UNGASS COUNTRY PROGRESS REPORT

AUSTRALIA

For the period

January 2008–December 2009

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II. Status at a glance

Inclusiveness of stakeholders in the report writing process

A central tenet of Australia's response to HIV/AIDS is the participation of people living with HIV/AIDS in the development of policies and programs, implementation, monitoring and evaluation. This involvement ensures policies and programs are informed by the experiences of people living with HIV/AIDS, are responsive to need, and take adequate account of the full range of personal and community effects of policy.

The development of Australia's *Country Progress Report 2008-09* continued this partnership approach. Key non-government, community-based organisations, including the Australian Federation of AIDS Organisations, the National Association of People Living with HIV/AIDS, the Australian Injecting and Illicit Drug Users' League, the AIDS Council of New South Wales and the Scarlet Alliance (representing Australian sex workers) were invited to contribute to the report.

Statistical and other information was provided by national research centres funded by the Australian government to provide epidemiological data and undertake HIV clinical and social research, HIV and hepatitis virology research, and research focusing on sex, health and society.

The National Centre in HIV Epidemiology and Clinical Research's Annual Surveillance Report 2009[1] and the National Centre in HIV Social Research's Annual Report of trends in Behaviour 2009 are the resources providing epidemiological data for this report.

Status of the epidemic

Australia continues to have one of the lowest population rates of new HIV diagnoses among similarly developed countries.

By 31 December 2008, there was a cumulative total of 28,330 diagnoses of HIV infection in Australia since reporting commenced in 1986. There were 10,348 people with diagnosed AIDS and of those people 6,765 have died. Following a long-term decline, the annual number of new HIV diagnoses has gradually increased by 38% from 718 in 1999 to 995 in 2008[2].

Over the past ten years, combination antiretroviral treatment of HIV infection has been effective in delaying the progression to AIDS and for improving survival following AIDS diagnosis. The annual number of AIDS diagnoses in Australia has remained relatively stable between the years 2001-2007 at around 240. This is as a result of the wide availability of effective antiretroviral therapies[3].

[1] Note: At the time of writing, confirmed data on HIV and AIDS in Australia are available only to the end of 2008. This report confines itself to the reporting of confirmed data
[2] National Centre for HIV Epidemiology and Clinical Research (2009) Annual Surveillance Report. University of New South Wales
[3] Ibid

The policy and programmatic response

Australia's response to HIV/AIDS has included a series of national strategies for HIV/AIDS, the support of community-based organisations to deliver education, prevention and support services, the establishment of national research centres to conduct strategic research on the disease and national participation in World AIDS Day.

The Australian Government Department of Health and Ageing is responsible for the coordination of Australia's national response to HIV and other blood borne viruses and sexually transmissible infections through the implementation of national strategies. One of the aims of the strategies is to reduce the incidence of infection. The strategies focus on health promotion, prevention, education, improved awareness of transmission and improved access to health services for testing, treatment and support for people who are infected.

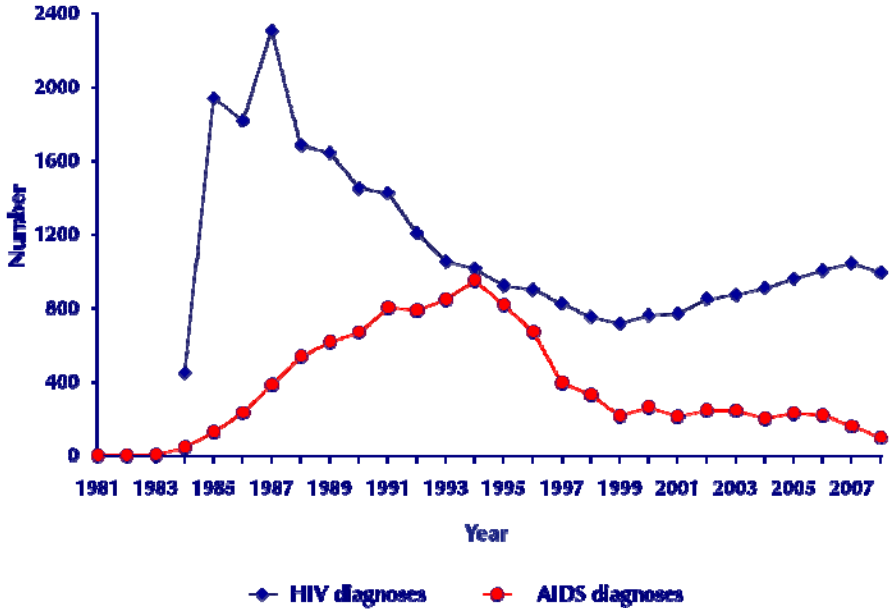
In 2009, the Australian Government Minister for Health and Ageing, the Hon Nicola Roxon MP, established a committee that would advise her on issues relating to blood borne viruses and sexually transmissible infections. This committee has played a valuable role in response to the Minister's desire to re-invigorate Australia's response to blood borne viruses and sexually transmissible infections. The committee actively seeks information from leading experts, liaises with key stakeholders, and provides advice to the Minister.

III. Overview of the HIV/AIDS epidemic

In contrast to comparable countries, Australia has low HIV/AIDS prevalence in all populations, including among men who have sex with men (MSM), injecting drug users and sex workers.

Following a long-term decline, the annual number of new HIV diagnoses in Australia has gradually increased, from 718 cases in 1999 to 995 in 2008 (Figure 1). Among cases of newly diagnosed HIV infection, an increasing number were in people who had acquired HIV infection within the previous year.

Figure 1: Number of HIV and AIDS diagnoses in Australia, 1981 to 2007.



Source: **National Centre in HIV Epidemiology and Clinical Research: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2009.**

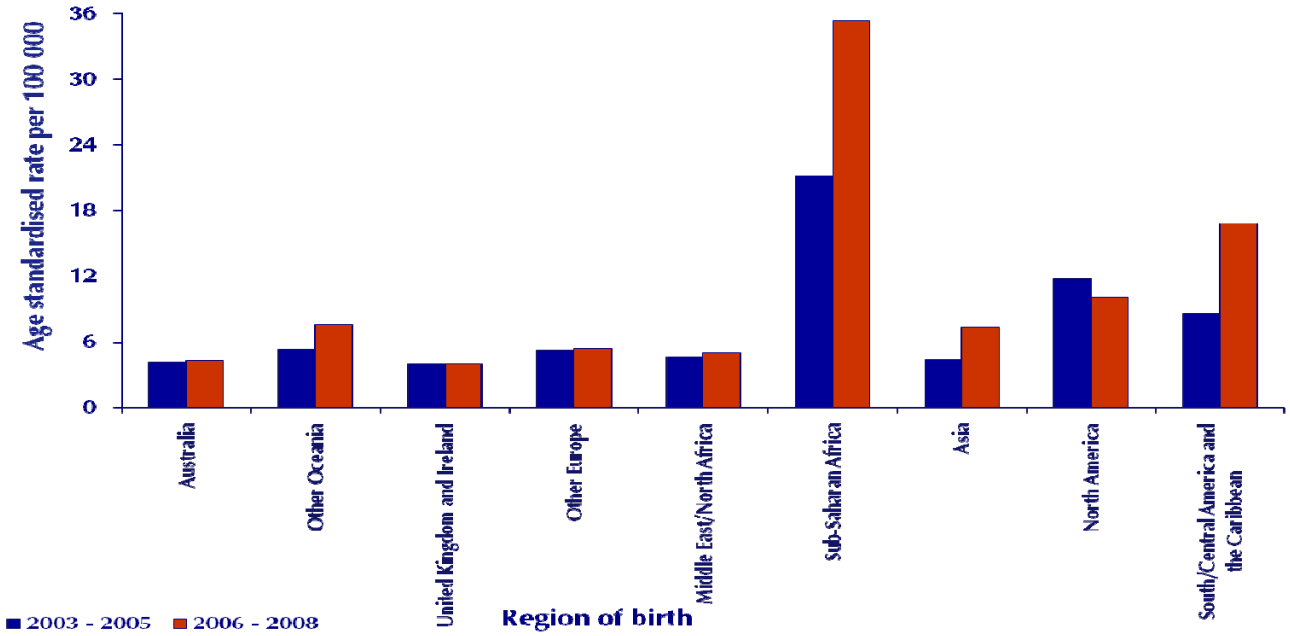
There was a similar *per capita* rate of new HIV diagnoses in the Aboriginal and Torres Strait Islander and non-Indigenous populations. However, a higher proportion of cases was attributed to heterosexual contact and injecting drug use in the Aboriginal and Torres Strait Islander population than in the non-Indigenous population. Around 58% of new HIV diagnoses in 2004-2008 were in people who were born in Australia. People from countries in sub-Saharan Africa, South East Asia, and South and Central America and the Caribbean were associated with the highest population rate of HIV diagnosis in Australia in the years from 2003-2008[4].

HIV in Australia continues to be transmitted primarily through sexual contact between men. Among cases of newly acquired HIV infection, exposure to HIV was attributed to sex between men in 86%; 1% was among women and heterosexual men who had injected drugs; a history of heterosexual contact only was reported in 10%; and in 3%, exposure to HIV remained undetermined[5].

As a result of the wide availability of effective antiretroviral therapies, the annual number of AIDS diagnoses in Australia has remained relatively stable in 2001-2007 at around 240.

[4] Ibid (pp10)
[5] Ibid (pp10)

Figure 2: HIV diagnoses in Australia, 2003 – 2009, by year and region of birth



Source: **National Centre in HIV Epidemiology and Clinical Research: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2009.**

HIV infections in selected populations

Population groups regarded as priorities for prevention and health promotion activities under the previous *National HIV/AIDS Strategy* include MSM, Aboriginal and Torres Strait Islander peoples and people who have injected drugs. These populations are identified as priority groups because they are recognised as either experiencing ongoing HIV transmission or having the potential for increases in transmission.

Men who have sex with men
MSM continue to make up the majority of people with diagnosed HIV infection in Australia. Sexual transmission between men accounted for a higher proportion of diagnoses of newly acquired HIV infection (90%) than total HIV diagnoses (77%) in 2008. This difference may partly reflect higher levels of HIV antibody testing among men who have sex with men[6].

Among MSM seen at metropolitan sexual health clinics, the percentage with newly acquired HIV infection was relatively stable, both in those aged less than 25 years and in those aged 25 years or older.

Aboriginal and Torres Strait Islander people
The rates of HIV diagnosis *per capita* in the Aboriginal and Torres Strait Islander and non-Indigenous populations differed in 1999-2008. In the Aboriginal and Torres Strait Islander population, the rate of HIV diagnosis increased from 2.2 in 1999 to 6.5 in 2002 and then declined

[6] Ibid (pp16)

to around 3.7 in 2005-2008. In the non-Indigenous population, the rate increased steadily from 3.6 per 100,000 population in 1999 to 5.0 in 2007 and declined to 4.8 in 2008. The recent trends in the rates of HIV diagnoses in the Aboriginal and Torres Strait Islander population are based on small numbers and may reflect localised occurrences rather than national patterns.

In 2004-2008, the most frequently reported route of HIV transmission was sexual contact between men in both the non-Indigenous population (67%) and in the Aboriginal and Torres Strait Islander population (54%). Heterosexual contact was the reported source of exposure to HIV in 23% of cases in both the Aboriginal and Torres Strait Islander population and in the non-Indigenous population. Aboriginal and Torres Strait Islander cases differed from non-Indigenous cases in that a higher proportion of infections were attributed to injecting drug use (22% among Aboriginal and Torres Strait Islander cases and 3% for non-Indigenous cases), and a higher proportion of infections were among women (26.9% among Aboriginal and Torres Strait Islander cases and 11.6% for non-Indigenous cases)[7].

People who have injected drugs
In 1999-2008, approximately 8% of HIV diagnoses in Australia were in people with a history of injecting drug use, of whom more than half were MSM.

HIV prevalence among people attending needle and syringe programs has remained low (around 1% in 1999-2008) but in the subgroup of men who identified as homosexual, it was 37% in 2008. Of 670 men and 475 women with a history of injecting drug use who were tested for HIV antibody at metropolitan sexual health centres in 2007-2008, one male (0.1%) and two women (0.4%) were diagnosed with HIV infection[8].

Heterosexual transmission of HIV infection
The number of new HIV diagnoses for which exposure to HIV was attributed to heterosexual contact increased from 781 in 1999-2003 to 1,104 in 2004-2008, according for 19.6% and 22.4% of total HIV diagnoses in 1999-2003 and in 2004-2008, respectively.

Men and women who came from a country with high HIV prevalence accounted for 36% and 40% of HIV diagnoses attributed to heterosexual contact in 1999-2003 and 2004-2008, respectively. In both five year intervals, the majority of cases came from high HIV prevalence countries in sub-Saharan Africa (63% and 60%) in South East Asia (33% and 27%). The proportion of cases from high prevalence countries that were among women increased from 56% in 1999-2003 to 62% in 2004-2008[9].

IV. National response to the AIDS epidemic

The annual number of AIDS diagnoses in Australia has remained relatively stable between the years 2001 to 2007 at around 240, as a result of the wide availability of effective antiretroviral therapies (See Figure 1).

[7] Ibid (pp18)
[8] Ibid (pp21)
[9] Ibid (pp22)

Prevention

Prevention education and health promotion is delivered nationally on behalf of the Australian Government by community-based organisations and state and territory government health services. Community-based organisations are funded by both Australian government and state and territory governments and contribute to the development and implementation of programs linked to the HIV/AIDS strategy. State and territory health services also receive funding through National Healthcare Agreements to provide public health education, prevention, treatment and counselling services.

At the beginning of Australia's epidemic, unprotected anal intercourse was an almost universal practice among MSM. Prevention programs aimed at informing gay and other homosexually active men of the risks of this behaviour and influencing behaviour change have had mixed results. The Gay Community Periodic Survey indicated that the proportion of Sydney respondents who reported unprotected anal intercourse with casual partners peaked in 2001 at 25.7% and then steadily declined to a plateau of 19% by 2007-2008.

There exists:

- an effective partnership between government, clinicians, researchers and the community. There are clear, well-supported mechanisms for liaison and priority-setting, frankness of debate, the sharing of evidence, the absence of blame and the respect of different roles among partners;
- a comparatively high *per capita* investment in HIV prevention programs targeting homosexually active men;
- maintenance of a skilled workforce in HIV health promotion and policy, with key personnel working across different settings, including community-based organisations, area health services and the national research centres. The maintenance of a skilled workforce within the New South Wales Department of Health has enabled the department to maintain a leadership and coordination role in the response;
- effective social marketing initiatives that have targeted both broad and specific audiences of MSM, including HIV positive men. The material is comprehensive in terms of both the diversity and volume of education material and in the range of different MSM to whom it speaks. It is also integrated with other interventions (e.g. a comprehensive range of community development and group support programs, sexual health testing and treatment, mental health and self-esteem and drug harm initiatives); and
- a health promotion response that prioritises and integrates issues of service access, clinician support and education. The evidence is that health promotion social marketing works best when reinforcing well thought through clinical and service responses. That is, linking social marketing to a health promotion message and investment in the development of more appropriate sexual health services in high prevalence areas. Nationally, achievements in prevention activities include the establishment of successful partnerships between jurisdictional and community-based organisations and affected individuals for the development and delivery of targeted prevention education and other health promotion activities.

Care, treatment and support

Initiatives in treatment and care are aimed at improving access to systems that promote the health and quality of life for people living with HIV/AIDS.

Treatment and care embrace a range of services, including testing, early access to health maintenance programs, antiretroviral therapy, counselling, treatment adherence programs and management of HIV-associated conditions. Initiatives have been tailored to the identified needs of priority groups under the strategy. For example, there are care, treatment and support initiatives for:

- the development of health promotion programs to increase the awareness of HIV/AIDS risk among Aboriginal and Torres Strait Islander people in both remote and urban settings, including specific programs focused on gay and other homosexually active men, women and people who inject drugs within Indigenous communities. A *Sexually Transmissible Infections and Blood Borne Viruses Infections Manual* has been developed by the Aboriginal Health and Medical Research Council of NSW to improve access to early detection and treatment programs for Aboriginal and Torres Strait Islander people and communities in that state;
- workforce development for health care workers, with the aim of maintaining high quality expert knowledge and skills in relation to HIV/AIDS in both government and non-government health and community services. Partner organisations continue to develop and deliver high quality training and education to health care professionals and focus attention on the need for resources for culturally and linguistically diverse communities; and
- ensuring that people living with HIV/AIDS can access appropriate treatment, care and support, including appropriate income support, disability support and carer allowances.

Antiretroviral therapy

The rate of AIDS diagnoses and death in Australia has continued to decline, predominantly due to the widespread uptake of antiretroviral therapy. An estimated 10,596 people were prescribed antiretroviral treatment for HIV infection (up from 7,598 in 2004) at an estimated cost of AUD 135 million dollars in the 2007-2008 financial year. In addition, via government funded HIV/AIDS programs, people living with HIV/AIDS have been assisted to participate in trials of new treatments, special treatment access schemes and studies that intend to address the social and physical impacts of antiretroviral therapy.

The proportion of HIV-positive men who reported that they were taking antiretroviral treatment in recent years has risen. The *Australian HIV Observational Database* indicated that 75% of 1,950 people in 2008 were receiving triple combination antiretroviral treatment for HIV infection. Use of combination antiretroviral therapy by men who have sex with men participating in the *Gay Community Periodic Surveys* in Sydney remained stable at around 66% in 2004-2007 and increased to 73.5% in 2008. The percentage of men in Melbourne who reported use of antiretroviral therapy increased from 60% in 2004-2006 to 65% in 2008. In Queensland, increased uptake of combination antiretroviral therapy was also reported, from 63.9% in 2004 to 70.2% in 2008 and relatively high rate of uptake were maintained in Perth in 2008.

Knowledge and behaviour change

The development of knowledge, behaviour change and maintenance of behaviour change are priority areas for action under the HIV/AIDS strategy. The promotion of safe sex practices, in particular, among MSM and sex workers, and the avoidance of contaminated drug injecting equipment among intravenous drug users, have been important prevention education messages.

Awareness of safe sex practices
In 2009, the Australian Government established the *National STI Prevention Program: Sexual Health Campaign* to raise awareness of sexually transmissible infections (STIs) and encourage safe sexual practices among target populations to contribute to a reduction in the prevalence of STIs.

The advertising campaign included radio, magazine, street and medical press, and online advertising. Outdoor activity included phone booth highlights, roadside billboards, cross tracks (subway billboards), chalking, street posters, bus side panels and interiors, and licensed venues featuring the heat and water sensitive decals in urinals and mirror decals in bathrooms.

Awareness of HIV testing
From 2004 to 2008, HIV testing among men who had previously never tested HIV-positive was more common than testing for other sexually transmissible infections and this remained stable over the period. The *Gay Community Periodic Survey* samples show over 80% of the respondents reported having been tested for HIV at some point in time. The highest levels of HIV testing coverage were observed in Sydney and Queensland (about 93%). In the last five years, significant increased in HIV testing coverage were observed in Sydney, Queensland and Perth, while other states showed no significant change[10].

Needle and syringe programs
One of the most dramatic factors contributing to Australia's success in HIV/AIDS prevention has been the success of needle and syringe programs in keeping HIV/AIDS rates low among injecting drug users.

Negotiation of high levels of condom use amongst sex workers
Due to the work of community-based sex worker organisations and projects conducted in partnership with state and territory governments there is presently a low prevalence of HIV/AIDS among Australian sex workers. Sex workers are able to negotiate high levels of condom use in their work and voluntary testing has also been an effective component.

V. Best practices

Australia's successful response to HIV/AIDS is based on a partnership approach with close collaboration of affected communities, all levels of government, and the health and research sectors. The Australian response to HIV/AIDS has contributed to the comparatively low rates of the disease in Australia.

Partnership approach and national HIV/AIDS strategies

Australia has one of the lowest population rates of new HIV diagnoses among similar countries, due in part to its partnership approach to the HIV/AIDS response.

The HIV/AIDS response has included a series of national strategies, active community-based organisations to deliver education, prevention and support services, the establishment of national

[10] Reference NCHSR – Annual Report 2009 (pp15)

centres to conduct strategic research, national participation in World AIDS Day and the involvement of people living with HIV/AIDS in program development and implementation.

The maintenance of the response to the disease has also been important. The first national HIV/AIDS strategy was released in 1989, and four strategies have since followed, each one extending and building on the one before it. A new national strategy for HIV is to be released in 2010.

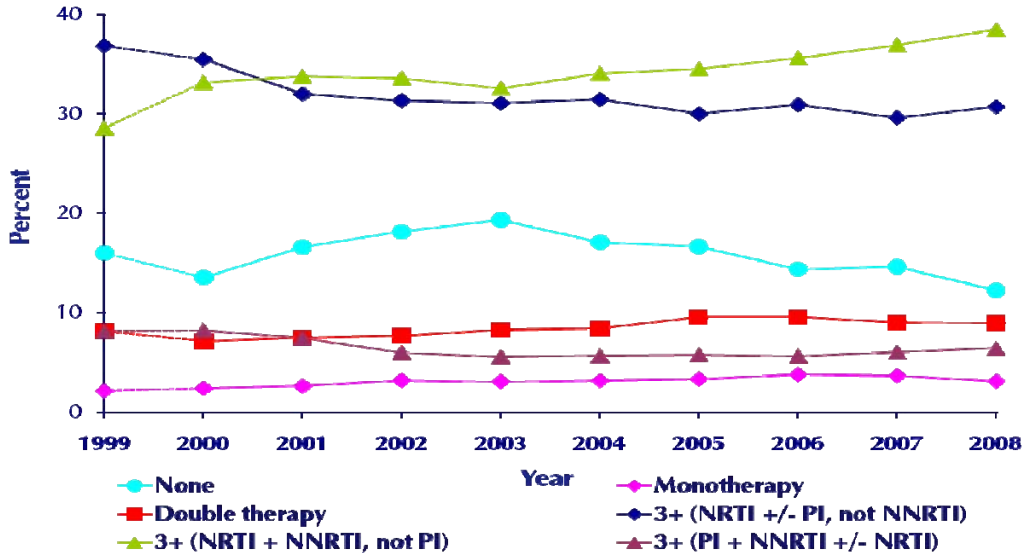
Centrality of people living with HIV/AIDS

The *National HIV/AIDS Strategy* recognises the overriding importance of the participation of people living with HIV/AIDS in policy and program development, implementation, monitoring and evaluation. The National Association of People Living with HIV/AIDS (NAPWA) is funded by the Australian Government to ensure the engagement and representation of people living with HIV/AIDS on treatment, legal, women's, Indigenous, international, and care, support and education issues. The value of involving people living with HIV/AIDS in the national response has been demonstrated by the effective strategies and messages that have been developed with the benefit of personal knowledge and experience.

Antiretroviral treatment and viral load

There has been significant success in the use of antiretroviral therapies in reducing viral load (and thereby reducing infectivity) in some communities. The Australian HIV Observational Database indicated that 75% of 1,950 people under follow up in 2008 were receiving triple combination antiretroviral treatment for HIV infection. The proportion of people with an undetectable viral load increased from 30% in 1999 to over 70% in 2008. Similarly, CD4+ cell count has increased from 480 cells/µl in 1999 to over 580 cells/µl in 2008.

Figure 3: HIV viral load and CD4+ cell count among people enrolled on the Australian HIV Observational Database*



* Dashed lines indicate the years of retrospective data collection.

Source: **National Centre in HIV Epidemiology and Clinical Research: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2009.**

VI. Major challenges and remedial actions

A review of the *National HIV/AIDS Strategy* was undertaken in 2009 under the guidance of the Ministerial Advisory Committee on Blood Borne Virus and Sexually Transmissible Infections (MACBBVS). A new national HIV Strategy for 2010-2013 has now been finalised.

Partnerships and implementation of the National HIV/AIDS Strategy

The strength of Australia's response to HIV/AIDS is through continued partnership adopted for the coordination and implementation of activities under the *National HIV/AIDS Strategy*. This is also one of the enduring challenges. In addition to the Australian Government Department of Health and Ageing, each state and territory has its own government department responsible for health services, and its own AIDS councils. Improved coordination of the activities of all levels of government and community and research organisations to ensure that services are not unnecessarily duplicated and to eliminate instances of overlapping research will improve the efficiency and effectiveness of the response.

Increasing incidence of STIs

Chlamydia continues to be the most frequently reported notifiable condition in Australia with 58,456 reported diagnoses in 2008. The population rate of diagnosis of chlamydia in 2008 was 270 per 100,000 population with a 10% increase over the rate in 2007, continuing the increase seen over the past ten years. The Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS) is a new surveillance system for monitoring the uptake and outcome of chlamydia testing. Initial results have indicated increased testing rates among young heterosexual men and women seen at sexual health services, from 72.3% and 66.6% in 2004 to 80% and 77.4%, respectively in 2008.

The chlamydia positivity rate increased among young heterosexual men and women from 12.4% and 10.4%, respectively in 2004 to 14.6% and 14.2% respectively, in 2008.

The rate of diagnosis of infectious syphilis doubled from 3.1 in 2004 to 6.8 in 2007 and declined to 6.1 in 2008. These increases largely occurred among men who have sex with men. In response to this increase, Australia has developed the *National Gay Men's Syphilis Action Plan*, aimed at reducing the incidence of syphilis in this group. Higher rates of diagnosis of chlamydia, gonorrhoea and infectious syphilis were recorded among Aboriginal and Torres Strait Islander people compared with non-Indigenous people.

Late HIV diagnosis in people from culturally and linguistically diverse (CALD) backgrounds

People from CALD backgrounds are more likely to have a late diagnosis of HIV and associated poorer health outcomes. The per capita rate of HIV diagnoses in Australia 2006-2008 was more than eight times higher among people born in countries in sub-Saharan Africa than among people born in Australia. In the past five years, 59% of cases of HIV infection attributed to heterosexual

contact were in people who were from a high HIV prevalence country or whose sexual partner was from a high prevalence country[11].

Among cases of HIV infection newly diagnosed in the past five years, 9% were in people who reported speaking a language other than English at home[12]. Communities originally from a country with high HIV prevalence have now become a priority population in Australia's response to HIV.

Rises in notification rates in gay and other homosexually active men

Approximately one in two participants in national periodic surveys reported having engaged in any unprotected anal intercourse. Data showed a significant upward increase in Queensland in the proportion of men who reported having had any unprotected anal intercourse between 2004 and 2008. In other states the proportions of men engaging in unprotected anal intercourse have stabilised at around 50%. The challenge in Australia continues to be to reverse the increasing rates of notifications among gay and other homosexually active me.

Barriers to services

HIV-positive heterosexual men, people from culturally and linguistically diverse communities, sex workers and Aboriginal and Torres Strait Islanders have been identified as requiring better access to HIV support and medical services.

VII. Support from the country's development partners

This criterion is not applicable as Australia does not have development partners that contribute to the achievement of UNGASS targets in Australia.

VIII. Monitoring and evaluation environment

The surveillance and monitoring systems for HIV and AIDS in Australia are extensive and well developed.

Overview of HIV/AIDS surveillance

National surveillance for HIV and AIDS is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR) in collaboration with state and territory health authorities, the Australian Government Department of Health and Ageing, the Australian Institute of Health and Welfare and other collaborating networks in surveillance for HIV/AIDS.

Newly diagnosed HIV infections and AIDS are notifiable conditions in each state and territory health jurisdiction in Australia. Under national HIV/AIDS surveillance procedures, AIDS notifications are forwarded to the *National AIDS Registry* and newly diagnosed HIV infections

[11] National Centre for HIV Epidemiology and Clinical Research (2009) Annual Surveillance Report. University of New South Wales (pp7)
[12] Ibid (pp10)

are reported to the *National HIV Registry* for national collation and analysis. A range of information is sought at notification, including state/territory of diagnosis, name code, sex, date of birth, country of birth, Aboriginal and Torres Strait Islander status, date of diagnosis, CD4+ cell count at diagnosis, source of HIV exposure and AIDS defining illness.

Diagnoses of specific sexually transmissible infections are notified by state and territory health authorities to the *National Notifiable Disease Surveillance System*, maintained by the Australian Government Department of Health and Ageing.

Information on sexual behaviour in a cross section of gay men is collected annually via *Gay Community Periodic Surveys* conducted in six state and territory capitals. HIV incidence and incidence of specific sexually transmissible infections among gay and other homosexually active men is determined from longitudinal studies, such as the *Health in Men* study of HIV-negative men, and the *Positive Health* study of HIV-positive men, both based in New South Wales.

HIV seroprevalence among people who have injected drugs is determined via a blood test and self-administered questionnaire of people attending needle and syringe program sites during one week each year. HIV seroprevalence among people seen at sexual health clinics is determined through a network of selected metropolitan sexual health clinics that quarterly and annually provide tabulations of the number of people seen, the number tested for HIV antibody and the number newly diagnosed with HIV infection.

The *Australian HIV Observational Database* (AHOD) is a collaborative study that records observational data on the natural history of HIV infection and its treatment. The primary objective is to monitor the pattern of antiretroviral and prophylactic treatment use by demographic factors and markers of HIV infection stage. Other objectives are to monitor how often people with HIV infection change antiretroviral treatments and the reasons for treatment change.

All blood donations in Australia have been screened for HIV-1 antibodies since 1985 and HIV-2 antibodies since 1992. Prior to donation, all blood donors are required to sign a declaration that they do not have a history of any specified factors associated with a higher risk of HIV infection and other blood borne infections.

Monitoring of Australia's response

The implementation and effectiveness of the *National HIV/AIDS Strategy* and the status of the HIV/AIDS epidemic in Australia are monitored through mechanisms that include:

- regular meetings of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (MACBBVS) to consider ongoing and emerging issues and provide advice to the Australian Government Minister for Health and Ageing;
- publication of an annual surveillance report on HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), and an annual report of HIV/AIDS, hepatitis and sexually transmissible infections in Australia - trends in behaviour by the National Centre in HIV Social Research in collaboration with the NCHECR and the Australian Research Centre in Sex, Health and Society;
- monitoring and evaluation of activities undertaken by national community-based organisations concerned with HIV/AIDS;

- monitoring and surveillance activities of state and territory health authorities and AIDS councils, including activities undertaken in support of the *National HIV/AIDS Strategy*;
- state and territory government reporting against the National Health Care Agreement Indicators to reduce the incidence of HIV and to reduce the risk behaviours associated with the transmission of HIV; and
- a full evaluation of the *National HIV/AIDS Strategy* was undertaken in 2009. The evaluation provided a detailed assessment of the strategy's continuing appropriateness, effectiveness and efficiency, and recommendations supported by evidence, on ways to improve the national response.

Specific challenges for improvement

A partnership approach with representation from governments and the community sector is central to the development of policy and programs that strengthen the HIV response in Australia. The ongoing development of national surveillance programs will assist in monitoring and evaluation which in turn will best inform targeted prevention with priority populations.

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2. National Centre in HIV Epidemiology and Clinical Research. HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2009. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW; Australian Institute of Health and Welfare, Canberra, ACT. 2008.
3. National Centre in HIV Social Research, HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Report of trends in Behaviour 2009. National Centre in HIV Social Research, The University of New South Wales, Sydney, NSW; Australian Research Centre in Sex, Health and Society National Centre in HIV Epidemiology and Clinical Research.

ANNEXES

Annex 1. Consultation/preparation process for the report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

Annex 2. Departmental spending on HIV/AIDS programs in the reporting period

Annex 3. National Composite Policy Index online questionnaire, including:

Part A: a section to be administered to government officials; and

Part B: a section to be administered to representatives from non-government organisations.

Annex 4. The UNGASS data indicator set

Annex 5. (A and B) are the background questionnaires for Annex 3 administered to both government departments (Part A) and non-government organisations (Part B)

Annex 1

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC* or equivalent	**Yes**
b) NAP **	**Yes**
c) Others (please specify)	
Australian Federation of AIDS Organisations	**Yes**
National Association of People Living with HIV/AIDS	**Yes**

2) With inputs from:

Ministries:	
Education	**Yes**
Health	**Yes**
Labour	**No**
Foreign Affairs	**No**
Others (please specify)	
Australian Federal Police	**Yes**
Department of Defence	**Yes**
Attorney General's Department	**Yes**
Civil society organizations***	**Yes**
People living with HIV	**Yes**
Private sector	**No**
United Nations organisations	**No**
International NGOs	**No**

3) Was the report discussed in a large forum? **No**

4) Are the survey results stored centrally? **Yes**

5) Are data available for public consultation? **Yes**

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name/Title: **Ms Megan Parrish**
Director
BBVS Policy Section
Department of Health and Ageing

Date: 30 March **2010**

Address: **MDP 6 GPO 9848**
CANBERRA ACT 2601,

AUSTRALIA

Email: Megan.Parrish.health.gov.au

phone: **+ 61 2 6289 8512**

- NAC - National AIDS Committee

** NAP - National AIDS Program

*** Civil society organisations – Civil society includes among others: Networks of people living with HIV; women's organisations; faith-based organisations; AIDS service organisations; Community-based organisations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organisations, human rights organisations; etc. For the purpose of the NCPI (National Composite Policy Index), the private sector is considered separately.