes in mortality, morbidity or levels of dysfunction on one hand, or more positively, by improvements in equity, and/or in the perceived quality of life of individuals and communities. In relation to HIV/AIDS, examples include reductions in the incidence of infection with HIV, and improvements in the quality of life of people living with AIDS.

In this report, all three levels of outcomes have been reported on in Chapter 4.

Implications for reporting on outcomes and assessing effectiveness

The implications of reporting on outcomes using this model are that there can be no single measure of outcome, nor a single measure of the effectiveness of education programs because:

- the effects of education programs may be more than just improved knowledge;
- the impact of educational programs on behaviour and hence, on HIV infection, is significantly mediated by a wide range of other social and environmental influences.

The difference in meaning of the term 'outcome' is critical to this review. Throughout the report, the 'type' or 'level' of outcome being referred to is specified. This is intended to avoid confusion and to reinforce the fact that the achievement of a reduction in HIV infection is dependent upon a range of actions (including but not only, education) mediated by a range of other influences.

3.3 Measuring effectiveness

In light of the framework outlined above, the effectiveness of gay men's education programs has been assessed in terms of their impact on the health literacy of gay men, and, to a lesser extent, their impact on social action or influence, and the development and implementation of public policy and organisational practice relevant to preventing HIV infection.

The assessment of effectiveness that follows in this Review has been made in terms of impact of the accumulated educational (and other strategies) on the whole of the population of gay and other homosexually active men.

The outcomes (at each level) have been assumed to be the result of the combined actions taken under the auspice of the national HIV/AIDS Strategies. The inability to attribute specific outcomes to specific interventions is not confined to the HIV/AIDS area. Even in an area as well researched as tobacco control, it has been found impossible to do this.[49]

The information required to enable measurement of the effectiveness of health promotion (including education) programs is:

- well documented descriptions of the inputs to a program, including, in the case of educational programs, a description of the methods used and the modes through which the program was delivered. The results of process evaluation are also required to assess the extent to which the program was delivered as intended, the extent to which it was received by its intended audience, and the extent to which the audience attended to the 'message'.
- evaluation which has measured and recorded health promotion outcomes and intermediate health outcomes, depending upon the goals of the program.

3.4 Measuring efficiency

Studies of cost effectiveness in health education are in their infancy, and are greatly hampered by lack of appropriate data.[50] The data needed to enable cost effectiveness analysis to be completed include all of that required to measure efficiency. In addition, knowledge of the costs of the inputs, knowledge of the outcomes achieved as a result of the inputs (i.e. proven relationship), and knowledge of the costs of alternative interventions (or of doing nothing) is needed.

While this review acknowledges the need for studies of cost effectiveness it found significant limitations in the data available to permit such studies.

3.5 Conclusions

The Review has highlighted significant gaps in information that have prohibited more detailed assessment of the effectiveness and efficiency of gay men's education programs on the spread of HIV.

- **Need to describe inputs**

There is a need for much more detailed information about the inputs to the educational response. This includes descriptions of expected outcomes, target groups, methods used, and the resources used to develop and implement the program. It is impossible, for example, to measure cost effectiveness without first having the information on 'costs'.

- **Need for process evaluation**

Even for the many educational programs that were identified by the Review very few had reported evaluation results of any kind. This means that it is impossible to comment on the whether programs were of sufficient quality that it would be reasonable to expect them to achieve their intended health promotion or intermediate outcomes.

The information about the programs included in the Review revealed the need for much more extensive process evaluation to enable assessment of program integrity, and of program delivery including modes of delivery, reach, and the response of the proposed audience.

- **Need for impact and outcome evaluation**

The Review found almost no documented examples of impact or outcome evaluation for individual programs or for campaigns. It is essential that a much more systematic approach is taken to evaluation at process, impact, and outcome levels, measuring, as appropriate, health promotion, intermediate, and health outcomes.

Chapter 4

Outcomes – what has been achieved?

In keeping with the outcomes model presented in Chapter 3, the Review has assessed the effectiveness of Australia's initiatives to prevent the spread of HIV, and to reduce the mortality and morbidity associated with AIDS, using population-wide outcome measures at each level of the model (where such information is available). The Review has examined changes in health, intermediate, and health promotion outcomes (at the population level) that have occurred since the evaluation of the second National HIV/AIDS Strategy in 1995.

The Review recognises that attributing changes in population health outcomes solely to health education and promotion efforts is incorrect and impossible. Education, on the whole, has its greatest effect on health literacy on the individual and community knowledge, skills, and attitudes that are necessary precursors to the achievement of behaviour changes and, ultimately, reduced premature mortality or improved quality of life.

To examine trends and changes in population health over time social research and epidemiology has been used that meets as many of the following criteria as possible:

- indicates trends over time;
- focuses on changes since the evaluation of the second National HIV/AIDS Strategy;
- are national in scope, and examine both gay and other homosexually active men;
- are scientifically sound.

4.1 Annual Surveillance report and Male Call survey

All information in this chapter is based on comprehensive research reports produced by the National Centre in HIV Social Research and National Centre in HIV Epidemiology and Clinical Research. The Review has attempted to only provide a broad overview. More detailed information can be obtained by contacting the National Centres.

The following information and figures, unless otherwise stated, has been obtained from the Annual Surveillance Report published by the National Centre in HIV Epidemiology and Clinical Research in 1997,[51] and from Male Call 96, a telephone survey conducted by the National Centre in HIV Social Research.[52]

Male Call was a national telephone survey, conducted from 15 October to 16 December 1996, of gay identified and non-gay identified homosexually active men. A similar survey was also conducted in 1992 allowing for comparisons of the findings from the two surveys. Similar recruitment methods were used by both.

Recruitment sources included sections of the organised and formal gay community (radio, venues, gym, businesses, publications); a wide range of settings for sexual contact within, outside and marginal to an organised gay community (gay brothels, sex shops, beats); all relevant health centres; and all known pornography outlets; public community television advertisements; and the Internet.

The 1996 survey resulted in 3039 completed interviews. Respondents were included only if they had had sex with a man during the previous five years. Because there is no way to enumerate the total population of men who have sex with men in Australia it cannot be certain that the sample is unbiased. However the similarity between 1996 and 1992 samples suggests that whatever bias exists is consistent between samples.

In comparison with Census data men from non-English-speaking backgrounds are under-represented and middle class-professional, well-educated and comparatively wealthy men are over represented. The proportion of Aboriginal or Torres Strait Islander men in the sample was greater than that found in the 1996 Census. According to the information the men provided about their social lives 74 per cent (in both 1992 and 1996) were classified as 'gay-community-attached'.[53]

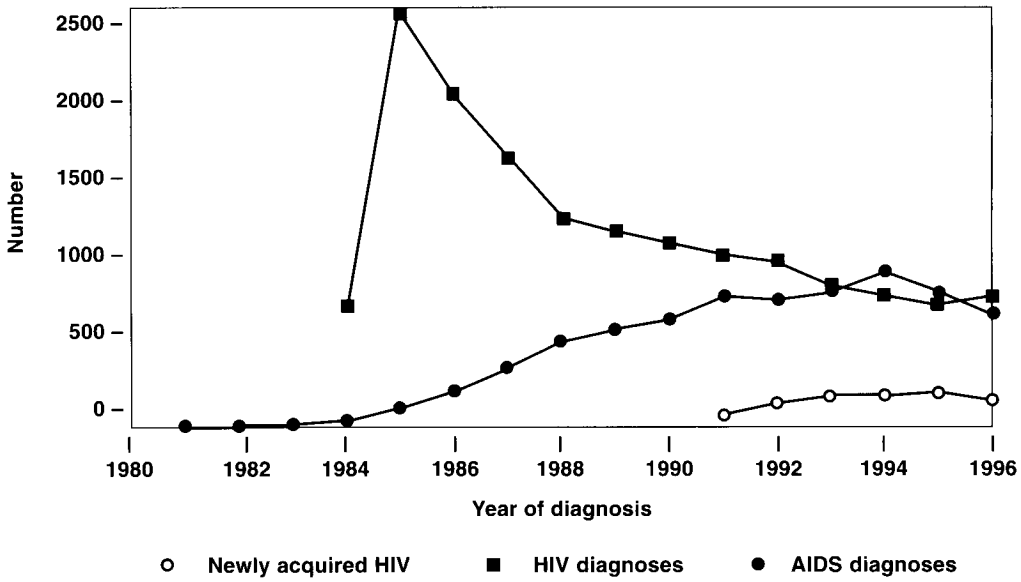
4.2 Health outcomes

The annual number of AIDS diagnoses in Australia, after adjustment for reporting delay, appears to have reached a peak in 1994 with an estimated 962 AIDS diagnoses. This is estimated to have declined to 706 cases in 1996 (Figure 2). The peak in the number of AIDS diagnoses has been predicted for several years on the basis of back-projection analyses (Figure 3) which estimated that the annual number of new HIV infections in Australia peaked around 1985 followed by a rapid decline.

HIV diagnoses fell between 1985 and 1995 from more than 2,500 to around 800 (Figure 2). AIDS diagnoses increased to 1994 and are now stable. However new HIV infections continue to occur in Australia with approximately 200 diagnoses of newly acquired HIV infections being reported each year since 1993 (Figure 2). This is likely to be an under-estimate of the total number of new infections as it excludes those men who are not diagnosed with HIV sero-conversion illness, or have not had a HIV negative test within 12 months of a positive test.

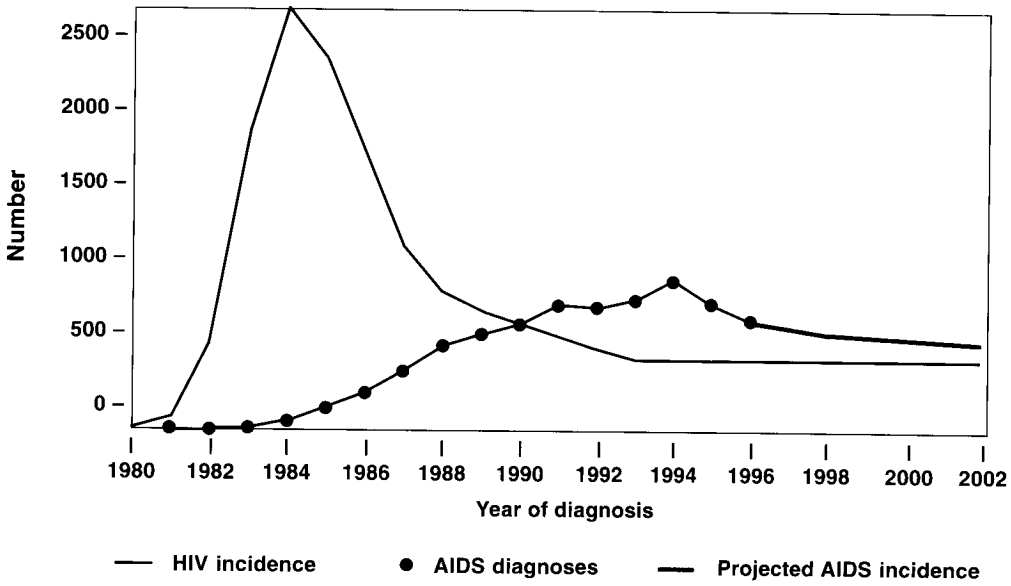
The most recent Australian HIV Surveillance Report indicates that the number of new diagnoses of HIV infection cumulative to 30 September 1997 was 20,902, while the estimated number of new diagnoses, adjusted for multiple reports, was 16,700.[54]

Figure 2 Diagnoses of HIV infection, newly acquired HIV infection and AIDS*, 1980-1996



* HIV diagnoses adjusted for multiple reporting. AIDS diagnoses adjusted for reporting delay

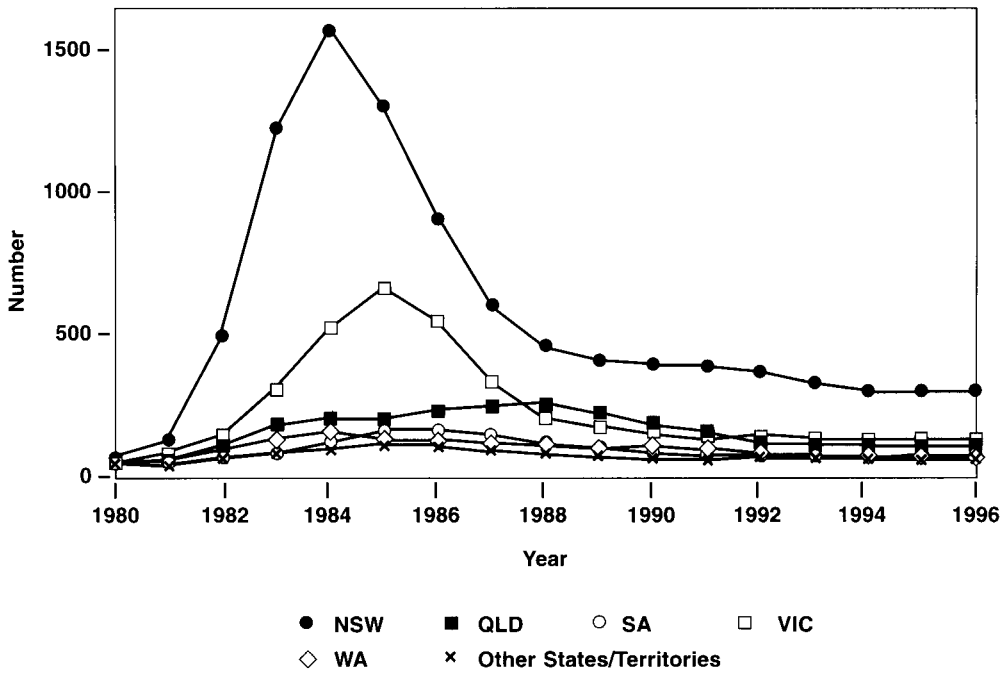
Figure 3 Estimated HIV incidence, observed AIDS diagnoses and projected AIDS incidence*, 1980-2002



*Observed AIDS diagnoses adjusted for reporting delay. HIV and projected AIDS incidence estimated by back-projection

There have been some differences between Australian States and Territories in estimated HIV incidence over the period 1980-1996 (Figure 4). Peak HIV incidence is believed to have occurred in New South Wales first, and somewhat later in other States and Territories

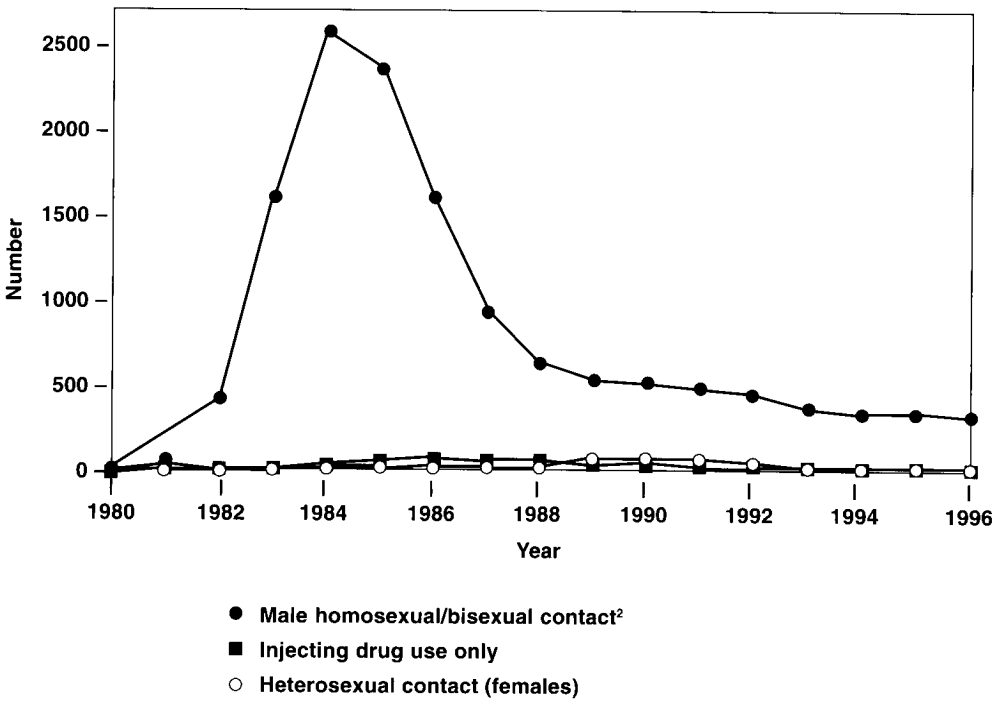
Figure 4 Estimated HIV incidence*, 1980-1996, by State/Territory



*HIV incidence estimated by back-projection

Transmission of HIV in Australia continues to be overwhelmingly through sexual contact between men (Figure 5). Over 85 per cent of all HIV transmission in Australia is estimated to have been via this route.

Figure 5 Estimated HIV incidence[1], 1980-1996, by HIV exposure category



[1] HIV incidence estimated by back-projection
[2] With or without a history of injecting drug use

From the peak incidence in 1985 there has been a dramatic decline in the incidence of HIV to a low rate which has been sustained for over a decade. Additionally the vast majority of men in the Male Call survey had not experienced a sexually transmissible disease or other blood borne virus within five years prior to the survey. Hepatitis C was most rarely reported with only 2 per cent of men having been infected.

4.3 Intermediate outcomes

- The proportion of men who engaged only in protected anal intercourse with casual partners increased 7 per cent (from 33.4 per cent in 1992 to 40.7 per cent in 1996). However there was also an increase in the percentage of men who engaged in unprotected anal intercourse with casual partners (from 11.5 per cent in 1992 to 15.3 per cent in 1996).

  This increase in unprotected anal intercourse was of similar magnitude in gay-community-attached and non-gay-community-attached men. An increase was found in all States and Territories except Tasmania and the Northern Territory (although the numbers are small). All regions showed an increase in this practice although the gay areas of Sydney and Melbourne showed the greatest increase although they had had the lowest percentage of men engaging in this practice in 1992.
- The increase in unprotected anal intercourse with casual partners was partly due to an increase in anal intercourse *per se*. There was a significant decrease in the percentage of men who reported no anal intercourse with casual partners.
- There was a significant increase in the percentage of respondents reporting unprotected anal intercourse with a regular partner (from 41 per cent in 1992 to 47.7 per cent in 1996). Almost all of this increase came from a decrease in the percentage reporting no anal intercourse (from 21.2 per cent in 1992 to 15.3 per cent in 1996).
- Young men (those under 25 years of age) were less likely to have been tested for HIV in 1996 than in 1992. Of men aged less than 20 years the proportion who had not been tested rose from 37 per cent in 1992 to 46.4 per cent in 1996, and for men aged 20-24 the proportion who had not been tested rose from 22.8 per cent in 1992 to 29.8 per cent in 1996. Men in all other age groups were more likely to have been tested in 1996 than in 1992. Gay-community-attached men were more likely than non-gay-community-attached men to have been tested and more likely to be HIV sero-positive. In both groups the percentage of men who had been tested increased in 1996.

4.4 Health promotion outcomes

- Knowledge of HIV transmission remains high (over 90 per cent for most items included in the survey).
- Knowledge of STDs was moderately high with average levels of accurate knowledge on most items around 70 per cent. Levels of knowledge were much lower in relation to genital warts and hepatitis, particularly hepatitis C. Data was only collected in the 1996 survey.

- Positive attitudes towards condoms are declining although young men's attitudes to condoms are, on the whole, more favourable than those of older men.
- Knowledge with respect to withdrawal (unprotected anal intercourse without ejaculation) was more accurate in 1996 than in 1992.

Differences according to population groups

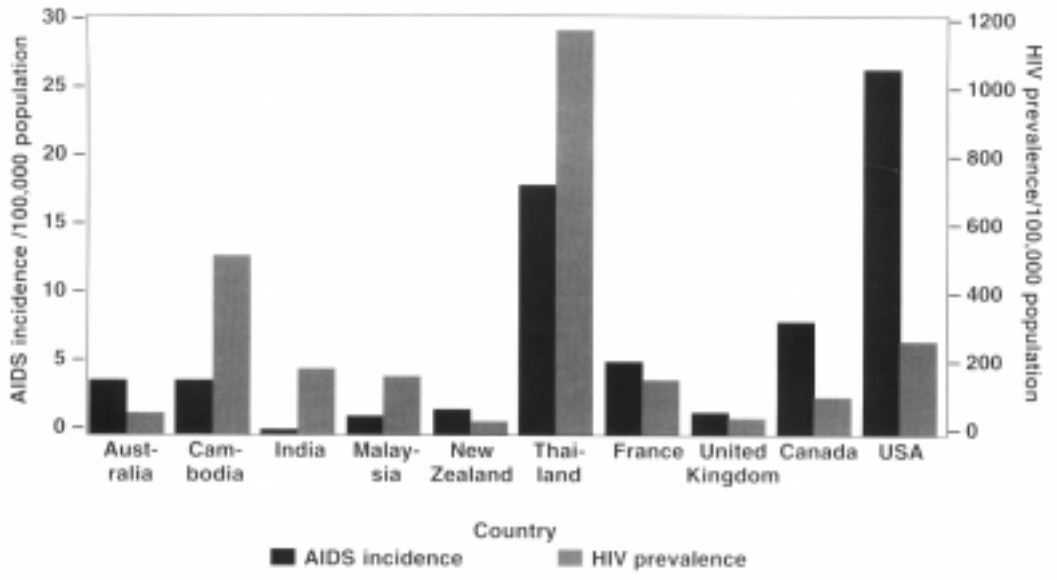
- HIV-positive men were most knowledgeable on means of HIV transmission, followed by those who had tested HIV negative, with untested men being least knowledgable. Rural men had lower levels of HIV knowledge on the whole. Men from the gay areas of Sydney and Melbourne had high levels of HIV knowledge. These men also had more male sexual partners and more casual sex. Gay-community-attached men, on the whole, had higher levels of knowledge than non-gay-community-attached men and men with higher levels of education tended to have more accurate knowledge than those with more limited education. This was the case with respect to knowledge about HIV transmission and even more so with respect to knowledge of other STDs and hepatitis A, B and C. Young gay men (under 20 years) were the least knowledgeable.
- Men in trade and labourer employment categories were less likely to have been tested than those in other occupations. Men with lower levels of education were also less likely to have been tested.
- Gay-community attached men were more likely to have engaged in unprotected anal intercourse with male partners than non-gay-community attached men. This is related to differences in sexual relationships. Much of the unprotected anal intercourse was within a regular relationship and gay-community-attached men were more likely to have had sex with regular partners during the six months prior to the interview.

  Higher rates of unprotected anal intercourse with casual partners were reported among those with a lower formal education and lower rates among those who were tertiary educated. The increase in unprotected anal intercourse with casual partners occurred among both gay-community-attached and non-gay-community-attached men, although the lower proportions of this latter group were engaging in this risk practice in both years.
- HIV-positive men were the group most likely to have engaged in unprotected anal intercourse with male partners, and they also showed the greatest increase in this practice between 1992 and 1996. It must be borne in mind that some unprotected anal intercourse engaged in by HIV-positive men is with other HIV-positive men. The survey did not ask whether respondents believed they knew the HIV serostatus of casual male partners.

4.5 Conclusions

Overall the Australian response to HIV/AIDS has been remarkably successful in containing the spread of the epidemic. As the following table indicates, in comparison to a range of selected countries, we have a remarkably low HIV prevalence and AIDS incidence rate per head of population.

Figure 6 AIDS incidence in 1996 and HIV prevalence in 1994 in selected countries



Most cases of HIV infection in Australia continue to be transmitted by sexual contact between men. There is no evidence among gay and other homosexually active men of an increase in HIV transmission. Non-gay-community attached men appear to have, on the whole, lower levels of HIV knowledge and less likely to have been tested, compared to gay-community attached men. However there remains a lack of epidemiological research to indicate the risk of HIV infection posed to these men, as compared to gay men.

Among Aboriginal and Torres Strait Islander people the rate of HIV diagnosis remains similar to that among non-indigenous people in Australia, although the former appears to have increased in recent years.[55] However Aboriginal and Torres Strait Islander communities are still experiencing very high rates of other sexually transmissible diseases, which may be an indicator of potential high risk behaviour that is associated with the transmission of HIV.[56]

Knowledge of HIV and the practice of safe sex and safe injecting remain high. Though recreational drug use is high amongst gay men by comparison with the general population, particularly use of so-called 'party drugs'.[57] Injecting drug use was reported by a very small minority of the sample, although the percentage who had injected during the six months prior to the survey is high by comparison with general population data. Needle sharing is very rare within the sample.

The increase in unprotected anal intercourse amongst casual partners is cause for concern. The results represent an increase in the practice of anal intercourse with casual partners. It would appear that more casual encounters in 1996 involved anal intercourse (both protected and occasionally unprotected) than in 1992. As noted in Chapter 2, the changing environment and nature of the epidemic, such as 'good news' about combination therapies and a sense that there is no longer a crisis, may be factors that have influenced behaviour.

An increase in unprotected anal intercourse with a regular partner may well be cause for concern. It must be recognised, however, that in some circumstances (for example in sero-concordant relationships where all sex outside the relationship is 'safe') the practice may not present a risk of HIV transmission.

Summary

- Most cases of HIV infection continue to be transmitted by sexual contact between men. There is no evidence among gay and other homosexually active men of an increase in HIV transmission since 1996.
- Knowledge of HIV, its means of transmission, and of appropriate preventive responses remains high among gay men
- The proportion of gay men being tested for antibodies remains high
- The practice of safe sex and safe injecting remain high
- There is an increase in the practice of unprotected anal intercourse with casual partners
- There is an increase in unprotected anal intercourse with a regular partner, though in some circumstances the practice may not present a risk of HIV .

Chapter 5

Overview of the education programs for gay and other homosexually active men

The outcomes reported in Chapter 4 confirm that the combined efforts in Australia to prevent the spread of HIV have been successful. The intermediate and health promotion outcomes reported confirm that there have been changes in the determinants of health (in this case, in the factors that influenced the spread of the virus – individual, cultural, social, and environmental factors). The challenge, now, is to understand how these outcomes were achieved.

5.1 Response to a crisis

The educational activities during the periods covered by the first two National Strategies reflected a response to a crisis. Urgent action was necessary. The gay community (and, to their credit, politicians and bureaucrats) saw the need to act quickly, using the tools that were most readily to hand. In the absence of a viable treatment or cure, education (in a range of forms) was one of the most powerful means available to prevent the spread of the virus within the gay men's population in particular and across the whole population.

As the immediate crisis now appears to have been averted it is essential to examine more closely, the nature of Australia's educational response and to identify the most effective and efficient means of continuing to ensure that the spread of HIV is controlled.

The challenges for this review, therefore, have been to:

1. identify the inputs – the extent and types of educational methods employed to control the spread of HIV among gay and other homosexually active men;
2. assess the quality of these, using benchmarks derived from theory and the literature on the effectiveness of health education;
3. assess the relative effectiveness of different educational methods in achieving improved health literacy;
4. recommend the balance of methods that is likely to ensure the on-going control of HIV/AIDS among gay and other homosexually active men, and to further reduce the spread of the virus.

5.2 What has been done since 1995 – education methods, target groups, content and delivery agency

This section provides an overview of the education activities that have been carried out in the period since the evaluation of the second National HIV/AIDS Strategy in 1995. As wide a range of organisations and individuals as possible was invited to contribute summaries of educational activities carried out since 1995, and particular effort was made to locate evaluation reports on educational programs.

Despite these efforts very few reports of evaluations or education programs were identified, indicating that there has been a general lack of evaluation reporting. This was confirmed during the consultation which found that, although educators appeared to have assessed the achievements of their work, they have failed to document this adequately or to disseminate their findings.

All information that has been received about specific activities is included in Appendix Four. It provides substantial detail on the breadth and variety of activities. However it should not be interpreted as a complete audit. Not all agencies engaging in education for gay and other homosexually active men responded to requests for information.

The following table summarises the education activities that have occurred since 1995. The table includes health promotion actions if this information was provided to the reviewers. The information is based, primarily, on summaries received directly from educators and their organisations. However information obtained from the literature and through the consultation meetings has also been used. Additionally annual reports from many community-based organisations have been a source for the information included in this summary.

The activities have been categorised as follows:

- ***Method*** describes the types of educational activities (or health promotion actions) and indicates the range of educational approaches used;
- ***Target group*** identifies the population group for whom the activity/program was intended;
- ***Content*** summarises the issues that have been covered by the educational activities;
- ***Agency*** identifies the organisation responsible for designing and delivering activities.

The table does not make reference to specific programs. Rather, it is an attempt to identify the range and scope of the overall educational effort. It has not been possible to specify the number of programs using each ‘method’, nor to specify the extent of the resources allocated to various methods.

The inability to be more specific about the nature and scope of the educational efforts in relation to HIV/AIDS education for gay and other homosexually active men has affected the extent to which it is possible to draw conclusions based on 'evidence' that is more than anecdotal. This does not mean that the activities or programs that have been identified are inadequate in themselves – rather, it means that there has been only limited documentation of inputs and even more limited evaluation of process, impact and outcomes. It must be added that this lack of documentation of inputs, and the lack of specific information about resources allocated to specific interventions has been identified as a problem across all areas of public health/health promotion in Australia.[58] This review confirms the need to redress this issue in view of increasing pressure to ensure that investment in health promotion is efficient and effective.

Table 1 Summary of health education and promotion activities

Method	Target groups	Content	Agencies
Group work Group work has been identified as the use of any group, workshop or retreat that may include a social, discussion support, or therapeutic focus. ('Peer education' is often used to describe group work only. We have interpreted peer education as a value that is utilised in a broad range of education activities than just group work)	• Gay men • Young gay men (26 and under) • Older gay men (over 45) • Gay men in sero-discordant relationships • Gay men from different ethnic backgrounds • Gay men in relationships • Married gay men • Non-gay identified homosexually active men, including bisexual men • Male prisoners • HIV positive gay men • Sex workers • Unemployed gay men	• Coming out • Relationships • Sexual identity • HIV/AIDS information and safe sex • Self development • Rape and sexual abuse • Drugs and alcohol • Grief and loss • Employment skills • Impact of HIV/AIDS • General gay men's health • Skills development • Sexuality and ethnic identity • HIV positive sexuality • Depression and self esteem • Sex and sexual health	• AIDS Councils • Sexual health clinics • Sex worker organisations • Gay and lesbian community organisations • Gay and Married Men's Association • NSW Area Health Services

Print Media Print media includes press advertisements, pamphlets, magazines, booklets, fact sheets, posters, stickers, t-shirts, tea towels, postcards and other paraphernalia	• Gay men • HIV positive gay men • HIV negative gay men • Young gay men • Asian gay men • Gay men travelling • Non-gay identified homosexually active men • Sex workers • Men from a non-English speaking background	• Withdrawal • Gay relationships • Discrimination and support within the gay community • Negotiation of unprotected anal intercourse in relationships • Promotion of support services (including telephone, groups, workshops, counsellors) • Travelling safely • Condom use with casual partners • Excuses for unsafe sex • HIV/AIDS information • Living with HIV • STDs • Identity and sexuality issues • HIV treatments • HIV anti-body testing • Hepatitis vaccinations • General sexual health	• AIDS Councils • Australian Federation of AIDS Organisations • Sexual health clinics/ services • Gay and lesbian community organisations • NSW Area Health Services

One-on-one Outreach Includes beats*, venues and brothel outreach, and medical clinics established in gay sex on premises venues	• Gay men • Non-gay identified homosexually active men • Beat users • Male sex workers • Gay venue patrons	• HIV/AIDS and safe sex information • Distribution of condoms and lubricant • Peer counselling on sexuality, identity, support issues • HIV and STD testing, Hepatitis vaccination • Impact of HIV/AIDS	• AIDS Councils • NSW Area Health Services • STD clinics/ services • Sex worker organisations
Resource outreach Resource outreach focuses more on the distribution of resources at special events, venues, dance parties, etc.	• Gay men • Young gay men • Dance party patrons • Gay venue patrons	• Distribution of condoms and lubricant • Provision of safe sex and HIV/AIDS information	• AIDS Councils • Gay and lesbian community organisations

* Beats are public sex environments where men meet other men for sex. They are frequently public toilets and parks.

Theatre and culture Includes gay venue performances, cabaret events, community theatre, photographic exhibitions, computer and slide project installations, writing workshops, art exhibitions, drag performances	• Gay men • HIV positive gay men	• HIV/AIDS • Living with HIV • Impact of HIV/AIDS • Relationships • Unprotected anal intercourse • HIV Treatments • Injecting drug use • Gay identity and community • Promotion of services	• AIDS Councils • Gay and lesbian community organisations
Community forums	• Gay men • Male sex workers	• Unprotected anal intercourse • Recreational drug use • HIV treatments • Legal and general health issues • General gay men's health • Sex	• AIDS Councils • Sex worker organisations
Telephone services	• Gay men • Young gay and other homosexually active men • Non-gay identified homosexually active men, including from different ethnic backgrounds	• HIV/AIDS and safe sex information • Counselling on sexuality, identity, support issues • Referrals to other services	• AIDS Councils • Sex worker organisations • State Health Departments and NSW Area Health Services • Gay and Married Men's Association

Community development Includes working with members of the community to increase their capacity to respond to HIV/AIDS and other health issues or problems.	• Gay men • Positive gay men • Non-community attached gay men • Men in rural areas	• Initiating, supporting and developing the growth of gay groups/networks/ communities • Skills development • HIV/AIDS information	• AIDS Councils • NSW Area Health Services • Gay and lesbian community organisations
Needle and syringe exchange	• Gay men • Non-gay identified homosexually active men HIV positive gay men	• Needle and syringe exchange • HIV/AIDS information • Hepatitis and STD information	• AIDS Councils • State Health Departments
New technologies Includes the Internet web sites, chat lines, e-mail.	• Gay men • Young gay men	• HIV/AIDS and safe sex information • Sexuality issues • STDs	• AIDS Councils • NSW Area Health Services
Counselling	• Gay men • HIV positive gay men • Non-gay identified homosexually active men	• HIV/AIDS and safe sex • Pre and post HIV testing • Relationships • Living with HIV	• AIDS Councils • Community Health Centres • Gay and Married Men's Association • Sexual health clinics/centres • NSW Area Health Services

Training – creating supportive environments Training includes work with other service providers to ensure greater access for gay and other homosexually active men who need to access the service.	• Health care workers • Teachers • Rural health and community workers • Youth workers • Community workers	• Ensuring access to gay and other homosexually active men to the service • Challenging attitudes that inhibit the service been accessed	• Family Planning Association • AIDS Councils • NSW Area Health Services • Gay and Married Men's Association
Policy – creating supportive environments Includes work with gay venue owners and local councils to develop policies and practices that, in turn, encourage and support the adoption of safer sexual practices by clients.	• Gay venue owners • Local government	• Ensuring the provision of HIV/AIDS resources, education and condoms.	• AIDS Councils • NSW Health Department and Area Health Services • Australian Federation of AIDS Organisations

5.3 The effectiveness of HIV/AIDS education

Benchmarks are standards against which the inputs, process, impact and outcomes of single or comprehensive programs or services can be compared. So that, for example, Australia's overall performance in terms of combating the HIV/AIDS epidemic is compared with that of other nations (see Chapter 4). This is a form of benchmarking.

It is possible to set benchmarks for either an individual health education program or for the overall national program developed in response to an epidemic or health problem (e.g. the national HIV/AIDS program). One of the challenges for Australia is to develop such benchmarks based on its experience in the HIV/AIDS field. Given the overall success of Australia's achievements in comparison with those of other developed nations, Australia has much to contribute in terms of developing benchmarks for national performance in responding to the threat of an epidemic such as HIV/AIDS.

As outlined above, the lack of documentation of the inputs to and the outcomes achieved by the activities that have formed the core of Australia's education of gay and other homosexually active men has hampered the development of benchmarks of good practice in relation to different educational methods. However, there is a growing body of evidence from the health promotion literature in general and from specific HIV/AIDS literature, of benchmarks against which to assess the quality of individual education programs. The Jakarta Declaration, prepared by the participants at the Fourth International Conference on Health Promotion in 1997 also provides some benchmarks for assessing the quality of a national program to promote health or prevent disease.[59]

Building on the Ottawa Charter for Health Promotion, the Jakarta Declaration states that there is now clear evidence that:

- comprehensive approaches are most effective;
- particular settings offer practical opportunities for the implementation of comprehensive strategies. These settings include cities, hospitals, schools, local communities, workplaces and health care facilities.
- participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective.
- health literacy fosters participation. Access to education and information is essential to achieving effective participation and empowerment of people and communities.

Table 2, at right, outlines some benchmarks of effective education and prevention programs drawn from analysis of the literature – both HIV/AIDS specific, and wider health promotion.

Table 2 Characteristics of effective health promotion intervention[60 61]

Effective	Not effective
Well planned programs that	**Poorly planned programs that**
• clearly define outcomes or objectives based on analysis of needs, context, and contributing factors[62 63] • clearly define target populations or organisations[64] (eg by age, race, risk behaviour, culture, peer and social group)	• do not have clearly defined outcomes or objectives • do not have clearly defined target populations
• tailor the intervention strategies (education, facilitation, advocacy) and methods (e.g. mass media, small groups) to ensure a rational fit between program activities and program objectives or outcomes[65]	• do not tailor the message for different population groups • give ambiguous, vague, or inappropriate messages
• adopt a multifaceted, or comprehensive approach including building personal skills, developing social support, building supportive environments, implementing healthy public policy, and ensuring appropriate services[66 67]	• use a single strategy, such as education, to achieve population-wide behaviour change
• use multiple strategies that link program components – a community organising strategy – a community development strategy – a communications (or media) strategy – a social marketing strategy – a group empowerment strategy – a self–help, self–care strategy[68]	

Effective	Not effective
Well planned programs that	**Poorly planned programs that**
• use sound methods, including sound educational methods[69 70]	• use poor quality materials • deliver programs using inappropriate methods
• focus on changing the physical and social environments that determine individuals' and communities' capacity to change.[71 72 73]	
• have sufficient resources to allow long-term, incremental intervention related to each of the levels of outcome (health promotion, intermediate, and health outcomes)[74]	• attempt to achieve objectives or outcomes with insufficient resources, including insufficient time
• evaluate appropriately to ensure program quality, and to assess impact, and outcome[75 76]	• do not evaluate at any level
Programs that use effective processes for planning and delivery, including	**Programs that ignore the importance of process in planning and delivery**
Programs that are 'for and by' the target populations and • use 'natural leaders' among peers • are developed for peers by peers • are carried out or led by peers[77 78]	Programs that: • are devised by 'experts' or professionals who are not familiar with the people whom they are trying to reach • are developed from the 'top down', rather than from the 'bottom-up' • function with a 'do to', rather than a 'do with' orientation or approach
Programs that • use language at the literacy level of the targeted population • ensure that the cultural and social context is appropriate • 'ring true' to people's experiences[79]	Programs that are not personal or user friendly

Effective	Not effective
Well planned programs that	**Poorly planned programs that**
Programs that • ensure that group process is as important as the content[80] • provide group support for individuals in the initiation and maintenance of behaviour change. – group provides context and opportunities to learn and practice – personal sharing in group leads to personal and group transformation – transformation of group lays groundwork for broader changes in community norms in behaviour[81]	Programs that fail to reinforce maintenance of safe behaviours and send messages that are judgemental, moralistic or attempt to instil fear
Programs that • enhance individual self-esteem • enable people to develop the skills they need to, for example, implement change in personal relationships[82] • enhance participants' self-efficacy[83]	
Programs that reach people where they live, where they work, and where they go	

Much of the above has been derived from established psycho-social and other health promotion theories tempered by practical experience. There are many established theories to guide the development of educational programs for health promotion.[84 85] Although many of the theories have been developed in areas other than HIV/AIDS they also apply to the methods used in Australia's educational responses to the HIV/AIDS epidemic.

5.4 Assessment of the effectiveness of Australia's HIV/AIDS education for gay and other homosexually active men

In the absence of documented evaluation the Review has been unable to draw conclusions about the relative effectiveness of specific education methods used in Australia. However, it is important to repeat that, measured in terms of outcomes at each level in the framework outlined in Chapter 3, the main finding of the Review is that Australia has succeeded in containing the epidemic and in sustaining the control over a prolonged period.

Although it is not possible to assess the effectiveness of specific educational methods, it is possible to use the benchmarks provided by the Jakarta Declaration to review the range of action across the nation.

Table 1 highlights the extent to which a comprehensive range of methods has been used to educate gay and other homosexually active men about the transmission of HIV and about ways to prevent its spread. There have been sustained, targeted efforts to educate gay and other homosexually active men to prevent the spread of HIV. There have also been efforts to change the culture and environments within which gay and other homosexually active men live, work and play.

The table highlights the fact that programs have been designed and delivered to the whole range of sub-groups that make up the gay and other homosexually active men's population, covering issues specific to the needs of each group. The range of target groups identified by the Review confirms that the greatest volume of effort has been directed toward gay men, but that there has been some effort to ensure that other homosexually active men are reached by educational programs.

It also points to the major involvement of both the community-based organisations (AIDS Councils) and the State/Territory health authorities in program development and delivery. It also reflects the development of a national response, directed by the National HIV/AIDS Strategy. The development of partnerships between State/Territory health authorities and the community-based organisations has been an essential component of success. Such partnerships are examples of what is possible when government and community work together. While such partnerships have not always run smoothly, it is clear that without such combined effort, the achievements would not have been possible.

5.5 What has been learned?

Despite the absence of formal evaluation of individual activities and programs, such a range of activity and experience provides a considerable base from which lessons for the future can be drawn. The key findings for this review are considered below in terms of educational method, target groups, educational content, and delivery agencies.

5.5.1 Method

- Overall a comprehensive mix of methods has been used to inform and educate gay and other homosexually active men about HIV/AIDS and preventing transmission of the virus. This confirms the evidence from the wider health promotion literature of the need for such a mix of methods to be used to reach different target groups and to address different determinants of health. Of the methods identified, however, those used most commonly are print media, group work, and outreach. While these are likely to remain central to the educational component of the national preventive strategy, it is important that there be increase emphasis on methods that develop the environmental and structural support necessary to support and reinforce the educational 'messages'.
- The broad mix of individual interventions are often not developed as part of a comprehensive education program or strategy, which at times results in particular methods been over-utilised or, alternatively, neglected.
- There has been a high level of involvement of gay men in all aspects of identification of need, program design and implementation. However, the Review has revealed increasing concern that maintaining such involvement is becoming more difficult as the sense of crisis within the gay community wanes.
- Given strong criticisms that safe sex education had failed to ensure the input and inclusion of gay men living with HIV in earlier responses,[86] there has been widespread effort to ensure this is addressed in current education programs.
- The methods reflect an emphasis on the use of education as the major means of bringing about changes in the knowledge and behaviours of gay and other homosexually active men in relation to HIV/AIDS. The consultation found that many educators had used advocacy and facilitation to bring about structural and environmental changes. However, these have been under-valued and under-recognised because the immediate benefits are less obvious.
- There appears to be some increased experimentation with new educational approaches, such as theatre and culture and community forums, although several people consulted were concerned at the apparent lack of innovation in current educational activities.
- The Review found increasing acknowledgment that activities need to be carefully targeted and prioritised.
- The use of theory, as in other health promotion areas, has been under-utilised in the development of activities.
- The Review highlighted the need for well designed, well executed and documented evaluation at every level of evaluation – process, impact and outcome.

5.5.2 Target Groups

- Efforts have overwhelmingly been targeted at gay men, and particularly gay-community-attached men. Given the data that is available, this would appear to be appropriate.

- There are some high quality local initiatives targeting non gay identified homosexually active men, but there remains a lack of national initiatives and cohesive effort.
- During the consultations many agencies working with gay and other homosexually active men pointed out that they had found that these groups are not distinct categories. There were suggestions that in the future it would be more effective to focus on better targeting of context (including physical, symbolic, emotional) rather than to strive toward better definition of target groups.
- A range of activities targeting gay and other homosexually active Aboriginal and Torres Strait Islander men is occurring. Many of these programs are recent initiatives and it is too soon to evaluate their effectiveness.
- There has been a range of efforts to reach gay men living in rural and suburban areas (that is, outside the inner city gay communities in major cities). However these have varied across the nation and depend on the geography of each state, resources available, and population distribution. These efforts tend to be overlooked when criticism is levelled at community-based organisations, in particular, for their strong focus on inner city gay communities. These efforts are easier to overlook because they often use less visible approaches, such as community development, that are more appropriate for the local context.
- There has been an increased focus on programs that target the various contexts, rather than particular population sub-groups. However increased targeting has also led to criticism of the lack of transparency of the processes and criteria used to make decisions about priorities and methods.
- There has been limited attention given to ensuring that activities are designed to reach groups such as people with limited formal education, and some members of some immigrants of non-English-speaking background.
- People who are intellectually disabled and prisoners have been targeted to varying extents in different states and territories.
- There have been limited efforts to reach young men, who may or may not be homosexually active, through school based HIV/AIDS and sexual health education. The consultation revealed concern among some people that there has been insufficient attention paid to the need for continuing action to bring about the social change that is necessary to reduce the stigma attached to and increase acceptance of diverse sexual preference.

5.5.3 Content

- Interventions have covered a variety of content issues, addressed changes in the environment (eg new combination treatments) relatively quickly and adjusted objectives accordingly. However changes do not always occur systematically and do not, always, include key stakeholders in the decision-making process.
- Research is widely used to assist in identifying content issues needing to be addressed, although smaller capital cities and rural areas often lack local research to guide their efforts.

- HIV/AIDS education efforts have frequently occurred in the broader context of sexual and general health, and there has been an increasing recognition that just providing and constantly re-enforcing safe sex messages will have limited impact. There have been few specific interventions focussed on the hepatitides, in part thanks to confusion about what is expected and to the fact that the need to control hepatitides among gay men has not, yet, been well established.
- There has been an increasing recognition that there is not a single universal message appropriate for all audiences. However the increase in multi-targeted messages has also caused concern that interventions lack continuity, and that newly sexual men are not been exposed to 'old' messages.
- At times, it appears that the mode of delivery (method) has driven education activities, rather than content.

5.5.4 Delivery

- The majority of education efforts targeted at gay and other homosexually active men has been through the State and Territory AIDS Councils, which have been funded to do the work through agreements with the State/Territory health authorities.
- Some State and Territory health authorities also provide health education and promotion activities to gay and other homosexually active men, through area or regional health services. Community health centres and STD clinics also frequently engage in specific activities targeted at gay and other homosexually active men.
- To a lesser extent, there are other state based HIV/AIDS community-based organisations, gay and lesbian community-based organisations and general health community-based organisations that provide HIV/AIDS education activities targeted at gay and/or other homosexually active men.
- The Commonwealth Department of Health and Family Services provides no direct health education activities, but provides strategic leadership for national action.
- The Australian Federation of AIDS Organisations has, since the establishment of the Gay Education Strategies project in 1994, become involved in developing direct education activities through the production of print media resources.
- The effective partnerships that have been developed among HIV/AIDS agencies, government, non-government, and community-based organisations, including health, youth, sex worker and gay and lesbian organisations, appear to have been under-used at the level of local program development and implementation.

5.6 An unresolved issue: sexual health and related communicable diseases

An important issue that arose throughout the consultation was that of the place of programs to promote sexual health and to prevent communicable diseases other than HIV/AIDS. This issue needs attention as the third National HIV/AIDS Strategy was framed with a view to integrating action to promote sexual health and to prevent related communicable diseases with action to reduce the incidence of HIV infection. In particular the Strategy encouraged the exploration of overlap between public health responses to HIV/AIDS and hepatitis C, while also cautioning against detracting from the focus that should be accorded to HIV/AIDS.[87] However, this has led to confusion for managers and educators attempting to implement programs that fulfil these goals.

The second and third National HIV/AIDS Strategies have each attempted to refocus the seemingly narrow emphasis of education programs on preventing HIV/AIDS to the wider issue of promoting sexual health and, in some cases, the prevention of related communicable diseases. However, there has been limited further policy development in the area of sexual health, leaving educators without clear guidance as to goals and expected actions. The evaluation the second Strategy recommended clarifying what was meant by broader sexual health particularly in the absence of a national sexual health strategic plan.[88] However, this has not yet been developed.

Despite this lack of clarity the Review found that many educators already locate their HIV/AIDS activities within a broader sexual health context. This has been born from belief that HIV/AIDS activities are likely to be more effective if they focus more broadly on sexual health rather than on HIV/AIDS. Programs are also more likely to succeed if they address other factors that impact upon safe sex practice, and if they address clients' expressed needs, which may not always focus specifically on HIV/AIDS. For example HIV education activities with young homosexually active men who are just beginning to deal with issues of sexual identity inevitably address sexual identity issues as well as the ways in which HIV is transmitted and ways to avoid infection.

Incorporating education about other sexually transmitted or blood borne diseases into HIV/AIDS also occurs. For example many small group work education activities consistently incorporate a focus on other diseases. There have also been print media resources developed periodically addressing other diseases. However it is difficult to gauge the extent to which this is occurring, or more appropriately, whether greater effort is required.

Despite education interventions occurring in the context of broader sexual health, there is no consistent agreement about the need to address other communicable diseases or about the priority they should be accorded. Factors that appear to influence the extent to which individuals or services have extended their activities to include a focus on sexually transmitted or blood borne diseases are:

- whether there is a well funded sexual health infrastructure (eg sexual health clinics) already established;
- whether a community mandate has been given to the agency, particularly community-based organisations, to expand there focus beyond HIV/AIDS;

- whether, given the resources devoted to the education intervention, it can assist in achieving improved intermediate or health promotion outcomes among a population group;
- the impact of HIV/AIDS on a community, in comparison to the impact of other diseases.

These factors highlight the need for a more consistent national approach, or even a consistent approach amongst various state based agencies.

Hepatitis C

Hepatitis C is transmitted via infected blood. The main transmission pathway for Hepatitis C is through sharing of contaminated equipment by injecting drug users. Sexual transmission of hepatitis C is rare.[89] The third National HIV/AIDS Strategy refers to the need to explore the overlap between hepatitis C and HIV/AIDS efforts, yet the strategy does not provide strategic guidance or adequate description of this overlap. As a result this has caused some confusion as to implications for education efforts. The Strategy is about HIV/AIDS and responses to the HIV/AIDS epidemic. Hepatitis C is only discussed marginally and no strategic direction is suggested, though a National Hepatitis C action plan has been developed and evaluated.

Throughout the country agencies are responding differently. Amongst community-based organisations the response is also taking account of local context. The AIDS Council in Tasmania has formally adopted hepatitis C service provision and advocacy, alongside HIV/AIDS into its brief, and changed its name to more accurately reflect this new brief. The Tasmanian Council on AIDS and Related Diseases (TASCARD) has an active needle exchange, one of the few in the state, and found itself, as a result of the needs of clients of the exchange, doing more and more hepatitis C work.[90] Several other AIDS Councils, also with busy needle exchanges, are moving in similar ways.

For some of the larger states, where needle exchanges are more widespread, injecting drug users may not be a core part of the client group or constituency of the organisations doing gay men's education. As a result, they are less likely to take on hepatitis C as a key part of the organisation's focus. They are more likely to incorporate it into other parts of their work only as appropriate and, at times, work with user groups and hepatitis C groups on joint initiatives.

This Review has confirmed the need for a national strategic approach. In the meantime HIV/AIDS educators and their agencies will need to focus on hepatitis C where it is appropriate in their local context, most obviously when working with gay and other homosexually active men who inject drugs.

5.7 Conclusions

5.7.1 Method

- Australia's success in HIV/AIDS education[91 92 93] confirms the need to continue to actively involve gay men in all aspects of program planning and delivery. Efforts also need to continue to ensure the inclusion of gay men living with HIV in education initiatives.
- The mix of methods needs to be sustained. However better evaluation needs to occur to ensure ongoing adjustment of the mix of methods, to ensure that effective interventions are well documented, and that 'best practice' is systematically introduced across the country. The use of theory[94 95] to guide program development needs to be further encouraged, and an appropriate level of innovation[96] should be included.

The comprehensive mix of educational methods used has, undoubtedly, contributed to the population-wide achievement of improved health literacy. While it will be important to preserve a comprehensive mix in the future, it will be necessary to develop more evidence on the effectiveness of different methods with different target groups, and in different contexts. It will also be important to develop more sustained, consistent programs that are linked to the wider set of strategies that will be needed to maintain and improve on the success of the overall effort to control HIV in Australia.

5.7.2 Target groups

- Gay men should continue to be the principal focus of educational efforts. However further epidemiological research is needed to understand the risk posed to other homosexually active men (ie current levels of HIV infection).
- National initiatives for programs targeting non-gay identified homosexually active men need to be developed and systems established to improve communication and cohesiveness amongst various state-based programs.
- Aboriginal and Torres Strait Islander gay men should also continue to remain a priority and newly established programs targeting them need to be sustained and systematically evaluated.
- Prioritisation of target groups or health issues needs to occur using open and transparent criteria.
- As confirmed by several recent reports and projects, greater attention also needs to be given to the accessibility of programs for people from culturally and linguistically diverse backgrounds.[97 98]
- Young people in general, and young gay men in particular, constitute target groups that will require particular attention in view of their developing sexual identities and the likelihood of sexual experimentation during adolescence and young adulthood.[99]

For the future, the Review has pointed to the need to define target groups both more widely (as in the case of young people) and more narrowly to ensure that the differing needs and contexts of specific sub-groups of gay and other homosexually active men are addressed.

It has also highlighted the need for research to assist in ensuring that educational activities are developed with a view to ensuring equity – not only equity of access to educational activities, and but also to the achievement of equitable outcomes.

5.7.3 Content

- Multiple messages are appropriate given the changing environment and different ways that gay and other homosexually active men are responding to the epidemic. However 'basic' HIV/AIDS messages for people who are newly sexually active and continuity of message needs to be maintained.
- There is need to develop programs that encourage the development of healthy sexuality and safer sexual practice among young people.[100]

The Review has shown that the combination of well-executed, timely research and the active involvement of gay men in the development and delivery of education has been very effective in ensuring that the content of the education has been relevant and up-to-date, particularly in the large, urban centres.

The Review has also shown the need for such links between research and practice to continue and to be strengthened. It reinforces the powerful contribution that relevant research makes to effective interventions. In all, the Review has confirmed that the educational needs of gay-identified men have been well served by the educational response to date.

5.7.4 Agencies

- The roles and responsibilities of the different agencies involved in HIV/AIDS health education for gay and other homosexually active men will require continuous scrutiny and refinement by all members of the 'partnership'.
- Partnerships are a key component of the infrastructure needed to develop effective programs, to ensure efficient use of resources and to enhance the likelihood of achieving positive outcomes. The range of agencies among whom partnerships will be needed is likely to expand as the focus of education expands, more complex issues that are arising are addressed, and as it becomes clear that there is to be no simple method to prevent the spread of HIV nor to ameliorate its effects.
- The national and state systems that have been developed to engage key agencies in developing programs that are effectively responding to the changing environment need to be sustained and further developed.

5.7.5 Evaluation

The combined effect of all the activities designed to control the spread of HIV among gay and other homosexually active men has been the achievement of significant reductions in the incidence of HIV infection and in mortality from AIDS. There have been significant changes in the adoption of safer sexual practice among gay men, and there have been significant increases in the knowledge of the whole population of means of transmission of HIV and of means of preventing its spread.

It is possible to conclude that education has been a significant component of the overall response to the epidemic, measured in terms of volume of activity, although it is also true that education has been only one of the strategies used to control the epidemic. However, this review was unable to identify information that would allow the measurement of the contribution of education (alone) to the control of the epidemic. Nor has the Review been able to identify information to enable assessment of the relative effectiveness of different educational methods to the overall outcome.

The success of the overall effort to control the HIV epidemic in Australia across the population has tended to obscure the fact that there appear to have been few documented evaluations of the impact of different educational methods, and that there appears to have been only limited process or impact evaluation at the individual program level. There has never been a review of the relative effectiveness of different 'educational' methods in the achievement of the intermediate and health promotion outcomes achieved in Australia. These limitations have made it impossible to attribute the achievement of the control of the epidemic to any specific type of intervention.

Using the benchmarks outlined in the Jakarta Declaration it is reasonable to conclude from this review that the quality of the education of gay and other homosexually active men re HIV/AIDS has been sufficient to achieve significant improvements in health literacy and to contribute to the changes in risk behaviours, knowledge, and attitudes that, in turn, determine health outcomes.

There is need, now, for significantly improved documentation of the methods, target groups, reach and effectiveness of education programs and other interventions to reduce the spread of HIV among gay and other homosexually active men, and of the resources allocated to each. There is also urgent need to develop an evaluation framework that requires appropriate use of evaluation to assess the quality, impact and outcomes of different education programs,[101] and to assess the outcomes, more directly, of the combined educational activities on improvements in health literacy and its contribution to other health promotion and intermediate outcomes across the population.

In all, the Review found that the period of the third National HIV/AIDS strategy has been characterised by developing awareness of the need to assess the quality of individual education programs. As the sense of crisis has receded and as the field of HIV/AIDS education has matured, there has been a growing sense among educators and managers of the need for benchmarks of 'good practice' to guide their program development and delivery.

The challenge for the future is to develop such benchmarks for programs and to extend the use of theory as a guide to program development.

Chapter 6

Infrastructure

6.1 Infrastructure

In this Review infrastructure[102] refers to the *systems* for policy development, monitoring and surveillance, research and evaluation, workforce development and program delivery that direct and support action to promote, protect, and maintain health.

6.2 An effective infrastructure for the control of HIV/AIDS

The Review confirmed the findings of the second National HIV/AIDS Strategy that the development of an effective infrastructure to design, deliver, and evaluate the range of interventions (including diagnosis, treatment and care) required to control and combat the HIV/AIDS epidemic has been a major contribution to the success of Australia's initiatives.[103]

The combination of bilateral political support, leadership and advocacy from the gay men's community and other affected groups, a strong research base (including both epidemiological and social research), and effective partnerships between government, non-government and community organisations, and strong, community-based structures to design and deliver education programs (and other interventions) for gay and other homosexually active men, has been critical to the development of effective interventions to combat the virus.

Insofar as evidence is available, it appears that this infrastructure support is one of the factors that distinguishes the Australian response from that of many other developed nations.

6.3 Issues arising from the Review: maintaining and strengthening the infrastructure to direct and support HIV/AIDS education for gay and other homosexually active men

6.3.1 Leadership, direction and resources

The Review identified leadership, direction and resources as three key issues that must be addressed if we are to preserve structures and processes that have resulted in the success of Australia's response to the epidemic to date.

- **Policy support for education: the National HIV/AIDS Strategy**

The third National HIV/AIDS Strategy was developed for 1996-97 to 1998-99. This Review has confirmed that the development and implementation of the National Strategies has been crucial to the success of Australia's response. The National Strategies represent agreement among all the key stakeholders in the HIV/AIDS field about priorities across the whole range of actions needed to combat the epidemic. The Strategies have created a policy environment within which education has been a key element of action to address the epidemic. This has, in turn, ensured significant levels of resources have been allocated to education, and hence, a significant range of activity has been possible and sustainable over time.

Despite Australia's success in combating HIV/AIDS the need for education about HIV remains.[104] The National Strategies have ensured a national educational response to the epidemic. They have allowed each State and Territory to implement programs suited to their populations, geography, and resources, and have ensured nation-wide action.

- **National agreement on priorities and goals: the National HIV/AIDS Strategy**

The National Strategies have also enabled national priority population groups and goals to be established. This has ensured that harm minimisation has been adopted as a goal across the country, and that there has been national commitment to the achievement of goals. In the absence of the National Strategy it is likely that different States and Territories would have established different goals and that efforts would have been more fragmented and inefficient.

- **Resources**

The implementation of the National HIV/AIDS Strategies has been funded through a matched funding program (Specific Purpose Payment) that meant 'ring-fenced' funding.

Recently, as part of a wider national process of reform of health and other community-related services under the auspice of the Council of Australian Governments (COAG), agreement was reached between the Commonwealth and the States/Territories to establish broadbanding bilateral funding agreements that are intended to overcome the disadvantages of specific purpose payments. The purpose is to achieve greater coordination and integration of national public health strategies, in addition to simplifying administrative and financial arrangements in the short term and achieving greater flexibility in deploying funds to meet evolving public health priorities in the longer term.[105]

- **Potential threat in a changed environment: Public Health Outcome Funding Agreements**

There is concern amongst community-based organisations that the leadership that has been provided by the Commonwealth will be diluted and that the oversight of progress by the Public Health Partnership and ANCARD will be inadequate to ensure that there is a national, coordinated approach to education. There is also concern that the broadbanding of funding will make it difficult to safeguard the level of funding and intensity of the State/Territory education (and other) programs designed to combat HIV/AIDS, particularly among gay and other homosexually active men.

There is also concern that, at State and Territory level, consultation with the community and other members of the partnership on the inclusion of performance indicators has been inadequate. The Australian Federation of AIDS Organisations has been consulted by the Commonwealth Department of Health and Family Services on the development of indicators for inclusion in the Agreements. However the consultation revealed concern that the commitment in the third National HIV/AIDS Strategy to the development of valid, verifiable and reliable performance measures ***accepted by all parties***, including the community, has not been honoured by the States and Territories.

There is widespread support for efforts by the National Public Health Partnership between the Commonwealth and State and Territory Governments to improve national coordination and strategic approaches to public health. However the implementation of the Agreements has the potential to result in fragmentation of national effort, in a reduction of resources for HIV/AIDS in some States and Territories, and in a loss of focus on education (particularly for gay and other homosexually active men) as a central component of the HIV/AIDS program.

- **Potential opportunities in a changed environment: Public Health Outcome Funding Agreements**

While the broadbanding that will result from the Partnership Agreements does appear to pose some threat to the resources available for HIV/AIDS education for gay and other homosexually active men, more flexible funding will also mean that new opportunities arise. In NSW, for example, several new initiatives in men's health appear to offer the chance to develop strategic partnerships that have the potential to extend the range and reach of education for gay and other homosexually active men.

It will be important, as the Public Health Outcome Funding Agreements are implemented, to identify opportunities for joint action with other groups where it is possible to identify joint goals.

Conclusions

- The leadership and direction for HIV/AIDS education for gay men and other sexually active men that has been provided by the National HIV/AIDS Strategies needs to be preserved in the new environment created by the Public Health Outcome Funding Agreements.
- There will be a need to ensure that the Public Health Funding Outcome Agreements reflect the central importance of health promotion (including education), particularly for gay and other homosexually active men, to the HIV/AIDS outcomes.
- There will be a need to ensure that the coordinated national approach to HIV/AIDS health promotion is preserved under the bilateral Public Health Outcome Funding Agreements.
- There will be a need for the further development of performance indicators that are relevant measures of the outcome of the health promotion programs for gay and other homosexually active men. This will require the active engagement of community-based organisations as well as the State/Territory and Commonwealth health authorities. *(See Appendix 5 for examples of the types of performance indicators that could be developed)* •
- There will be a need to build a strong body of evidence of effectiveness upon which to base arguments for resources.
- Opportunities for working more flexibly with a wider range of partners within and beyond the health sector to promote the sexual health of gay and other homosexually active men will need to be identified.

6.3.2 Partnership

One of the strengths of the Australian response to HIV/AIDS has widely been acknowledged as the partnerships on which the National Strategies have been developed. The third National HIV/AIDS Strategy has been based upon partnerships between:[106]

- all levels of government – Commonwealth, State/Territory, and local;
- government, particularly health authorities, and communities, including communities made up of and representing people with HIV/AIDS;
- the research community and those involved in turning research results into practical outcomes;
- Australia and others in the international community;
- all levels of government, the community and the medical sector;
- all people of goodwill – those with the virus and those without – in politics, the community, the media and elsewhere.

The national partnership that has characterised the strategic and infrastructure response to HIV/AIDS in Australia is a model for organising responses to other health issues in Australia. However the Review identified, amongst the community sector, growing fear that the partnership approach is being threatened.

Conclusion

- The flexibility that the new Public Health Outcome Funding Agreements confer on the States and Territories means that it will be important for the HIV/AIDS sector to develop a range of strategic partnerships within and beyond the health sector. Such work will require the identification of potential partners with similar goals and the development of effective working relationships.[107]

6.3.3 Research

The Australian response to the HIV/AIDS epidemic has been underpinned by a strong research capacity. A recent publication specified the data that governments should collect on HIV and other STDs to enable the design and delivery of effective measures to reduce 'high risk' behaviour.[108] The recommended data were:

- levels and trends of HIV and other STD infections
- prevalence of high-risk behaviour and the characteristics of those who practice it
- the costs of interventions and their impact on HIV incidence, in addition to their impact on knowledge and behaviour. [Note: The authors of the report comment that there is 'much information on the impact of programs on knowledge and behaviour, but regrettably few studies of these behaviours on the incidence of HIV; fewer still have attempted to estimate cost-effectiveness'.]

The research program established in Australia in the 1980s has collected high quality data in the first two categories. The research has been of high quality and has been an essential component of the success of interventions to control the epidemic.

Stages of research and relevance to educators

However, the Review identified several ways in which the current research effort might be extended to strengthen the evidence upon which educational interventions are based.

In all, the experience of the HIV/AIDS program in Australia to date reflects stages that have been common in research in health promotion. The first stage is that of defining problems, identifying causal pathways, and identifying the scope for intervention. Epidemiology, demography, and community needs assessment are the major research methods used here. The next stage of research, using social, behavioural and organisational methods, is focused on solution generation. This stage sometimes includes theory development that identifies possible methods for achieving change in the personal, social and environmental characteristics that determine the health of populations.

These two inputs represent the basic building blocks for health promotion interventions. They describe a problem, identify determinants of that problem, indicate individuals and groups most in need of attention, and propose likely solutions.[109]

Stages three and four of the range of research required to assist practitioners (in this case, educators) to improve practice are solution testing and solution maintenance. Although this latter type of research provides information of great interest to managers and practitioners, it is this type of research that is least common in the health promotion research literature.[110]

In parallel with the stages of research, health promotion practice, too, tends to develop in stages – **reactive** (in response to a crisis), **responsive** (responding to expressed needs), and **planned** (based on systematic assessment of evidence).

This review has confirmed that these stages of research and of health promotion practice are consistent with experience in Australia to date. In terms of research, the greatest emphasis has been on stages one and two, and in practice, there has been movement through the reactive and responsive stages to recognition of the need for a more planned response that builds on evidence.

The new strategy provides an opportunity to recommend steps to improve the fit between research and practice.

Improving the fit between research and practice

This review identified three issues in relation to the research that has underpinned and guided HIV/AIDS education for gay and other homosexually active men.

1. Improving the fit between research and practice – mechanisms to improve communication and collaboration
2. Extending research to assist in generating solutions and to maintain positive changes in knowledge, behaviours and environments
3. Improving the dissemination and application of research findings to practice

- **Improve communication**

One of the more obvious approaches to improving the fit between research and practice is that of improving communication between researchers, managers and practitioners. The Review found that educators had been, to a large extent, satisfied with the extent of their influence on the research agenda of the major research institutions. Community representation on advisory committees, the appointment of Community Liaison Officers at the La Trobe Unit, and the close relationships between the Macquarie Unit, NSW Health, the AIDS Council of NSW and Australian Federation of AIDS Organisations were all valued as mechanisms for enabling close links to develop between researchers and practitioners.

Such mechanisms are one means by which to encourage the development of research that is viewed by educators as relevant to their work, as well as being a means by which to build the research skills of educators.

- **Collaborate on research policies, practices and innovations**[111]

While there were several examples of researchers responding to suggested research proposals from the community sector, there remains some concern about the way the current research priorities are decided upon. Particularly outside Sydney and Melbourne there is confusion and uncertainty about how educators can influence the research agenda. There is a need to ensure greater understanding of the decision making processes that determine research agendas, and to ensure the development of stronger partnerships between researchers and practitioners at every stage of research.

- **Collaborate to conduct research projects**

A further means to improve the fit between research and practice is for researchers and practitioners to collaborate on research projects. The model of collaboration that has developed between researchers and educators is important in ensuring the utilisation of research findings in developing education interventions. The Australian model of collaboration is not only recognised and praised locally, but also internationally.[112] The Review confirmed the need to maintain and extend such collaboration.

- **Extend research priorities to include solution generation and maintenance**

Using the analysis outlined above [8] the research conducted by the National Centre in HIV Social Research has concentrated on social, behavioural and organisational research to improve understanding of target populations, and the range of personal, social and environmental characteristics which may be modifiable, to form the *content* for intervention. Studies such as Sydney Men and Sexual Health, Melbourne Men and Sexual Health, Brisbane Region and Sexual Health, Futures Study, Male Call, Periodic Surveys are examples of research that educators across Australia have at their disposal when developing education interventions.

The National Centre however has also undertaken research which identifies emerging issues. Positive Living Utilising Treatment Options Study, Sero-converters study, Withdrawal study, The Sex Culture Project, are examples of this type of research.

There is widespread acknowledgment among educators, researchers, and service managers, alike, that this research has proven to be invaluable in directing both the national and local education strategies. The Centre has been able to extensively shape the Australian, and to an extent, international response to HIV prevention for gay and other homosexually active men. Furthermore, the research has been fundamental to the development of an understanding of the outcomes of the collective efforts of all activities directed to prevent the spread of HIV in Australia.

The Review identified some criticisms about the lack of research specific to the needs of some States, Territories, and rural areas. The Centres have clearly focussed on the populations at greatest risk. More than 60 per cent of diagnoses of people with HIV in Australia have occurred in NSW,[113] and therefore there has been a significant research focus in NSW. The current level of national research available, particularly Male Call, would seem appropriate, given both current epidemiological patterns and the limited resources available.

Given the success of the Centre in conducting research that has been valuable to policy makers and practitioners, alike, it is, again, timely to consider ways in which to strengthen the link between research and practice. This will mean, in part, extending the focus of research to include solution generation and maintenance.

- **Support systems for dissemination and utilisation of research findings**

Dissemination of research findings was also raised as an important ongoing issue. The Review identified several mechanisms that have resulted in research findings being used quickly and effectively in the development of education interventions:

- researchers reporting on their research findings at annual National Gay Education Conferences, and other conferences (eg Health in Difference);
- special forums and meetings to discuss research findings and their implication for education interventions;
- publication of reports or executive summaries that are aimed at educators and the community, and the timeliness with which this occurs;
- the willingness of researchers to provide special briefings to key stakeholders on important findings before the official release of data;
- the presence of researchers on advisory bodies developing education interventions.

The Review confirmed the need to continue such practices. However some of these approaches are less beneficial to educators outside the major cities and so further dissemination strategies should also be investigated to enable wider engagement of the full range of educators and researchers.

Worthy of note is the employment by the New South Wales Health Department, of a project officer to assist in developing the relationship between HIV/AIDS educators and researchers. This project appears to have been successful in developing a range of initiatives. Some of these include including organising forums so that new research findings can be presented and debated, developing initiatives that examine ‘best practice’, promoting research into the practice of education, initiating research into new and emerging interests. The applicability of this model nationally should be explored.

The generally strong focus on ensuring effective dissemination of research findings has meant that, on the whole, research appears to be widely utilised in developing education interventions. Many educators highlighted, as a good example of research being used to guide interventions, the identification of the widespread practice of ‘negotiated safety’ by researchers, which led to the development of education interventions that provided gay men with information on how to safely engage in the practice.

Continuing the strong collaborative approach that has developed between researchers and educators will ensure that research that is conducted will continue to be used to guide more effective health promotion practice. Research is needed not only to guide the content or focus of programs; but also to identify the most effective mix of strategies to used to bring about changes in knowledge, skills, behaviours, or policies and services.

Conclusions

- Improve communication
- Collaborate on research policies, practices and innovation
- Collaborate to conduct research projects
- Extend research priorities to include solution generation and maintenance
- Support the systems established to disseminate and ensure use of research findings

6.3.4 Evaluation

Australia's experience in responding to the HIV/AIDS epidemic is acknowledged internationally as having been one of the most effective in the world. The evaluations of the first and second national strategies have identified factors that have been responsible for this success – including a combination of technically effective education, treatment, and research and a level of infrastructure support that has provided leadership, direction, and the capacity to deliver effective interventions.

However, this review of HIV/AIDS education for gay and other homosexually active men has highlighted the extent to which we lack evidence of 'what works'. There has been extensive macro-level evaluation that has measured the gross effects of the range of education activities at national level. However, there has been only limited evaluation of individual programs.

The effectiveness of specific health promotion strategies (such as education, for example) can be measured only in terms of the 'outcomes' it is reasonable to expect. That is, education is best measured in terms of its contribution to improved health literacy; advocacy is more likely to contribute to social mobilisation, and to organisational and policy changes. But changes in behaviours (and health outcomes) across populations, particularly sustained changes, are the result of the combined effect of the achievement of health literacy on the part of individuals and communities, and changes in the environments and services that determine behaviours and attitudes.

It is usually impossible to identify single strategies that have brought about sustained changes in the health of populations – the combined effect of the five strategies outlined in the Ottawa Charter for health promotion is required to improve the health of populations.[114 115]

Finally, assessment of the effectiveness of health promotion in general and health education in particular cannot be confined to measures of change in individuals. Rather, it is increasingly clear that there is a need for indicators of the characteristics of environments, settings, organisations, policies and services that ensure that they are enhancing the capacity of communities and individuals to improve their health.

The implications for evaluation are that different levels of evaluation measure different levels of effect. Each measures different endpoints, using different criteria for success. Each is necessary at different points in program development, and each contributes something different to our understanding of 'what works'.

High quality epidemiological and behavioural data are the building blocks upon which effective evaluation must be based.[116] The challenge for the future lies in further development of the evaluation capacity that has been built over the last decade. This includes an extension of the range of evaluation carried out, an extension in the range of research methods used for evaluation, and further development of the tools that are necessary to measure the health promotion and intermediate outcomes that determine the health of, in this case, gay men and homosexually active men. It means shifting from macro-monitoring of indicators across the population toward a more substantial focus on program evaluation.

It also means developing the knowledge and skills of the education workforce in evaluation, and the further development of collaborative research.

Finally, it means developing organisational cultures that value and support evaluation to assist in their work. It also means ensuring that resources are invested in appropriate levels of evaluation.

Current evaluation of interventions

The Review was able to locate very few evaluation reports, either published or unpublished, on individual health education and promotion interventions. The poor response to requests for reports has being interpreted as indicating the general lack of evaluation reporting, an assumption largely confirmed during the consultation. However the poor response to requests for reports may have been due to the reluctance of educators and agencies to submit unpublished reports or because of a belief that the work may not have been of sufficiently high quality to submit to the review.

Also the lack of evaluation documentation should not be interpreted to mean that educators are not evaluating their work. The consultation showed that educators have a solid understanding of the effectiveness of their work, but are failing to adequately document and disseminate their findings. Such documentation is critical if lessons are to be shared across the country, particularly for more innovative or high risk strategies.

Developing evaluation practice:

- **Change organisational cultures to support evaluation**

To ensure the development of systematic evaluation, organisational culture needs to support, value and promote evaluation practices. To assist in the development of an organisational culture of evaluation, infrastructure needs to be developed to promote and support high quality evaluations.

- **Ensure adequate financial resources**

There needs to be allocation of adequate financial resources to the task by funding bodies and agencies that engage in HIV/AIDS health education and promotion.

- **Define roles and responsibilities**

One consequence of more clearly defined roles and responsibilities for the major organisations engaged in gay men's education should be the clearer definition of responsibility for evaluation. So that, for example, the Commonwealth, through the Public Health Partnership might take responsibility for health outcome evaluation, and for commissioning research that is required to generate population-wide solutions. On the other hand, the States and Territories might take up the challenge of dissemination research, and community agencies take major responsibility for the development and implementation of high quality interventions at the local and regional levels.

Projects such as the NSW Department of Health 'best practice' booklets may also be worthy of further examination as a way of evaluating and developing understandings of current practice.

- **Develop the knowledge and skills of educators**

There also needs to be realistic expectations of the level of evaluation expected from educators and support given to them to ensure they are adequately skilled to fulfil expectations. Training is essential to improve the skills of educators. Some evaluation, however, is best contracted externally to professionals with greater experience in evaluation and who can ensure a degree of objectivity.

Conclusions

- Change organisational cultures to support evaluation
- Ensure adequate financial resources
- Define roles and responsibilities for evaluation
- Develop the knowledge and skills of educators

6.3.5 Training and workforce development

A skilled and knowledgeable workforce is an essential element of an effective infrastructure for improving health. While the third National HIV/AIDS Strategy mentions the need to continually educate and train health care workers it does not make specific reference to the need to ensure adequate training for educators.

While training and workforce development may potentially be an issue for all those working in HIV/AIDS who, as part of their positions, are required to educate, it appears to be most significant for those whose sole or primary task is education. Community agencies, in particular, have identified systematic training and development of the workforce as a key issue.[117 118 119]

The training and skills development of HIV/AIDS educators and competencies that are lacking or need further development have been identified already in a comprehensive report for the Commonwealth Department of Health and Family Services (referred to as the 'Lowe report' in this document).[120] The findings of the Lowe report have been used extensively by this Review.

Current situation

The issue of training and workforce development needs to be located in an historical context. The strength of the Australian response to HIV/AIDS has been attributed to the central involvement of affected groups in planning, designing and implementing health promotion activities targeted at them.

Within Australia this has meant that many of the educators working with gay men tend to be gay-identified themselves. This approach has been reinforced by health promotion theory that emphasises the importance of genuine participation and partnership by affected communities in developing health promotion activities.[121] However the involvement of 'peers' in education has increasingly led to a debate about the need to professionalise the HIV/AIDS workforce.[122] [123] This debate about professionalisation of the workforce is not isolated to the HIV/AIDS field but has also been occurring in the broader health promotion field.[124]

There is a growing recognition that being a peer, while still essential, is in itself no longer enough. Professionalisation of the work is required. This will mean ensuring educators have the knowledge and skills required for the task. The increasing complexity of the task and increasing demand for better performance mean that professionalisation of the work is a high priority.

An important and related issue is the high workforce turnover reported by some agencies. While it varies across the country and agencies some community-based organisations in particular, continue to experience a significant turnover of both educators and education managers.[125] [126]

High workforce turnover is damaging to the ongoing effectiveness and efficiency of programs. Program implementation is inevitably interrupted during the process of recruiting and inducting new staff but also, particularly given the poor documentation of practice, there is a loss of corporate memory. During the early 1990s, for example, when some educators believe there was a lull in the quantity and quality of education programs, turnover of leadership and expertise was identified as a contributing factor.[127]

Current training and skills development activities

HIV Study Grants was established to ensure funds were available for training of the workforce. In NSW a comprehensive HIV study grants system has been established whose coordinator administers the grants, issues a six monthly calendar of training events and organises training forums. In other States and Territories community-based organisations report that HIV/AIDS study grant monies are hard, if not impossible, to obtain and there often remains a lack of clarity about how to access such money.

The Lowe report found that the transfer of HIV Study Grants to the Matched Funding Program in the second National HIV/AIDS Strategy resulted in the States and Territories no longer having to spend their money on training.[128] While accountability mechanisms were established, these requirements can be met without any specific allocation to training or development activities.

Throughout Australia specific HIV/AIDS training activities available to develop the skills of the workforce vary considerably. The bulk of training and development activities for educators appears to be made up of short courses and updates (eg update on new combination treatments, one day forums on new research findings).[129] These appear to be inconsistent throughout the country. Some specific HIV/AIDS courses have been offered, including a post-graduate course in HIV/AIDS at the University of Western Sydney and a three week training course in Evaluation and Research offered by the National Centre in HIV Social Research. These have met with mixed success.

Other training opportunities include a wide variety of short courses generally offered by community and welfare training organisations on skills relevant, but not specific to, HIV/AIDS. However it has also been widely recognised that most educators develop skills from learning on the job. At times there are more formal activities (eg induction programs, mentor programs) and at other times from more self-directed or informal activities (eg using manuals, literature reviews, working with other educators).[130] Within community-based organisations there has also been an increased emphasis on developing a culture of critical reflection.[131 132]

Annual conferences for HIV/AIDS educators, held by the Australian Federation of AIDS Organisations, were also identified as a valuable training and development opportunity. The conferences are seen as an opportunity to develop staff skills in new knowledge areas, provide a forum for specific training streams to enhance skills and improve knowledge and to provide the opportunity to develop networks for information sharing and support.[133]

Future training and development activities

The professionalisation of the workforce needs to be a high priority to ensure an improvement in the effectiveness of health education and promotion activities. Professionalisation and valuing of peers within the workforce are not mutually exclusive. Additionally agencies experiencing a high turnover of staff need to investigate the causes and possible solutions to address such a problem. Several reasons such high and ongoing turnover of the workforce have been proposed, including burn out, inadequate remuneration and lack of career structures.

The Commonwealth Government needs to take an active leadership role in developing the workforce, through ensuring the implementation of the Lowe Report. There is widespread agreement that the report analyses the problem well, and proposes many solutions which are appropriate. A variety of methods needs to be explored to achieve the goal of having a professional workforce capable of meeting the current challenges posed by the epidemic.

Conclusions

Some of the activities that need to be developed are:

- Accreditation of educator experience
- Promoting access to existing university courses in relevant disciplines
- Development of systematic national training on priority content specific issues
- Expansion of the national Gay Educators Conferences to ensure incorporation of additional training opportunities
- Systematic and formalised learning opportunities within the workplace (including an increased focus on critical reflection)

6.4 Program delivery structures

The national policy environment that encouraged a national approach to the development and delivery of education programs to gay and other homosexually active men has also valued and ensured a high level of involvement of community organisations in policy development and implementation.

The HIV/AIDS Program has developed strong partnerships among all key stakeholders to ensure not only that education is a central component of the response to the epidemic, but also that there has been an effort to develop approaches to program delivery that include national, State/Territory, and local level components. Over time, different approaches have been used, including some driven by the Commonwealth (e.g. large-scale, community wide paid mass media campaigns) and some driven entirely by local agencies. In each State and Territory, a partnership between the State/Territory health authority and the local AIDS Council has meant that the majority of the educational effort directed toward gay and other homosexually active men has been the responsibility of the AIDS Councils and other community-based organisations.

By the mid 1990s there was growing recognition of the need to address some gaps and inefficiencies that had developed. There was a recognition of the important role national bodies could play in ensuring increased collaboration and co-ordination amongst various state based agencies, including promoting better utilisation of resources, and to provide leadership in developing education practice and interventions in areas that had been neglected or under-developed.

The two projects outlined below are examples of steps that have been taken already to improve the national coordination and effectiveness of education action.

6.4.1 Gay Education Strategies project

In 1994 the Commonwealth Department of Human Services and Health provided funds to the Australian Federation of AIDS Organisations to:[134]

- develop and implement national campaigns targeting gay identified men which are aimed at refining safe sex culture;
- support and resource local communities in running campaigns which seek to reinforce and maintain safe sex culture.

The Gay Education Strategies project was to consist of two phases – a consultation phase and campaigns phase. The steering committee recommended that the consultation be expanded to look at all context and content issues perceived to be a current priority by HIV/AIDS educators, counsellors and general practitioners.[135]

At the time of this review, GES has developed a range of print media resources that are at different stages of implementation throughout the country. Implementation remains the responsibility of State and Territory AIDS Councils.

GES has also focussed on developing the capacity of AIDS Councils and other organisations working with gay men to respond to their local epidemics. This was not considered to be part of the brief of the project but arose as a result of the consultation phase which found there was a need to ensure a greater understanding of the changing relationship of gay men and communities to the epidemic and of ways to ensure that HIV/AIDS education was effective in such a changing climate.

GES has carried out capacity enhancement by:

- organising yearly conferences for gay educators;
- assisting in information sharing, networking and communication amongst education managers and staff;
- distributing key documents from the Internet and other sources that are of relevance to educators;
- development of discussion papers on challenges facing gay educators and theory that can be used to refine the work of educators;
- development and distribution of a manual on the production of print media resources;
- funding a series of innovative demonstration projects;
- piloting new training sessions for educators.

A process evaluation of the GES project has recently been completed by an independent evaluator.[136] The findings are compatible with the key issues raised in this review. The recommendations included that the Gay Education Strategies Project needs to continue with appropriate funding, and that its brief be formally extended beyond resource development to developing the capacity of educators working with gay men.

Other key recommendations in the GES evaluation, supported by the findings of this review are:

- the role and responsibilities of GES, AIDS Councils and related committees be clarified;
- the National Gay Educators' Conference continue to be funded annually;
- all national print media resources be market tested and all national campaigns be evaluated;
- all parties involved take steps to ensure that future campaign materials appear on time, including realistic planning, speedy and constructive feedback and speedy approval processes.

The project has confirmed that a national approach can lead to improvements in the effectiveness and efficiency of educational activities. It has also confirmed the need for continuous attention to be given to maintaining the infrastructure responsible for program delivery – at local levels in particular.

6.4.2 The Positive Information and Education Project

The Positive Information and Education (PIE) project, jointly managed by the Australian Federation of AIDS Organisations (AFAO) and National Association of People Living with HIV/AIDS (NAPWA), was established to examine the needs of, and to develop a national information and education strategy for, people living with HIV/AIDS.

The consultation phase of the PIE project identified a gap between education for positive men and gay men's HIV/AIDS prevention education. This was partially because recent developments in the treatment and monitoring of HIV and AIDS had resulted in a cross-over between the once discrete areas of prevention education and positive information and education.[137] For example new combination treatments have the potential to have an impact on gay men's commitment to adhering to safe sex practices. Understanding of viral load testing and viral load, once primarily the domain of treatment officers, has now become essential for educators because of its implications for HIV transmission.[138]

The PIE project also identified a strong feeling that gay educators, whose primary role historically has been prevention education, should expand their role to incorporate health promotion for people with HIV. There are several reasons for this:[139]

- The articulation of the needs of positive gay men occurred well after the structures in most community based organisations for delivering education were established. This, together with the increasing complexity of HIV treatments and the issues associated with taking them, means that either additional resources need to be allocated, or existing resources reallocated, to meet this need.
- Many of the skills and techniques used by gay educators can be applied to address the needs of positive gay men. The paradigms used in positive education and gay men's education are quite different and both could benefit from more collaboration.
- HIV prevention education includes and is targeted towards both HIV-positive and HIV-negative men. Acknowledging this has consequences for program design, assumed motivation and the scope of issues that needs to be considered. Depending on particular program objectives, different strategies have been used successfully. Sometimes, differentiated education is most appropriate (education which differentiates according to serostatus), at other times no distinction is required.

The priority that needs to be given to positive education throughout Australia varies and depends on factors such as HIV incidence, the visibility of people with HIV, and their ability to be open. Several different organisational solutions have been proposed to meet the needs of positive gay men. At AFAO and NAPWA, a decision was made to integrate positive education, gay men's education and treatments education into one new unit.

Local solutions will be needed to ensure positive education issues are addressed and prevention education activities continue to examine and incorporate the needs of HIV positive gay men. The release of the PIE strategy may also have future resource implications for local organisations.

6.4.3 Summary

These projects are two examples of the strength of developing a cohesive, national approach to program development and delivery. Each level of the system has different responsibilities. The needs and goals have been decided at the national level, together with some responsibility for resource development. However, individual program delivery has been tailored to local needs, in keeping with the context and resources available. Each, too, is seeking to identify and build on knowledge of effective methods to use to educate their different target groups.

As is the case with so much of the infrastructure developed to combat HIV/AIDS, the Review found much that is positive regarding the structures that have been largely responsible for the delivery of education to gay and other homosexually active men. The AIDS Councils appear to have been singularly successful in engaging with the State/Territory health authorities, and, through AFAO the Commonwealth, in developing and delivering effective education programs.

Conclusions

- A national approach to program delivery is needed to ensure that the most effective health promotion (including education) programs are delivered consistently and systematically, over time, across the whole of the gay men's and other homosexually active men's populations (which also take account of local differences).
- The roles and responsibilities of State/Territory health authorities and community based organisations need to be clarified to ensure that there is national coordination of goals and resources.
- The partnership between government and community based organisations at national level will require particular fostering under the Public Health Outcome Funding Agreements.

Appendix 1

Terms of reference – specific issues

The project is to specifically address the following but is not limited to:

Technical issues – improving the quality of interventions

1. Inform current and future practice on the effectiveness of Australian gay men's education programs since the onset of the HIV pandemic in modifying incidence rates and/or risk behaviour;
2. The basis of identified best practice and promoting the best use of limited resources, appropriate outcome based benchmarks for the purpose of assessing or re-appraising priorities;
3. The extent to which the education and awareness programs for HIV/AIDS respond to the rapidly changing HIV environment, especially in relation to advances in the treatment and management of HIV/AIDS. This should take into account how favourable publicity and media coverage of these developments may encourage incorrect perceptions about the HIV pandemic and underestimate the risk of infection;
4. The need for education and awareness programs and activities to be effective by reaching as many gay and other homosexually active men as possible, including men in suburban and rural areas, men from non-English speaking backgrounds, indigenous men and men with disabilities;
5. The need to understand and address prevailing community values in each of the gay, indigenous and wider communities in planning and implementing education and awareness programs and activities, depending on the audiences for those programs and activities;

Strategic issues – building alliances

6. The need to enhance links with other related strategies and policies, including the Indigenous Sexual Health Strategy, Hepatitis C Action Plan, and State and Territory health promotion activities in the context of national public health broadbanding;

Infrastructure development – building a system to plan and deliver effective education

7. The role in education and awareness programs and activities of gay men's educators, health care workers, peer groups, general educators and other health care professionals, including their recruitment and training;
8. The range and mix of activities being undertaken specifically by the Commonwealth Government in funding and/or approving components of education and awareness programs and activities;
9. The need for education-related research strategies, and the quality and diversity of the available research resources; and
10. The appropriate levels of resources which should be allocated to encourage good practice in education and awareness programs and activities, while taking into account the benefits of effective measures of this type in reducing the treatment, personal and social costs of HIV/AIDS.

Appendix 2

People and organisations consulted

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AIDS Council of NSW
New South Wales

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Australian Capital Territory

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Victoria

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Service Against Male Sexual Assault
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Western Australian AIDS Council
Western Australia

Beer, Mr Ken
Wombats
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Queensland AIDS Council
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Bonney, Mr John
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Brew, Mr Ralph
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Victoria

Browne, Mr Kel
Gold Coast Hospital
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Bruce
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Hepatitis C Council of Victoria
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Cantwell, Ms Melanie
Aids Action Council
Australian Capital Territory

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Phoenix
Western Australia

Church, Mr Murray
South Australia

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South Australia

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CAPE Centre
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South Australia

Evans, Mr Terry
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South Australia

Fazulla, Mr Neville
Queensland AIDS Council
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New South Wales

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New South Wales

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Appendix 3

Written submissions received

1. Australian Federation of AIDS Organisations
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2. Bartos, Mr Michael
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   Victoria
3. Brew, Ralph
   Family Planning South Australia
   South Australia
4. Erskine, Mr Stephen
   Australian Capital Territory
5. Gay and Married Men's Association Project
   Victoria
6. Health Services Policy Branch
   New South Wales Department of Health
   New South Wales
7. Lowe, Mr David
   New South Wales
8. National Centre in HIV Social Research
   Macquarie University
   New South Wales
9. Queensland AIDS Council
   Queensland

Appendix 4

Activities for gay and other homosexually active men in Australia since 1995

STATE	AGENCY	PROGRAM TITLE	TARGET GROUP AND STRATEGIES	REPORTED OUTCOMES	FUNDING
ACT	AIDS Action Council ACT	MAGNET Mature Aged Gay Network	30 Plus Support and Information for mature men who have sex with men	66 members Regular meetings and workshops	Volunteers only No funding Support from AAC
ACT	AIDS Action Council ACT	Happy Healthy and Gay	26 Plus Workshop for gay and bisexual men Health, relationships and sexual issues discussed	All courses full Ongoing support network	Supported by AAC Volunteers conduct workshops
ACT	AIDS Action Council ACT	Community night	All new community members 6pm Tuesdays Hosts people and gives out local information Ongoing support and info for all Gay, Lesbian and Transgender communities	Regular attendances plus 12-30 people each evening	Volunteer only No funding Supported by AAC
ACT	AIDS Action Council ACT	First Step	Young (age<26) homosexually active men (HAM) A series of six peer-education workshops exploring sexuality and related issues for young men The course provides information, support and referral, as well as networking young ACT HAMs	94/95: Course was conducted three times, with a total of 26 participants for the year 95/96: Course was conducted twice, with a total of 22 participants for the year 96/97: Course was conducted twice, with a total of 17 participants for the year.	No explicit funding Facilitators are young gay/bisexual volunteers, trained by AAC. AAC used as a venue Administration by Education Unit Officer
ACT	AIDS Action Council ACT	Positive Support Network	Primary: People Living with HIV/AIDS Secondary: Partners, family, friends of primary target group Weekly social/support meeting with meal provided Informal group discussion on topical issues for PLWHAs Support worker provides regular updates on areas of interest to PLWHAs Open to partners, family, friends on advertised occasions	94/95: A total of 15 clients participated in these evenings, with an average attendance of 8 95/96: 17 positive people involved in the project (average: 7) 96/97: A total of 24 clients participated in these evenings, with an average attendance of 9	AAC budget allocation for catering as required, however most meals are provided by AAC volunteers Education Unit Officer and PLWHA Support workers assist on evenings

ACT	AIDS Action Council ACT	Beat Outreach Project	Primary: Non-gay identified men who have sex with men Secondary: Homosexually active men who use beats Outreach activity and the distribution of resources/ hardware in those environments where men engage in sex with each other The project: – provides accurate and appropriate information about HIV transmission and safe sex among men who use beats – HIV testing among men who use beats, within the context of health promotion – provides accurate and appropriate information to people living with HIV about health monitoring and maintenance – fosters the development of supportive and accepting attitudes among men who use beats towards HIV positive people	94/95: The project made 418 direct contacts, distributed 4,950 condom packs and coordinated a Winter Beats Party at a local SOPV which was attended by 100 men 95/96: 3,475 condom packs were distributed. A total of 322 client contacts from 334 outreach hours 96/97: The project made 589 direct contacts from 360 hours outreach	The project relies on funding from the AIDS Action Council to provide resources and hardware for distribution The project is administered by the AAC Education Unit
ACT	AIDS Action Council ACT	Gay Information and Counselling Service (GICS)	All homosexually active men A confidential peer-based telephone service for the ACT and surrounding areas. The GICS service is provided by trained gay and bisexual volunteers of the AAC. Operates Monday to Friday 6pm to 10pm Provides information, support and referral; for all ACT HAMs	94/95: The service received 8983 calls, was supported by 1,256 volunteer hours. Two training courses trained 11 new volunteers 95/96: A total of l569 calls were taken by volunteers who gave 870 hours. Two training course trained 9 volunteers 96/97: The service received 639 calls, was supported by a team of 21 volunteers, who provided 472 hours. Two training courses trained 12 new volunteers	

ACT	AIDS Action Council ACT	Man to Man	Non-gay identified men who have sex with men Utilises the existing GICS infrastructure to provide a similar service to non-gay identified men who have sex with men. The service operates Saturdays, from 1pm to 5pm	96/97: The project received 157 calls and trained 13 volunteers in issues for men who have sex with men	This project was funded from a successful 1996 grant application, and supplemented with AAC funding – $20,000 The project was administered by AAC Education Unit
ACT	Family Planning	Various: Professional Development Courses for Teachers	Secondary students Activities which address gender role, sexual orientation and sexual health	Increased knowledge of sexual health Greater understanding of social influences concerning gender role and attitudes towards homosexuality and heterosexuality Increased acceptance of homosexuality as a choice for oneself or for others	AIDS matched funding (to date)
ACT	ACT Division of General Practice	HIV/AIDS Project	HIV positive people and GPs providing their health care	External evaluation conducted	ACT Division of General Practice
NSW	Australian Federation of AIDS Organisations	Gay Education Strategies Project	Gay men Aims are to: • develop and implement national campaigns targeting gay identified men which are aimed at refining safe sex culture; • support and resource local communities in running campaigns which seek to reinforce and maintain safe sex culture.	17 campaigns have been developed. Evaluations in progress. External project process evaluation conducted	Commonwealth Department of Health and Family Services
NSW	Central Coast Area Health Service	Coastline ’97	Men who have sex with men. Three month phoneline to provide information and referrals to men who respond to adverts in local paper.	Improved access to relevant health services Improved access to social groups Improved access to printed resources regarding male sexual health issues	$15,000
NSW	Multicultural HIV/ AIDS Service	Ethnic Media Project	18 language, press and radio Media advocacy strategy	320 instances of print and radio coverage across all 18 languages	$80,000

NSW	Multicultural HIV/ AIDS Service	Positive Information and Education Project	PLWHA from NESB Provision of culturally relevant treatments, information and the development of a strategic response to HIV+ and NESB issues	The provision of a strategic action plan focussing on positive NESB issues Resources in LOTE for treatments	Sourcing
NSW	Multicultural HIV/ AIDS Service	Chinese Project	Gay and other homosexually active men from Chinese background Culturally relevant resources in Chinese for target group	Safe Pack in Chinese and an audio resource in Cantonese and Mandarin	Nov 1997- May 1998
NSW	HIV and Infectious Diseases Unit South-eastern Sydney Area Health Service	Beats Project	Outreach to gay, and other homosexually active men at beats Education on safer sex behaviours and referral to services Emphasis on outreach to men from a NESB	N= 723 Written information distributed to 35 per cent of men Verbal interaction with 74 per cent of men Condom and lube distributed to 44 per cent of men	$73,000 p.a.
NSW	HIV and Infectious Disease Unit South-eastern Sydney Area Health Service	Youth Beats Project	As above, however, with 2 young gay men employed to specifically target men under 30 years at beats Six week project, 20 hours per week	N= 73 Verbal interaction with 88 per cent of men Research based information collected rather than evaluation of program	$3,600
NSW	HIV and Infectious Disease Unit South-eastern Sydney Area Health Service	Gay and Lesbian Youth Social Support Network GLYSSN	Young gay and bisexual men in Southern Suburbs Social and educational meetings twice a month Utilising peer support	N=11 Information needs about STDs and safe-sex was met for 100 per cent of those requesting it	$3,000 (+ 0.5 project officer)
NSW	HIV Prevention Service Illawarra Area Health	Start Making Sense Workshops	18-26 yrs Gay; Bisexual; Curious A workshop based on 'Fun and Esteem" for Illawarra Shoalhaven Run when required (advertised local papers/radio)	Peer education Self esteem Coming out Sexuality HIV/AIDS/STDs/HEP A,B,C Social contact	Illawarra Area Health Service

NSW	HIV Prevention Service South-eastern Sydney Area Health Service	Illawarra and Shoalhaven 'Mens Line' * *Planning stages	Phone line Confidential referral service for men and men's issues	Anonymity Reaching wider community of 'hidden' target group MSM identifying and non Increase awareness of safe sex, HIV/ AIDS etc.	IAHS
NSW	HIV Prevention Service Illawarra Area Health	Illawarra and Shoalhaven G.I.N.G.H.A.M. Steering Committee	Gay Identified/Non Gay Identified Homosexually Active Men Key stakeholders input into future planning, direction outcomes Bringing together local service Reorientation around sexuality issues	Reorientation local community services Sense of ownership Increase skills Streamline future projects	IAHS
NSW	HIV Prevention Service Illawarra Area Health	Beat Outreach Illawarra, Shoalhaven	Diverse cross section Peer education/ Confidential referrals Education Training volunteers	To become familiar with clients – referral Work with representatives	IAHS
NSW	Mid-North Coast Health Service Central Sector	HIV Support	People living with HIV/AIDS in the Central Sector To disseminate information regarding new treatment options through relevant newsletters and social groups To be available to the target group to discuss treatment options and life style issues Provide in service education and individual consultation to Health Service staff to assist in providing quality service to PLWHA Promote the involvement of Medical Officers in the HIV Medicine Program Increase the level of awareness in the broader community of issues surrounding HIV to promote social tolerance and acceptance of PLWHA	By June 1998, three documented service promotions will have occurred. Records on numbers of enquires and referrals will have been maintained In service education and consultations with Health Service staff will be documented. At least five in service education sessions will have been provided. At least three individual consultations will have occurred. There will be one additional Medical Officer who will have completed the HIV Medicine Course. There will be at least two HIV related Media Releases produced and published	From within the HIV/AIDS Service budget

NSW	Mid-North Coast Health Service Central Sector	Venue Support	Men who have sex with other men Be available to speak with men at these venues to discuss safer sex and issues associated with behaviour change to incorporate safer sex practices into their sexual activity Deliver HIV and STD safer sex messages at these venues To supply persons accessing these venues with condoms, lubricant, and written material regarding safer sex	There will be a documented increased output of condoms and lubricant at these venues Persons frequenting these venues will seek out the worker for condoms, lubricant and further information regarding HIV and STDs Persons frequenting these venues will be in a position to educate their peers regarding safer sex, HIV and STDs	From within the HIV/STD Services budget
NSW	National Centre in HIV Epidemiology and Clinical Research	Sydney Men & Sexual Health (SMASH)	HIV-related policy development and service delivery staff Provide accessible reports and feedback on research and data analysis	Various project reports, conference presentations and staff workshops. Re: descriptions of samples, trends in HIV testing, unprotected anal intercourse and treatment uptake, and risk factors for unprotected anal intercourse and seroconversion	Commonwealth Health, NSW Health, National Centre in HIV Epidemiology and Clinical Research, National Centre in HIV Social Research
NSW	National Centre in HIV Epidemiology and Clinical Research	Sydney Gay Community Periodic Survey	HIV-related policy development and service delivery staff. Provide accessible reports and feedback on research and data analysis	Various project reports, conference presentations, and staff workshop Re: descriptions of samples, trends in HIV testing, unprotected anal intercourse and use of treatments	NSW Health, National Centre in HIV Epidemiology and Clinical Research, National Centre in HIV Social Research
NSW	National Centre in HIV Epidemiology and Clinical Research	Seroconversion Study	HIV-related policy development and service delivery staff. Provide accessible reports and feedback on research and data analysis	Various conference presentations and staff workshops Re: risk factors for HIV seroconversion	Commonwealth Health, National Centre in HIV Epidemiology and Clinical Research, National Centre in HIV Social Research

NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Beat Outreach	Homosexually active men (gay & non-gay identified) Provide access to information and resources to men who access beats for sexual and social purposes To increase the sexual health status of the target population	Provision of safe sex resources and information Skills development Advocacy for beat users	Department of Health
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Young Mens Social Group	Homosexually active men (gay & non-gay identified) Provide a supportive and safe environment for young homosexually active men and their friends To increase the sexual health status of the target population	Creation of supportive environment Skills development	Department Health and Local Government
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	BeatNet	Health Care Workers who work in the field of Beat Outreach aimed at homosexually active men (gay and non-gay identified) To develop partnerships and coalitions with other agencies To provide a forum for information exchange and encourage innovation in health education	Monthly meeting Attendance Problem solving and the development of new and innovative strategies	Department of Health and NGO
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Men's Sexual Health Resource	Men, including homosexually active men (gay and non-gay identified) To produce an up to date sexual health resource aimed at men (generic, non-identifying), to provide easily accessible non threatening sexual health information	Preliminary phases	Department of Health and NGO/ Private Sector
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Internet Project	Homosexually active men (gay and non-gay identified) To provide accurate information on sexual health and related issues for the target population To provide a means to assist target population to make contact with sexual health clinics, support groups and other appropriate agencies To provide a medium for the discussion of sexual health issues using IRC	Preliminary phases Establishment of Internet site for NSAHS HIV & Sexual Health Number accessing site Establishment of IRC room around HIV and sexual health related issues for HAMs	Department of Health

NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	NESB Forum	Health Care Providers who have access to Homosexually active men (gay and non-gay identified) To improve access and equity for HAMs through educating Health Care Providers around issues facing this target population	Provide strategic direction for services Establish networks between ethnic communities and key HIV/AIDS and sexual health organisations/HCW	Department of Health
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Farsi/Darsi Project	Armanian, Iranian and Afghanistanian communities of NSAHS, Homosexually active men (gay and non-gay identified) To determine sexual health needs of this emergent community	Provision of culturally appropriate education. Increased awareness and understanding of sexual health	Department of Health
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Northside Gay Men's Research	Research project aimed at gay identifying men living on the northshore of Sydney Harbour Using qualitative methodology to uncover attitudes and beliefs to sexual health, HIV and other STDs	Understand the local population Provision of culturally sensitive services	Department of Health
NSW	Northern Sydney Area Health Service HIV & Sexual Health Promotion – Men's Portfolio	Men's Sexual Health Project	Development of a broad based program for non-gay identified men to present for regular sexual health check-ups	Normalising of sexual health check-ups	Department of Health
NT	Northern Territory AIDS Council	Mensline Telephone support and information referral	MWM; gay/bisexual; anonymous Confidential peer support Territory-wide	Will begin May 1998	G.E.S AFAO
NT	Northern Territory AIDS Council	'Relationship' Campaign	Men in same-sex relationships To educate men about 'negotiated safety' through gay media	To be evaluated in June	G.E.S
NT	Northern Territory AIDS Council	Beats Outreach Education	MWM at beats Volunteer driven in providing information and safe sex information/ condoms/lube	Pilot program beginning April 1998	AIDS Council Funding through Territory Health

NT	Northern Territory AIDS Council	Gay Indigenous Men's Support Group	Gay/bisexual MWM Indigenous men Social and support Safe sex information	Increasing numbers attending the group Building a sense of a gay indigenous community Breaking down the isolation felt by Indigenous men	
QLD	Brisbane Sexual Health Services	Sex-on-premise venue clinical services (SOPV)	Homosexually active men	Report completed	AIDS (Commonwealth)
QLD	Brisbane Sexual Health Services	Commercial sex workers an clinical services (SQWISI)	Male sex workers, partners and clients	Report completed	Special initiatives (State)
QLD	Brisbane Sexual Health Services	Participation in QuAC programs (HEMP, EAC)	Homosexually active men	Post – BRASH survey of behaviour, initiation of local periodic study	Nil (Base budgets)
QLD	Brisbane Sexual Health Services	Injectors Health Clinic	Injecting drug users, particularly homosexually active injectors	being evaluated	AIDS (Commonwealth)
QLD	Brisbane Sexual Health Services	Gonorrhoea Surveillance Program	Homosexually active men who attend SOPV PCR screening of patrons attending various venues Community awareness campaign	Report completed	Pharmaceutical Company (State Based)
QLD	Brisbane Sexual Health Services	Mobile outreach	Male sex workers and beat users. Mobile clinical outreach to areas frequented by young opportunistic male sex workers and beat users	Recently commenced	Special Initiatives
QLD	Brisbane Sexual Health Services	Community Awareness	Gay community members Use of gay media to raise issues of sexual health	On-going	State-based
QLD	Brisbane Sexual Health Services	Hep A Vaccination Program	Patrons of SOPV community awareness, campaign strategies to increase uptake of vaccination	On-going	State-based
QLD	Gay and Lesbian Health Service	GLADS: Gay and Lesbian Alcohol and Drug Support Group	An open, non-judgemental, safe space where people of all sexualities can address issues of drug and alcohol use, dependency and recovery. Individual value and self honesty is respected (weekly group)	Personal safety, personal freedom and individual decision and self control achieved at persons own rate	No funding
QLD	Gay and Lesbian Health Service	MARS: Men affected by rape and sexual abuse	Men who have been raped or sexually abused (weekly group) Used by 122 men in last five years (out of 370 men who have sought help via our clinic)	Minimising depression, isolation, self harm, alcohol and drug dependency, and acting out behaviour including aggression	No funding

QLD	Gay and Lesbian Health Service	GAYABLE	Gay and Lesbian People with a disability Forums Networking Social events	Program folded after two years of trying (1995 – 1997)	Nil
QLD	Gay and Lesbian Health Service	Gay and Lesbian Health Service – itself	Gay/Lesbian/Bisexual/Transgender and the non-identifying community of Brisbane Developed testing campaigns Sauna and premises outreach clinics Printed Hepatitis A and B vaccination brochures HIV risk awareness comic book to help individuals identify and verbalise risks and responses	Wide community utilisation	Clinic runs on Medicare funding in contact with QuAC. Some specific grants for projects
QLD	Queensland AIDS Council	Indigenous Program	Indigenous gay, MSM and Transgender Liaison with Indigenous Health Workers Community work and community development with urban and rural indigenous communities Developing contacts with indigenous MSM in prisons	Established 2 support groups: Brisbane and North QLD Within indigenous communities raised awareness around Gay, MSM and transgender issues Raised HIV/AIDS awareness amongst MSM with particular emphasis in prisons	$105,568 for two workers and program 1997 – 98 financial year through national Indigenous Australian Sexual Health Strategy
QLD	Queensland AIDS Council	Regional Response Action Plan	Non gay identifying MSM Volunteer peer based education Telephone contact and referral line Beat outreach Promoting health public policy with local authorities	Operates in 11 areas across the state Currently 64 volunteers Telephone line has 81 per cent calls from target group 59 per cent in ongoing relationship with women while MSM Increased knowledge of safe sex and HIV prevention	$75,600 in a financial year
QLD	Queensland AIDS Council	Gay Men's Education Courses	Gay men of all ages Five forums & workshops on issues relevant to HIV prevention Issues covered included: • Sexual health • Relationships • Communication	Increased knowledge of STDs Improved skills in: • Communication • Assertiveness • Negotiation Promoting community discourse on matters relating to healthy gay lifestyle	$3,850 for one financial year

QLD	Queensland AIDS Council	Health Enhancement and Monitoring Program	People Living with HIV/AIDS A co-ordinated team consisting of Treatments Officer Peer Education Officer Publications Officer Community Development Officer Community Centre Worker Using each discipline to develop strategies to increase PLWHA capacities to enhance health	Publication of six magazines per year Treatment updates in all regions Capacity development training in • Public speaking • Informal referral • Advocacy • Peer support	$139,000
QLD	Self-health for Queensland Workers in the Sex Industry (SQWISI)	Male and Transgender Project	Male and transgender sex workers – private, parlour, street and beat SQWISI conducts sexual health workshops to educate target groups to reduce transmission of STI and HIV. For workers in the regions, a SQWISI staff member conducts a regional tour every six weeks to educate and support the isolated sex workers. Production of a bi-monthly magazine (‘Respect’) containing health related information and education material on the law, tax and safety issues. Designed to empower the workers.	Sex workers have a very low rate of STIs /HIV, and a good understanding of STIs/HIV. SQWISI operates the second largest sexual health clinic in Queensland.	Queensland Department of Health HIV and AIDS matched funding
QLD	Self-health for Queensland Workers in the Sex Industry (SQWISI)	Support Information and Referral (SIR) Program	Male opportunistic sex workers that operate in and around Albert Park In conjunction with Brisbane Youth Service (BYS) an outreach program is run, that supplies our target group with support, STDs and HIV/AIDS information, counselling, legal information, condoms, lube and needle exchange. This outreach program operates one night per week.	Establishing the trust of our target groups has been the most difficult obstacle. However, once that was achieved, we were able to talk to the boys and ascertain their immediate difficulty. We supply them with the relevant information or refer them to the most appropriate service if we are unable to help. There has been an increase in the number of male sex workers utilising the other services that SQWISI offers, because of the promotion through this program.	Queensland Department of Health HIV and AIDS matched funding

QLD	Self-health for Queensland Workers in the Sex Industry (SQWISI)	Support Education and Referral Van (SERV)	Male opportunistic sex workers that operate in and around Albert Park After running the SIR project for 12 months, we have noted a rise in the number of male sex workers who have identified a need for sexual health checks. We now have strong links with Drug Arm and we are working on a three- month pilot program. This new project will be a mobile sexual health clinic, where Drug Arm will provide the van and the two volunteers and our SQWISI clinician will provide the medical testing and treatment.	Three month pilot program The goal, after three months, is to take this service into the Fortitude Valley area to assist the Health Education and Referral (HER) Project. This is another outreach program that we have been running to supply the same support, educational and referral services to the transgender and female sex workers, and the occasional male sex worker in the Valley area. Drug Arm now has a better understanding of our target group and a more proactive approach to outreach. This new mobile can be used by other community-based organisations.	Queensland Department of Health HIV and AIDS matched funding
SA	AIDS Council of South Australia	Gay Men's Health Metropolitan Project	Gay men interested in the topic of relationships: Workshop courses (at 18 hours) with group directed agenda, held in suburban areas Gay man who are unemployed: Workshop course (15 hours), group directed agenda, suburban based Gay men seeking social connections and support: Monthly drop-in, 36 hours per year, volunteer driven, ice-breaker and conversation starter activities	26 participants, outcome evaluation in progress 9 participants, outcome evaluation in progress, group members initiate and direct on-going support group to find gay-friendly job vacancies and to develop skills Attendance since June 1997: 245 (rising from 11 to 32, current average 22)	$10,000
SA	AIDS Council of South Australia	Sauna Smart	Men who use saunas Chat to project officer to receive free pass to SOS venue Talk to project officer again after visit Sauna visit used as a contact with peers Re: intervention unsafe sex	Sauna users report to project officer regarding sauna culture Sauna users talk to peers regarding sexual behaviour, unsafe sex etc... Sauna users intervene in unsafe sex in group areas	South Australian Health Commission

SA	AIDS Council of South Australia	Beat Outreach	Men who use beats Project officer visits beats and chats to users regarding HIV/AIDS, sexual health Beat users meeting held monthly Beat users chat to peers at beats and pass out condoms while visiting beats	Beat users distribute condoms at beats Beat users get together and talk about sex Beat users encourage peers to practice safe sex while at the beat	South Australian Health Commission
SA	AIDS Council of South Australia	BAHMM Phoneline	Bisexual and married guys A weekly phoneline – guys can chat to peers or project officer about their issues Calls include safe sex information and information on weekly confidential meetings	Callers get info on safe sex/HIV/AIDS and support social group Callers can talk to someone confidentially	South Australian Health Commission
SA	AIDS Council of South Australia	BAHMM Group	Bisexual and married guys Weekly meeting to bring guys from similar backgrounds together to chat about issues including sexual health and HIV/AIDS	Attendees have a chance to talk about common issues and receive information on HIV/AIDS and sexual health	South Australian Health Commission
SA	AIDS Council of South Australia	South Australian Sex Industry (SIN)	Male Sex Workers To provide information about HIV/AIDS, Hepatitis and other STDs to male sex workers within a broad, participatory, health promotion framework To advocate for male sex workers in legal, health and occupational issues To increase the availability of condoms and water based lubricants to male sex workers To develop an appropriate outreach service to male sex workers To develop the participation of members of the male sex worker community in the activities, projects and planning of SA SIN	Questionaries have been circulated to male sex workers to ascertain their requirements of SA SIN – workshops are being formulated to address HIV/AIDS, Hepatitis and other STDs Pamphlets will be designed, also a video of,and for, male sex workers to be used a resource materials On the 15/4/98 the South Australian Prostitution Law Reform Forum will take place An increase in safe sex products has been noticed Community participation is actively encouraged through luncheons communication etc...However, it is an on-going process	$125,00 This is divided depending on numerous needs – issues etc… There is no set amount for the male sex worker project

SA	HIV/AIDS Worker Training Project/Cope	HIV Orientation Training	Three-day orientation training for HIV sector workers and volunteers	HIV information • Biological • Psychological • Social Understanding the impact of HIV Network and support Understanding the sector	HIV/AIDS matched funding SAHC
SA	HIV/AIDS Worker Training Project/Cope	Worker Training and Development	HIV funded workers, volunteers and agencies Coordinating the development and delivery of education and training	Worker training and delivery targeted to the needs of sector Responding to worker and agency needs	HIV/AIDS matched funding SAHC
SA	HIV/AIDS Worker Training Project/Cope	Block out	Workers and volunteers in the HIV sector, allied health and community sector	Challenge attitudinal restraints towards service delivery to gay and homosexually active men	HIV/AIDS matched funding SAHC
SA	HIV/AIDS Worker Training Project/Cope	Rural Training	Workers in rural communities	Improving service delivery to target populations identified in the strategy, particularly gay and homosexually active men	HIV/AIDS matched funding SAHC
SA	HIV/AIDS Worker Training Project/Cope	Tertiary Educators and students	Tertiary Contribute to relevant programs Advise on interpretation of HIV within curriculum Advise of delivery	Embedding HIV in curriculum Targeting attitudinal restraints	HIV/AIDS matched funding SAHC
SA	HIV/AIDS Worker Training Project/Cope	Industry Project	Delivery of HIV information • Biological • Psychological • Social to workers in industry in the Northern suburbs	Information provision Dispelling myths Challenging discrimination	Levis
SA	Rosemont	Support	Gay men over 30	Knowledge in issues of grief /loss Alternative therapies Vocational courses	SA Health Commission
SA	Rosemont	Support	Community	Computer training Awareness of programs and functions	A.C.E Training
SA	Rosemont	Positive Speaker Bureau	Gay Community	HIV positive speakers talking to gay community groups	Red Ribbon Fund

TAS	Tasmanian Council on AIDS and Related Diseases	Beat and Venue Outreach	Gay men and other MSM	July 1997 – April 1998 890 contacts	$3000 (Trust)
TAS	Tasmanian Council on AIDS and Related Diseases	Peer Support	Gay men and other MSM	July 1997 – April 1998 80 contacts	$3000 (Trust)
TAS	Tasmanian Council on AIDS and Related Diseases	Bass Straight Campaign	Gay men and other MSM	68% of those surveyed had seen campaign materials	$11,000 (AFAO)
TAS	Tasmanian Council on AIDS and Related Diseases	Rickline	Gay men and other MSM	July 1997 – April 1998 178 contacts	$6000 approx per year
TAS	Tasmanian Council on AIDS and Related Diseases	Health Promotion Co-ordinator (Gay education programs are only one area of responsibility)	Gay men and other MSM • Peer support • Counselling • Community development • Bfriend • Working it out • Police liaison • Anti-homophobia	July 1997 – April 1998 139 contacts • Report released • Recruit training etc • Ongoing	$31,000 (core)
TAS	Tasmanian Council on AIDS and Related Diseases	Northern Co-ordinator (Gay education programs are only one area of responsibility)	Gay men and other MSM • Drop in centre • Peer support	July 1997 – April 1998 95 contacts	$28,000 (core)
VIC	AIDSLINE	AIDSLINE Telephone Counselling	All at risk groups and the general population	11,000 counselling calls per year	AIDS matched funding
VIC	AIDSLINE	HIV/AIDS and STD Outreach Education Service	Community groups, workplaces, schools, TAFEs etc	Three workshop visits per month	AIDS matched funing
VIC	The Carlton Clinic	Medical Care in General Practice	Gay and Bisexual men		Medicare

VIC	The Gamma Project	GAMMALINE Telephone Counselling Service	A statewide telephone counselling service for men who have sex with men and women, and the female partners of these men	Men, sex, HIV and other STDs 'Research Report' Data on 9,000 primary callers between 1986 – 1997	Funded by the Blood Borne Virus Unit of the Victorian Department of Human Services
VIC	The Gamma Project	Bisexual men and their female partners workshop programs	A full day workshop program for healthcare workers, counsellors and others working with men who have sex with men and women	Five workshops attended by 60 participants in 1997	$90,000 in 1997/98 for total program
VIC	The Gamma Project	Men's Peer Support Group	Peer support, lifestyle management program for men who have sex with men and women	270 participants in the period 1994 – 1997	unfunded volunteer program
WA	Sexuality, Education, Counselling & Consultancy Agency (SECCA)	The HIV/AIDS and Related Diseases Disability Project	Staff, carers, family and friends Community education strategies, train the trainer programmes and individual counselling and education. Ensuring equity of access to support and education.	Number of people attending programs Number and type of programmes for specific organisation. Program evaluation Number and description of other agencies with whom joint programs undertaken. An account of education and counselling programmes carried out, including numbers, type, duration and outcome.	$2200p.a.
WA	Sexual Health Clinic	Routine Sexual Health Service	Homosexual/bisexual men – vaccination for Hepatitis A + B Counselling	>80% completion for Hepatitis	Internal
WA	Western Australian AIDS Council	Beat Outreach	HIV positive and HIV negative NGI MSM and gay men One on one information and referral On site medical clinic	2361 contacts	$45,500
WA	Western Australian AIDS Council	Sauna Outreach	HIV positive and HIV negative gay men One on one information and referral On-site medical clinic	303 contacts 78 HIV tests	$17,200
WA	Western Australian AIDS Council	Venue Outreach	HIV positive and HIV negative gay men One on one information and referral. Distribution of posters and information resources	9817 contacts	$17,700

WA	Western Australian AIDS Council	Peer Education Courses	HIV positive and HIV negative gay and bisexual men A range of safe sex and self development courses	14 courses conducted 161 participants	$16,700
WA	Western Australian AIDS Council	Spectrum	HIV positive and HIV negative gay men from NESB A group that co-ordinates regular social and educational events Produces a regular magazine – 'Speculations'	136 members 698 contacts 6 editions of 'Speculations' produced, 5000 copies distributed	$13,200
WA	Western Australian AIDS Council	Men's Line	NGI MSM A telephone information and referral service	1362 contacts	$28,000
WA	Western Australian AIDS Council	Positive Education and Support	HIV positive gay and bisexual men Support groups and one on one information and support		$19,500
WA	Western Australian AIDS Council	Information, Education and Promotional Resources	HIV positive and HIV negative gay and bisexual men Production of campaign material, printed resources and promotional advertising	A report on advertising, resources and campaigns produced	$60,200
WA	Western Australian AIDS Council	Other Voices	HIV positive and HIV negative gay and bisexual youth A social and support group	34 contacts	$21,200

Appendix 5
Examples of performance indicators

The following performance indicators are suggestions of the types of performance indicators that could be developed for HIV/AIDS health promotion programs for gay and other homosexually active men.

Health outcomes

- Reduce the number of diagnoses of newly acquired HIV infection among gay and other homosexually active men to fewer than 150 per annum by the year 2004;
- Minimise the harm associated with HIV infection among gay and other homosexually active men;
- Improve the proportion of gay and other homosexually active men living with HIV and/or, who have developed AIDS who comply correctly with their treatment regimen;
- Reduce the incidence of sexually transmitted diseases (including HIV) among Aboriginal people and Torres Strait Island people;
- Reduce the number of diagnoses of newly acquired sexually transmitted diseases other than HIV among gay and other homosexually active men;

Behaviours/risk factors

- An increase in the proportion of gay and other homosexually active men who engage only in protected anal intercourse with casual partners;
- An increase the proportion of gay and other homosexually active men who report unprotected anal intercourse with a regular partner only following effective negotiation of conditions that protect the safety of both partners;
- An increase in the proportion of men aged 25 years or less who have engaged in anal intercourse who have been tested for HIV;
- An increase in the proportion of gay men who have demonstrated skills in negotiating safe sex practices in a variety of situations;
- An increase in the proportion of men living with HIV/AIDS who correctly adhere to the treatment regimen required to reduce the harm associated with HIV/AIDS.

Health services

- An increase in the range of services that report action to ensure access of gay and other homosexually active men to culturally effective diagnostic and treatment services;

- An increase in the number of health services that provide 'accredited' testing services for gay men and other homosexually men;
- An increase in the range of services providing counselling/education/information about negotiated safety and the skills required by gay and other homosexually active men.

Environments

- An increase in the access of gay and other homosexually active men (particularly young men) to condoms
- An increase the number and proportion of venues that have implemented safe sex policies
- A reduction in the number of gay men who report experiencing discrimination, violence, or stigma as a result of their sexual preference
- An increase in the proportion of the population who express tolerance of the expression of sexual differences

Health promotion outcomes

- An increase in the proportions of newly sexually active gay men, people living with HIV/AIDS, and young men (particularly teenagers) who can correctly identify the principal methods of HIV transmission and prevention;
- An increase in the proportions of gay and other homosexually active men living with HIV/AIDS who correctly identify the elements of their treatment regimens;
- An increase in community advocacy for changes in policies, services, and organisations conducive to the adoption and maintenance of safer sexual practice;

Indicators of input

- Planned, comprehensive programs that address the range of factors that contribute to the 'issue' being addressed;
- Quality and reach of programs;
- Costs of intervention.

Indicators of capacity

AIDS Councils

- organisational policy supporting health promotion as a major focus of the work of the agency;
- access to epidemiological and population-wide data on the behaviours and knowledge of gay and other homosexually active men, including those who are HIV positive;

- access to information on supportive policies, environments, and services (or the lack thereof) that influence the sexual practice and sexual health of gay and other homosexually active men;
- a trained, well supervised workforce with skills in research, program design, delivery, and evaluation. This may mean a group that includes people with different strengths in each of these.
- a workforce development policy and strategy;
- a research and evaluation strategy;
- funding to support program implementation and evaluation.

Appendix 6
Project team and advisory committee

Project Manager

Mr Aldo Spina

Project Team

Ms Marilyn Wise
Professor Don Nutbeam
Associate Professor Adrian Bauman
Ms Elizabeth Harris

Principal Technical Advisor

Associate Professor Susan Kippax

Project Advisory Committee

Mr Phil Carswell
Mr Stephen Gallagher
Mr Eamonn Murphy
Mr Ross Duffin
Mr Mark Bebbington
Mr Paul Kinder
(resigned January 1998)
Mr Terry Evans
Michael Bartos
Dr Dennis Rhodes
Associate Professor Gary Dowsett
Professor Doreen Rosenthal
Mr Martyn Goddard
Mr Paul Cramer
Mr Neville Fazulla
Mr Darryl O'Donnell
(joined February 1998)
Mr Geoffrey Fysh
Mr Alan Thorpe

Glossary

Acquired immunodeficiency syndrome (AIDS)

A syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immunosuppression.

AIDS Council

Gay community-based organisation established to provide education, support and care, and advocacy for affected individuals and communities.

Australian Federation of AIDS Organisations (AFAO)

The peak organisation representing State and Territory AIDS councils, the National Association of People living with HIV/AIDS, the Australian Intravenous League and the Scarlet Alliance.

Australian National Council on AIDS and Related Diseases (ANCARD)

The Commonwealth Government's key advisory body on HIV/AIDS, established to provide independent and expert advice to the Minister for Health on the implementation of the National HIV/AIDS Strategy.

Community development

A process-oriented method of community organising that emphasises the development of skills, abilities, and understanding in an entire community for the purpose of social improvement.

Gay man

A homosexually active men who identifies himself as gay or is attached to the gay community, or both. Education programs typically distinguish between gay and other homosexually active men.

Human immunodeficiency virus (HIV)

A human retrovirus that leads to AIDS.

National Association of People living with HIV/AIDS (NAPWA)

The peak national organisation representing people who are HIV positive.

Other homosexually active men

Used to describe homosexually active men who neither describe themselves as gay nor are attached to the gay community.

Peer Education

A peer who identifies with a particular subculture, group, or community who is involved in educating other members of that same subculture, group or community.

Abbreviations

AFAO	Australian Federation of AIDS Organisations
AIDS	acquired immunodeficiency syndrome
ANCARD	Australian National Council on AIDS and Related Diseases
CBO	Community-based organisation
COAG	Council of Australian Governments
GES	Gay Education Strategies project
HIV	human immunodeficiency virus
IDU	injecting drug users
IGCA	Intergovermental Committee on AIDS
MFP	Matched Funding Program
NAPWA	National Association of People Living with HIV/AIDS
PIE	Positive Information and Education project
PLWHA	people living with HIV/AIDS
STD	sexually transmitted disease

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