

AUSTRALIAN FEDERATION  
OF AIDS ORGANISATIONS

AFAO

# REPORTING HIV IN AUSTRALIA

INFORMATION FOR JOURNALISTS

**REVISED SEPTEMBER 2011**



## Acknowledgements

The first edition of the *HIV/AIDS Media Guide* was published in 1995. The second edition, edited by Ruth Pollard, was published in 2000. The third edition, retitled as *Reporting HIV in Australia: Information for Journalists* (2009), was compiled by Sally Cameron and edited by Abigail Groves.

This edition (2011) is a revision of the 2009 edition and was edited by Linda Forbes. It is the fourth edition of this resource.

There are many expert agencies around the world which specialise in different aspects of our combined response to the HIV pandemic. The Australian Federation of AIDS Organisations (AFAO) would like to acknowledge all those individuals and agencies on whose expertise we have drawn. In particular, AFAO would like to acknowledge the work of:

- ❖ Australian Research Centre in Sex, Health and Society
- ❖ Canadian HIV/AIDS Legal Network
- ❖ Canadian AIDS Society
- ❖ Global Media AIDS Initiative
- ❖ International Federation of Journalists
- ❖ Franz Krüger
- ❖ Journ-AIDS
- ❖ Kaiser Family Foundation
- ❖ Media Alliance
- ❖ National Association of People Living with HIV/AIDS
- ❖ The Kirby Institute, previously the National Centre in HIV Epidemiology and Clinical Research
- ❖ National Centre in HIV Social Research
- ❖ UNAIDS



**The Australian Federation of AIDS Organisations (AFAO)** is the national federation for the HIV community response. AFAO provides leadership, coordination and support to Australia's policy, advocacy and health promotion response to HIV/AIDS. Internationally, AFAO contributes to the development of effective policy and programmatic responses to HIV/AIDS at the global level, particularly in Asia and the Pacific. (AFAO member organisations' contact details are listed on page 11.)

AFAO advocates for its member organisations, promotes medical and social research into HIV and its effects, develops and formulates policy on HIV issues, and provides HIV policy advice to the Australian Government.

## ***Reporting HIV in Australia: Information for Journalists***

ISBN 978 1 876469 50 1

**2011 edition edited by** Linda Forbes

**Design + Production** Ascending Horse

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# THE ROLE OF THE MEDIA

ALL AUDIENCES  
DESERVE FULL,  
ACCURATE AND  
INTELLIGENT  
COVERAGE OF HIV

AND THE MEDIA HAS  
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TO PLAY.

**HIV is a story of critical importance. All audiences deserve full, accurate and intelligent coverage of HIV and the media has a significant role to play. Effective reporting requires a solid understanding of HIV and its social and medical implications. It should, by default, challenge myths and misinformation about HIV.**

Though many consider HIV irrelevant to their lives, HIV potentially affects all sections of Australian society. Strong media output can better inform the Australian population about the risk of HIV transmission and the realities of living with the virus, while inaccurate or inappropriate reporting can undermine HIV prevention efforts and stigmatise people living with HIV. Publication of inaccurate or misleading misinformation has the potential to hamper public health efforts. Therefore it is important that HIV is reported in an informed, balanced way. Journalists can assist in preventing HIV transmission and HIV-related stigma and discrimination by doing their utmost to report stories involving HIV with objectivity, care and attention to detail.

In recent years, news stories relating to HIV in Australia have focused on two main areas: prosecutions of individuals for transmission of HIV or exposing others to HIV transmission risk, and increasing levels of HIV diagnoses in the community.

## **Criminal cases involving HIV exposure or transmission**

There have been a number of people prosecuted for HIV exposure or transmission during the last few years (see also 'Criminal prosecution of HIV transmission' on page 37). The quality of reporting on criminal cases has been variable: on some occasions accurate but on others inaccurate and even sensationalist. A number of issues have arisen, including the following:

- ❖ Coverage rarely places the actions of people charged or convicted for HIV exposure/transmission within the broader context of people living with HIV. With 31 prosecutions over twenty years among more than 29,000 Australians ever diagnosed with HIV, these cases are exceptional.

- ❖ Stories have included reference to scientific data (particularly genotyping) which implies that it is possible to track strains of HIV that can be linked to individuals. This is not correct.
- ❖ The reportage of witness phraseology such as ‘conversion parties’ and ‘bug chasing’ appears to have led to their adoption in the broader community: see, for example, an article on a proposed gay sauna in *The Port Phillip Leader* (8/5/07) in which a local resident refers to ‘bug chasers’ – people who get a thrill out of unprotected sex; and ‘bug-spreaders’ – HIV-positive people who try to infect others. This is despite there being no confirmed evidence that such practices exist.
- ❖ HIV agencies reporting an increase in the number of HIV-positive people contacting them to discuss the increased sense of stigma arising from negative media coverage.

There has also been some confusion around notions of ‘exposure’ and ‘transmission’. For example, in June 2011, a man was convicted for HIV exposure. The content of news reports about the conviction reflected this; however, the headline that ran across several news outlets was ‘man admits infecting women’. Sub-editors should ensure that headlines accurately reflect the facts and do not inadvertently defame individuals.

Another problematic example relates to an ACT man found guilty of working as a sex worker while HIV-positive. There was no evidence to suggest he had practised unsafe sex or transmitted HIV; however, early stories ran with the sensational estimate that as many as 250 people may have been at risk. In fact, that estimate was based solely on the number of people listed in his mobile phone directory. Headlines suggested that he had ‘deliberately infected’ people.

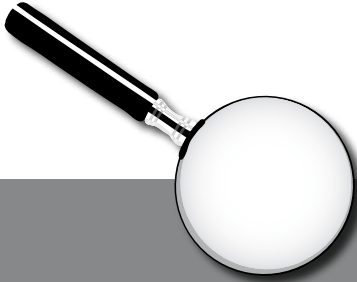
In 2010 print, television and other electronic media similarly ran with headlines that a Queensland-based African-Australian man may have exposed hundreds of women to HIV. Photos and video images of the man generally accompanied these reports. Some coverage included a suggestion that an ‘HIV register’ be used to track people with HIV. A year later, the man was tried in relation to charges in respect of one woman.

The issue of accurate reporting has gained increased currency as media outlets have centralised their news sources and the internet has enabled mass reproduction of stories in very short time-frames. Not only are news feeds immediately and simultaneously circulated among subscribing media

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INFECT  
HUNDRE  
INOCCE**

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For further points on reporting criminal cases involving HIV transmission or exposure see **'Criminal Laws'** in **Section 13** on page 37

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outlets but independent internet based sites also 'pick up' and reproduce media output. Erroneous reporting by Australian news outlets continue to exist on sites based around the globe – including some stories and/or headlines that were deliberately corrected/removed from originating Australian sites when the error was identified. Many such stories attract a vitriolic response against both the accused (whose actions have been misrepresented) and all people living with HIV. Correcting errors – no matter how promptly – cannot turn back the effect of this vitriol.

#### **Increasing HIV diagnoses**

Rates of HIV diagnoses have increased in recent years, and careful reporting of this is important. For example, when the Victorian Government reported its annual HIV notification statistics for 2006 – which revealed a 17 percent increase in HIV infections over the previous year – the health minister announced that, of those notifications, almost half were 'immigrants' to the state. That triggered the following headline in Melbourne's *Herald Sun*: 'HIV migrants pour into the state' (13 April 2007).

In fact, the 'immigrants' the Victorian health minister was referring to included both Australians who had been diagnosed overseas and Australians who had moved (migrated) from other states. Fifty of the 70 'immigrants' were people who had been previously diagnosed in another state. Of the 20 recorded as having come from overseas, most came from low-prevalence countries such as New Zealand and the UK or were people born in Australia who had travelled and been diagnosed overseas.

## **HIV and immigration**

Moral panics conflating the issues of HIV and immigration continue to play out in political and public debates to this day, fuelled partly by media reporting.

In 2010, media reports on the complex issue of migration policy reform for people with disability suggested that the Australian Government had 'loosened' its grip on migration policy for migrants with HIV and cancer, implying that a 'loophole' had been created which would lead to a surge in HIV-positive entrants into Australia. It was far less frequently reported that, in effect, current Australian migration policies regarding HIV are extremely strict. The granting of most Australian visas requires passing a 'health requirement', where applicants with a disease or condition are assessed as to potential future costs in providing them with health care and community services. An HIV test is compulsory for people over 15 seeking permanent residence, and for some children.

Sensationalised reporting of HIV-related criminal prosecutions involving migrants can have the effect of disproportionately linking HIV to ethnicity. Reporting of cases against non-Australian born accused consistently refers to the accused's country of origin, resulting in the conflation of ethnicity, HIV and selfish/irresponsible behaviour. In reality, the population of people living with HIV in Australia is as diverse as the wider population. The number of people living with HIV in Australia is around 22,000 – the majority of whom were born in this country.

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# LANGUAGE GUIDE: DO'S AND DON'TS IN REPORTING HIV

DUE TO THE  
EFFECTIVENESS  
OF MODERN  
ANTIRETROVIRAL  
TREATMENTS

AIDS DIAGNOSES  
ARE NOW RARE IN  
AUSTRALIA.

## **Don't confuse HIV and AIDS**

There is a difference between HIV and AIDS, so the two terms should not be used interchangeably. A person infected with HIV is described as 'HIV-positive', meaning that they have received a 'positive' result from a blood test for HIV infection. HIV can live in the body for years without causing immediate or obvious damage, although the virus is constantly replicating. Many people with HIV continue to look and feel well throughout their lifetime. They may not even be aware that they are living with the virus.

Someone who has an AIDS diagnosis has a syndrome characterised by a severely weakened immune system and typically has debilitating symptoms. There are many effective treatments available for HIV that can stop the infection developing into AIDS. People on treatments can live a long and productive life equal to that of a person without HIV. Due to the effectiveness of modern antiretroviral treatments, AIDS diagnoses are now rare in Australia.

## **Avoid stereotyping**

People living with HIV constitute a diverse population, which should be reflected in good media reporting. The notion that a person must belong to a 'high-risk group' is not only wrong, but potentially damaging to public health measures aiming to educate the public about high-risk practices. Everyone has a responsibility to minimise the risk of HIV transmission. Journalists must avoid making value judgements about how people acquire HIV and instead focus on reporting on its impact.

## **Take care with language**

Avoid damaging language. This includes language that is derogatory or that perpetuates myths or stereotypes about HIV. Do not inappropriately apply labels to people as 'innocent victims' of HIV (which suggests that others are guilty and deserve infection). Doing so is hurtful and harmful to individuals and also works against Australia's HIV prevention efforts.

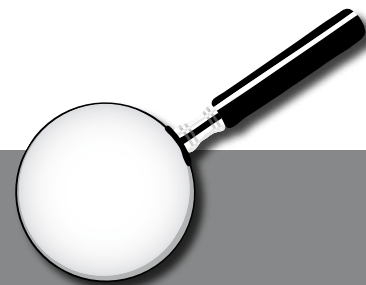
### Take care with data

Statistics have the potential to provide clarity about the situation being reported but they can be difficult to find and to interpret. Disease surveillance reporting includes a variety of complexities and nuances so it is important to ensure that data is current and correctly reported. Disease surveillance capacity and technologies have improved over time, which also has an impact on using 'comparative' data. Terms like 'incidence' and 'prevalence' do not have the same meaning but have at times been used interchangeably.

In Australia there are several expert agencies analysing HIV-related data, so rather than relying on printed sources, it is generally preferable for journalists to contact research agencies directly to check that data are clearly understood. Australian agencies are listed below under 'HIV in Australia'. For international comparative data, UNAIDS is often the best starting point.

### Respect confidentiality

HIV-positive people continue to experience discrimination, and sometimes violence, due to their HIV-positive status. In 2008, for example, a Sydney man was murdered, apparently because his assailant had been told (incorrectly) that the man was HIV-positive. A person's HIV status should not be disclosed without their explicit permission unless it is already a matter of public record (for example, in court proceedings). If permission is being sought, the journalist has a responsibility to ensure the person understands the repercussions of the disclosure.



For more information on analysing data see *Understanding and Reporting on HIV/AIDS Data*, including an explanation of how UNAIDS develops HIV and AIDS estimates at <http://www.kff.org/hivaids/upload/7742.pdf>

For a list of Australian HIV/AIDS organisations see **page 11**

**DISEASE  
SURVEILLANCE  
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# SOME TERMS CAN BE MISLEADING OR DENIGRATING TO PEOPLE LIVING WITH HIV. HERE ARE SOME EXAMPLES OF THESE AND SUGGESTIONS OF ALTERNATIVE TERMS AND PHRASES.

**USE:** HIV infection, HIV-positive, HIV/AIDS

**DON'T USE:** AIDS if the intention is to refer to HIV

AIDS is a syndrome encompassing a range of conditions that occur when a person's immune system is seriously damaged by HIV infection. Someone who has HIV infection has antibodies to the virus but may not have developed any of the illnesses which constitute AIDS.

**DON'T USE:** AIDS virus or HIV virus

There is no such thing as the AIDS virus. There is only HIV (Human Immunodeficiency Virus): the virus that can cause AIDS. The term 'HIV virus' means 'Human Immunodeficiency Virus virus': a tautology.

**USE:** person living with HIV, HIV-positive person

**DON'T USE:** AIDS victim, HIV sufferer or AIDS sufferer

The words 'victim' and 'sufferer' are disempowering. Many people living with HIV dislike these terms because they are patronising and imply they are powerless, with no control over their lives. Use of the term 'sufferer' or 'victim' to refer to someone with HIV implies an individual is at the mercy of the condition. People do not necessarily suffer because they have HIV. Use HIV-positive person or person living with HIV.

**DON'T USE:** AIDS patient

Most of the time, a person living with HIV or AIDS is not in the role of patient. Use 'AIDS patient' only to describe someone who has AIDS and who is in a medical setting in the context of the story.

**DON'T USE:** AIDS carrier

This term is highly stigmatising and offensive to many people living with HIV. It is also incorrect as the infective agent is HIV. A person cannot catch 'AIDS'.

**DON'T USE:** AIDS-infected

No-one can be infected with AIDS because it is not an infectious agent. AIDS is a surveillance definition that describes a syndrome of opportunistic infections and diseases that can develop as immunosuppression deepens.

**DON'T USE:** AIDS test

There is no test for AIDS, only for HIV. Use HIV test or HIV antibody test.

**DON'T USE:** body fluids

Confusion about the body fluids that transmit HIV is a cause of fear and misunderstanding about HIV, and continues to cause discrimination against people living with HIV. There are only certain body fluids that contain HIV in sufficient concentration to be implicated in HIV transmission (i.e. blood, semen, pre-ejaculate, vaginal fluids and breast milk). HIV cannot be transmitted through body fluids such as saliva, sweat, tears or urine.

**USE:** sex worker

**DON'T USE:** prostitute

Prostitute is a loaded and disparaging term and does not reflect the fact that sex work is a form of employment for sex workers, not a way of life.

**USE:** street worker

**DON'T USE:** street walker

Again, the term 'street walker' does not represent the employment aspect of sex work and is therefore derogatory and misleading.

**USE:** person who injects drugs, injecting drug user

**DON'T USE:** junkie, drug addict

Instead use less judgmental terms such as 'people who use injecting drugs'. Drug dependency is a medical condition and is not, in itself, a crime. Illicit drug use is only one part of an injecting drug user's life. Terms such as 'junkie' rely on a stereotyped image that is not accurate, and often greatly misrepresents drug users' varied lives.

**USE:** person with AIDS, or person with HIV

**DON'T USE:** full-blown AIDS

This term is overly dramatic and also implies that there is such a thing as a partial case of AIDS. A person has AIDS or they do not.

**USE:** affected communities, high-risk behaviour

**DON'T USE:** high-risk group

Using the term HIV 'risk group' implies that membership of a particular group rather than behaviour, is the significant factor in HIV transmission. This term may lull people who don't identify with a particular group into a false sense of security. It is high-risk *behaviours* such as unprotected sex or unsafe injecting practices that can spread HIV, not 'belonging' to a high-risk group.

**USE:** risk of HIV infection

**DON'T USE:** risk of AIDS

HIV is the virus, not AIDS. Use 'risk of HIV infection' or 'risk of exposure to HIV'.

**USE:** people with medically-acquired HIV or AIDS, children with HIV

**DON'T USE:** innocent victims

'Innocent victims' is usually used to describe children with HIV, or people with medically-acquired HIV infection. It implies that people infected in other ways are guilty of some wrong-doing and deserved to be infected with HIV. This feeds stigma and discrimination and should be avoided.

**USE:** Australian population, HIV-negative people, all Australians

**DON'T USE:** general population

Don't use 'general population' unless HIV-positive people are included in it. Otherwise the term implies that people in populations targeted for HIV prevention, education and care are not part of the general population.



For more information, see:

- **Kaiser Family Foundation.** Global Health Facts website at [www.globalhealthfacts.org](http://www.globalhealthfacts.org)
- **UNAIDS Terminology Guidelines** at [http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/jc1336\\_unaids\\_terminology\\_guide\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/jc1336_unaids_terminology_guide_en.pdf)
- **Pan American Health Organization.** HIV-related Language: PAHO 2006 Update at <http://www.paho.org/English/AD/FCH/AI/HIVLANGUAGE.PDF>

# TOP TEN WEBSITES FOR HIV INFORMATION

HERE ARE SOME USEFUL WEBSITES CONTAINING INFORMATION ABOUT VARIOUS ASPECTS OF HIV AND AIDS IN AUSTRALIA AND AROUND THE WORLD:

## AUSTRALIAN FEDERATION OF AIDS ORGANISATIONS

**Website** [www.afao.org.au](http://www.afao.org.au)

**Address** Level 1, 222 King St, Newtown NSW 2042

**Postal Address** PO Box 51, Newtown NSW 2042.

**Telephone** +61 (2) 9557 9399

**Facsimile** +61 (2) 9557 9867

**Email** [mail@afao.org.au](mailto:mail@afao.org.au)

## THE KIRBY INSTITUTE FOR INFECTION AND IMMUNITY IN SOCIETY (FORMERLY NATIONAL CENTRE IN HIV EPIDEMIOLOGY AND CLINICAL RESEARCH [NCHCECR])

**Website** <http://hiv.cms.med.unsw.edu.au>

**Address** The CFI Building, cnr Boundary and West Streets, Darlinghurst NSW 2010

**Telephone** +61 (2) 9385 0900

**Facsimile** +61 (2) 9385 0920

**Email** [recpt@kirby.unsw.edu.au](mailto:recpt@kirby.unsw.edu.au)

## NATIONAL CENTRE IN HIV SOCIAL RESEARCH (NCHSR)

**Website** <http://nchsr.arts.unsw.edu.au>

**Address** Robert Webster Building, The University of New South Wales, Sydney NSW 2052

**Telephone** +61 (2) 9385 6776

**Facsimile** + 61(2) 9385 6455

**Email** [nchsr@unsw.edu.au](mailto:nchsr@unsw.edu.au)

## AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH AND SOCIETY (ARCSHS)

**Website** [www.latrobe.edu.au/arcshs](http://www.latrobe.edu.au/arcshs)

**Address** La Trobe University, 1st floor, 215 Franklin St, Melbourne VIC 3000

**Telephone** +61 (3) 9285 5382

**Facsimile** +61 (3) 9285 5220

**Email** [arcshs@latrobe.edu.au](mailto:arcshs@latrobe.edu.au)

## NATIONAL ASSOCIATION OF PEOPLE LIVING WITH HIV/AIDS (NAPWA)

**Website** [www.napwa.org.au](http://www.napwa.org.au)

**Address** Suite G5, 1 Erskineville Rd, Newtown NSW 2042

**Postal Address** PO Box 917, Newtown NSW 2042

**Telephone** +61 (2) 8568 0300

**Facsimile** +61 (2) 9565 4860

## AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING: ACTION ON HIV/AIDS

**Website** <http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-hiv>

**Postal Address** GPO Box 9848, Canberra ACT 2601

**Telephone** +61 (2) 6289 1555

**Email** [enquiries@health.gov.au](mailto:enquiries@health.gov.au)

## UNAIDS

**Website** [www.unaids.org/en](http://www.unaids.org/en) and <http://www.unaids.org/globalreport/>

## THE BODY: THE COMPLETE HIV/AIDS RESOURCE (BODY HEALTH RESOURCES CORPORATION)

**Website** [www.thebody.com](http://www.thebody.com)

## AIDSMAP: INFORMATION ON HIV AND AIDS

**Website** [www.aidsmap.com](http://www.aidsmap.com)

## KAISER FAMILY FOUNDATION: HIV/AIDS

**Website** [www.kff.org/hivaids/index.cfm](http://www.kff.org/hivaids/index.cfm)

# AFAO MEMBER ORGANISATION CONTACT DETAILS

AUSTRALIA HAS HIV/AIDS ORGANISATIONS IN EACH STATE AND TERRITORY, AS WELL AS SEVERAL NATIONAL ORGANISATIONS THAT REPRESENT DIFFERENT COMMUNITIES AFFECTED BY HIV.

## **AIDS ACTION COUNCIL OF THE ACT (AACACT)**

**Website** [www.aidsaction.org.au](http://www.aidsaction.org.au)

**Address** Westlund House, 16 Gordon St, Acton ACT 2601

**Postal Address** GPO Box 229, Canberra ACT 2601

**Telephone** +61 (2) 6257 2855

**Facsimile** +61 (2) 6257 4838

**Email** [enquiries@aidSACTION.org.au](mailto:enquiries@aidSACTION.org.au)

## **ACON (FORMERLY THE AIDS COUNCIL OF NSW)**

**Website** [www.acon.org.au](http://www.acon.org.au)

**Address** 414 Elizabeth Street, Surry Hills NSW 2010

**Postal Address** PO Box 350, Darlinghurst NSW 1300

**Phone** +61 (2) 9206 2000

**Facsimile** +61 (2) 9206 2069

**Email** [acon@acon.org.au](mailto:acon@acon.org.au)

## **AIDS COUNCIL OF SA (ACSA)**

**Website** [www.acsa.org.au](http://www.acsa.org.au)

**Address** Darling House, Office of the AIDS Council of South Australia Inc. 64 Fullarton Rd, Norwood SA 5067

**Postal Address** PO Box 907, Kent Town SA 5071

**Telephone** +61 (8) 8334 1611

**Facsimile** +61 (8) 8363 1046

**Email** [information@acsa.org.au](mailto:information@acsa.org.au)

## **NORTHERN TERRITORY AIDS AND HEPATITIS COUNCIL (NTAHC)**

**Website** <http://www.ntahc.org.au>

**Address** 46 Woods St (cnr Woods & Gardiner Sts), Darwin NT 0801 (Darwin Office)

**Postal Address** GPO Box 2826 Darwin NT 0801

**Telephone** +61 (8) 8941 1711

**Facsimile** +61 (8) 8941 2590

**Email** [info@ntahc.org.au](mailto:info@ntahc.org.au)

## **HEALTHY COMMUNITIES (QAHc)**

**Website** <http://www.qahc.org.au>

**Address** 30 Helen St, Newstead QLD 4006

**Postal Address** PO Box 1372, Eagle Farm QLD 4009 Australia

**Telephone** +61 (7) 3017 1777

**Facsimile** +61 (7) 3844 4206

**Email** [info@qahc.org.au](mailto:info@qahc.org.au)

## **TASMANIAN COUNCIL ON AIDS, HEPATITIS AND RELATED DISEASES (TASCAHRD)**

**Website** [www.tascahrd.org.au](http://www.tascahrd.org.au)

**Address** 319 Liverpool St, Hobart TAS 7000

**Postal Address** GPO Box 595, Hobart TAS 7001

**Telephone** +61 (3) 6234 1242

**Facsimile** +61 (3) 6234 1630

**Email** [mail@tascahrd.org.au](mailto:mail@tascahrd.org.au)

## **VICTORIAN AIDS COUNCIL/GAY MEN'S HEALTH CENTRE (VAC/GMHC)**

**Website** [www.vicaids.asn.au](http://www.vicaids.asn.au)

**Address** 6 Claremont St, South Yarra VIC 3141

**Telephone** +61 (3) 9865 6700

**Facsimile** +61 (3) 9826 2700

**Email** [enquiries@vicaids.asn.au](mailto:enquiries@vicaids.asn.au)

## **WESTERN AUSTRALIAN AIDS COUNCIL (WAAC)**

**Website** [www.waaidS.com](http://www.waaidS.com)

**Address** 664 Murray St, West Perth WA 6872

**Postal Address** PO Box 1510, West Perth WA 6872

**Telephone** +61 (8) 9482 0000

**Facsimile** +61 (8) 9482 0001

**Email** [waac@waaidS.com](mailto:waac@waaidS.com)



**ANWERNEKENHE NATIONAL ABORIGINAL  
AND TORRES STRAIT ISLANDER HIV/AIDS  
ALLIANCE (ANA)**

**Website** [www.ana.org.au](http://www.ana.org.au)

**Telephone** +61 (2) 9557 9399

**Facsimile** +61 (2) 9557 9867

**Postal Address** PO Box 51, Newtown NSW 2042

**Email** [info@ana.org.au](mailto:info@ana.org.au)

**AUSTRALIAN INJECTING & ILLICIT DRUG USERS  
LEAGUE (AIVL)**

**Website** [www.aivl.org.au](http://www.aivl.org.au)

**Address** Level 2, Sydney Building, 112–116 Alinga St,  
Canberra ACT 2600

**Postal Address** GPO Box 1552, Canberra ACT 2601

**Telephone** +61 (2) 6279 1600

**Facsimile** +61 (2) 6279 1610

**Email** [info@aivl.org.au](mailto:info@aivl.org.au)

**NATIONAL ASSOCIATION OF PEOPLE  
LIVING WITH HIV/AIDS (NAPWA)**

**Website** [www.napwa.org.au](http://www.napwa.org.au)

**Address** Suite G5, 1 Erskineville Rd, Newtown NSW 2042

**Postal Address** PO Box 917, Newtown NSW 2042

**Telephone** +61 (2) 8568 0300 or 1800 259 666

**Facsimile** +61 (2) 9565 4860

**Email** [admin@napwa.org.au](mailto:admin@napwa.org.au)

**SCARLET ALLIANCE, AUSTRALIAN  
SEX WORKERS ASSOCIATION**

**Website** [www.scarletalliance.org.au](http://www.scarletalliance.org.au)

**Address** Suite 9, 245 Chalmers Street, Redfern

**Postal Address** PO Box 261, Darlinghurst NSW 1300

**Telephone** +61 (2) 9690 0551

**Facsimile** +61 (2) 9690 1013

**Email** [info@scarletalliance.org.au](mailto:info@scarletalliance.org.au)

# THE FACTS ABOUT HIV AND AIDS

## HIV

HIV stands for 'Human Immunodeficiency Virus'. HIV is a virus that infects cells of the human immune system and impairs or destroys their function. HIV infection results in the progressive deterioration of the immune system leading to 'immune deficiency', where the immune system cannot effectively fight infection or disease. Consequently, people who are immunodeficient are more susceptible to a wide range of infections, most of which are rare among people without immune deficiency. Infections associated with severe immunodeficiency are known as 'opportunistic infections' because they take advantage of a weakened immune system.

### What are the symptoms of HIV?

Most people are unaware they have been infected with HIV at the time of infection because they experience no sense of illness. This has major implications for transmission as HIV is highly infectious during the early stage of infection.

Seroconversion usually occurs between one and six weeks after HIV infection. It refers to the development of antibodies to HIV and it is at this point some people develop a glandular fever-like illness with fever, rash, joint pains and enlarged lymph nodes (this is also known as a seroconversion illness or 'acute retroviral syndrome'). However, HIV cannot be diagnosed by symptoms – symptoms may not be present or symptoms experienced may relate to other conditions.

The only way to determine whether HIV is present in a person's body is by testing for HIV antibodies or HIV itself.

After HIV has caused progressive deterioration of the immune system, increased susceptibility to infections may lead to illness. The stages of HIV are defined on the basis of certain signs, symptoms, infections and cancers grouped by the World Health Organization (WHO). *(See Table 1 next page.)*

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**Table 1** Interim WHO clinical staging of HIV/AIDS and HIV/AIDS case definitions for surveillance (2005)

<b>Primary HIV infection</b>	May be asymptomatic (showing no symptoms) or experienced as acute retroviral syndrome (which typically manifests as flu-like symptoms)
<b>Clinical stage 1</b>	May be asymptomatic, or have generalised swelling of the lymph nodes
<b>Clinical stage 2</b>	Symptoms include minor weight loss, minor mucocutaneous manifestations, and recurrent upper respiratory tract infections
<b>Clinical stage 3 (patient may or may not have AIDS)</b>	Symptoms include unexplained chronic diarrhoea, unexplained persistent fever, oral candidiasis (thrush) or leukoplakia, severe bacterial infections, pulmonary tuberculosis, and acute necrotising inflammation in the mouth
<b>Clinical stage 4 (patient has AIDS)</b>	Symptoms include a range of HIV-related opportunistic infections or cancers

Note: Most of the above conditions are opportunistic infections that can be treated easily in healthy people.

Source: WHO, <http://www.who.int/hiv/pub/guidelines/clinicalstaging.pdf>

### **What is AIDS?**

AIDS stands for 'Acquired Immune Deficiency Syndrome'. AIDS is a surveillance definition based on signs, symptoms, infections and cancers associated with HIV-related deficiency of the immune system.

AIDS describes the most advanced stages of HIV infection, defined by the occurrence of any of more than 20 opportunistic infections or HIV-related cancers. The US Centers for Disease Control and Prevention (CDC) defines AIDS on the basis of a CD4 positive T cell count of less than 200 per mm<sup>3</sup> of blood. 'CD4 T cells' are a type of white blood cell that plays an important role in the body's immune system. Where HIV damages the immune system, the number of CD4 cells in the blood decreases.

### **How quickly do people infected with HIV develop AIDS?**

The length of time varies significantly between individuals. The majority of people infected with HIV develop signs of HIV-related illness within five to ten years if they do not receive treatment, but even then, the time between HIV infection and developing AIDS can be ten to 15 years or even longer. Antiretroviral therapies (often referred to as ART or ARVs) slow down HIV disease progression to AIDS by decreasing the infected person's HIV viral load (that is, the amount of the virus in their blood). Progression to AIDS can be much faster in countries where treatments are not available and where people often have other diseases such as tuberculosis, hepatitis or malaria.

# HIV IN AUSTRALIA

## Who has HIV?

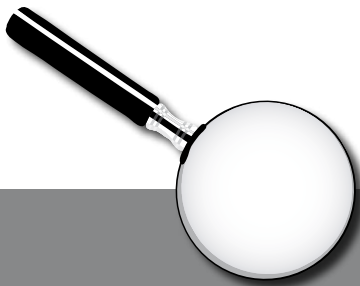
Detailed HIV surveillance data are collected and analysed to inform HIV prevention, care and treatment. All states and territories require doctors and/or laboratories to notify cases of HIV diagnosis to their state health department, which then forwards that information to The Kirby Institute for infection and immunity in society ('The Kirby Institute' was previously known as the National Centre in HIV Epidemiology and Clinical Research or NCHECR), for inclusion in the National HIV Registry. Information is coded to protect client confidentiality. Likewise, AIDS diagnoses and HIV-related deaths also require notification. This careful management of data has been crucial to Australia's successful public health response to HIV.

The following information is drawn from the *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010* (reporting to March 2010). It is essential that any data reported accurately reflects the official statistics. To ensure this, media organisations should contact The Kirby Institute or relevant state/territory health departments, for the most up-to-date information.

- ❖ By 31 December 2009, there had been 29,395 diagnoses of HIV infection in Australia, 10,446 diagnoses of AIDS and 6,776 deaths following AIDS. Some 20,171 people were estimated to be living with HIV in Australia at the end of 2009.
- ❖ The number of new HIV diagnoses in Australia peaked in 1987, and then declined each year until 1999 when there were 718 diagnoses. Since 1999 the number of diagnoses has risen each year, and reached 1,050 in 2009.
- ❖ The annual number of AIDS diagnoses in Australia peaked at 953 cases in 1994. After 1994, AIDS diagnoses declined rapidly to 216 in 1999. Since that time AIDS diagnoses have remained relatively stable. This is due to the introduction of effective antiretroviral therapies which delay progression from HIV to AIDS.

*(See Figure 1 on page 17.)*

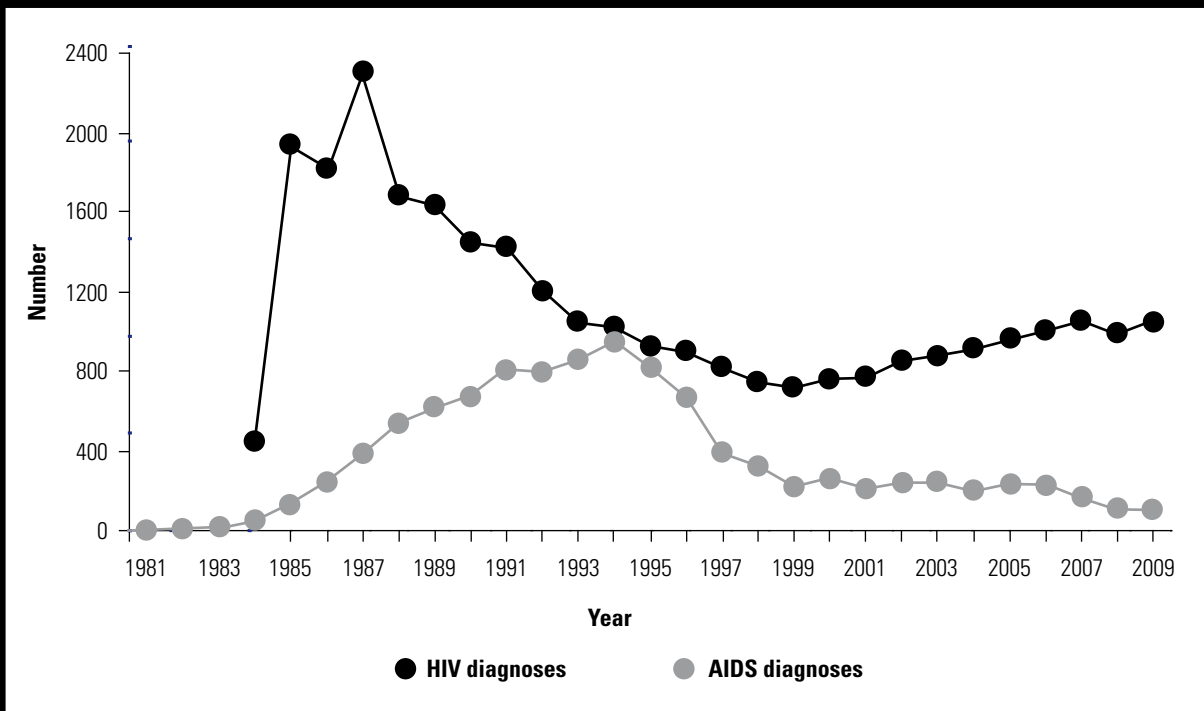
ALL STATES AND TERRITORIES REQUIRE DOCTORS AND/OR LABORATORIES TO NOTIFY CASES OF HIV DIAGNOSIS TO THEIR STATE HEALTH DEPARTMENT, WHICH THEN FORWARDS THAT INFORMATION TO THE KIRBY INSTITUTE FOR INFECTION AND IMMUNITY IN SOCIETY FOR INCLUSION ON THE NATIONAL HIV DATABASE.



For the latest data on HIV in Australia, see the website of **The Kirby Institute for infection and immunity in society** at <http://hiv.cms.med.unsw.edu.au>

- ❖ In Australia, transmission of HIV continues to occur primarily through sexual contact between men. Between 2005 and 2009, a history of male homosexual contact was reported in 66 percent of cases of newly diagnosed HIV infection. Another 3 percent were men with a history of both homosexual contact and injecting drug use.
- ❖ During 2005–2009, 23 percent of HIV diagnoses were attributed to heterosexual contact. During that time, 58 percent of cases of HIV infection attributed to heterosexual contact were in people from high prevalence countries or their sexual partners.
- ❖ During the same period, three percent of HIV diagnoses were attributed to injecting drug use. *(See Figure 2 on the next page.)*
- ❖ The per capita rate of HIV diagnosis in the Aboriginal and Torres Strait Islander population is similar to the non-Indigenous population. For example, among Indigenous people the rate was 3.9 per 100,000 population during 2005–2009, while among non-Indigenous people it reached 3.6 per 100,000 population in 2005–2009.
- ❖ In the Aboriginal and Torres Strait Islander population a higher proportion of cases were attributed to heterosexual contact and injecting drug use. For example, 21 percent of HIV diagnoses in Indigenous people were attributed to heterosexual contact, as opposed to 15 percent in non-Indigenous people, while 20 percent of diagnoses in Indigenous people were attributed to injecting drug use and 3 percent among non-Indigenous people.
- ❖ Around 12 percent of cases of HIV infection newly diagnosed in 2009 had been previously diagnosed overseas.

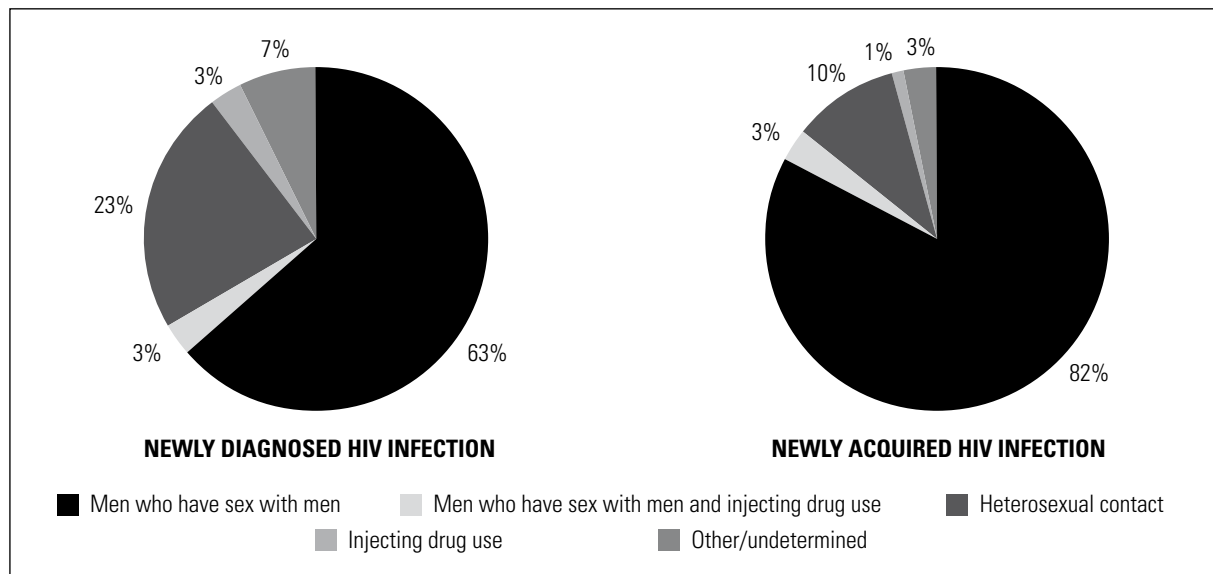




**Figure 1** HIV/AIDS Diagnoses in Australia, 1981–2009

Please note: AIDS diagnoses in NSW are not included from 1 January 2008

Source: *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010*



**Figure 2** HIV diagnosis, 2005–2009, by HIV exposure category

Source: *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010*



### The experience of living with HIV

The Australian Research Centre in Sex, Health and Society (ARCSHS) conducts a national program of social research focusing on the experience of living with HIV, to help increase understanding of the issues affecting people living with HIV. One key piece of work is the HIV Futures study which surveys approximately 1,100 HIV-positive Australians every two years. The most recent study is *HIV Futures 6: Making Positive Lives Count* (Futures 6), published in 2009. A summary of some key points from Futures 6 are cited below.

Of those interviewed for Futures 6:

- ❖ 72.6 percent of people living with HIV rated their health as good or excellent and 66.2 percent rated their general wellbeing as good or excellent.
- ❖ Just over half of respondents were currently in paid employment (54.7 percent), the majority of these being in full-time work (37.4 percent of total sample). The majority of the remainder described themselves as either not working or retired.
- ❖ When asked if they had experienced any of the following conditions in the previous 12 months:
  - 77.6 percent reported low energy or fatigue
  - 60.7 percent experienced a sleep disorder
  - 40.1 percent experienced confusion or memory loss
  - 31.9 percent experienced weight loss
  - 29 percent reported experiencing lipodystrophy (changes in fat distribution).
- ❖ In the last six months, 27.0 percent of respondents had taken prescribed medication for depression and 28.6 percent for anxiety – 44.6 percent had been diagnosed with a mental illness at some

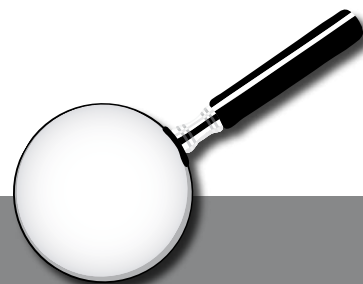


time during their lives and 40.5 percent had been diagnosed with depression at some time, 8.8 percent in the last two years.

- ❖ Almost all had disclosed their HIV status to at least one person, generally partners, close friends and family, while 51.4 percent of respondents had had their HIV status disclosed to another person when they did not want it to be disclosed (22.0 percent in the last two years).
- ❖ 26.4 percent experienced less favourable treatment because of HIV in relation to health services, 2.6 percent in the last two years. Another 7.9 percent experienced less favourable treatment in relation to accommodation, 2.6 percent in the last two years.
- ❖ 31.0 percent of people living with HIV lived below the poverty line. Just under one-quarter of respondents have a partner with whom they share financial resources.

The National Centre in HIV Social Research (NCHSR), based at the University of New South Wales, conducts research into the social and behavioural aspects of HIV, particularly relating to sexual practices, but also regarding hepatitis C, injecting and illicit drug use, and issues affecting Aboriginal and Torres Strait Islander health.

NCHSR reports on behavioural and attitudinal data related to HIV transmission in the *HIV/AIDS, hepatitis, and sexually transmissible infections in Australia: Annual Report on Trends in Behaviour*. The report includes current information on sexual practice and partnerships among gay-identified men and other men who have sex with men. The 2010 report notes there has been relatively little change in patterns of sexual practice and partnerships among gay-identified men participating in *Gay Community Periodic Surveys* over the last few years, suggesting many HIV prevention practices are well-established.



A range of publications and reports on social aspects of HIV prevention are available on **The Australian Research Centre in Sex, Health and Society (ARCSHS) website** at <http://www.latrobe.edu.au/arcsHS>

For more information on social research into HIV and the current Annual Report Trends in Behavior, see **The National Centre in HIV Social Research (NCHSR) website** at <http://nchsr.arts.unsw.edu.au>

**Pictured far left from top** WA AIDS Council volunteers collect donations on World AIDS Day, December 1, 2009; The Drama Downunder campaign produced by the Australian Federation of AIDS Organisations; AFAO's president Graham Brown at a protest rally staged during the 2010 International AIDS Society conference in Vienna; the Chinese Community Review Panel hard at work considering applications for AFAO's International Small Grants Scheme; Scarlet Alliance raising the visibility of sex workers in the wider community; and event invitation produced by the AIDS Action Council of the ACT for the International AIDS Candlelight Memorial – one of the world's oldest and largest grassroots mobilisation campaigns for HIV/AIDS awareness.



# AUSTRALIA IN THE GLOBAL CONTEXT

AUSTRALIA'S RESPONSE TO HIV HAS PRODUCED SIGNIFICANT RESULTS, WITH HIV PREVALENCE FAR LOWER THAN IN MANY PARTS OF THE WORLD, INCLUDING MANY OTHER WEALTHY NATIONS.

**Internationally, HIV is a significant threat to development and stability, with over 25 million deaths to date. In many areas, HIV-related deaths have caused a demographic imbalance due to the impact on people in their most productive years, with resulting social and economic implications. HIV continues to devastate families, communities and nations.**

UNAIDS suggests the global epidemic is stabilising but at an unacceptably high level. According to the *UNAIDS 2010 Global Report* (the Global Report), there were an estimated 33.3 million people living with HIV in 2009. The annual number of new HIV infections declined from some 3.1 million in 1999 to around 2.6 million in 2009.

Australia's response to HIV has produced significant results, with HIV prevalence far lower than in many parts of the world, including many other wealthy nations. In virtually all regions outside sub-Saharan Africa, HIV disproportionately affects injecting drug users, men who have sex with men, and sex workers. However, in Australia effective prevention efforts among key population groups (gay and other homosexually active men, Aboriginal and Torres Strait Islander people, people who have injected drugs, and sex workers and their clients) has had a dramatic impact on both the number of HIV infections and the profile of the epidemic in Australia.

Australia's early response to HIV and AIDS is widely recognised as being one of the best in the world. Following the identification of HIV and AIDS in Australia, federal and state governments responded pro-actively. They implemented often controversial public health strategies such as condom vending machines, needle and syringe exchange programs and, most importantly, publicly talked about the risk factors for HIV transmission.

Australian communities also mobilised to prevent HIV transmission and provide support to those living with HIV. Communication with government was strong, and the partnership between government and those communities most affected by HIV (such as gay men, sex workers and injecting drug users) remains a distinguishing feature of the Australian response to HIV.

For a comparison of Australia's estimated HIV prevalence and that of other countries, see Table 2 (next page) which shows that Australia's rate of HIV diagnoses per 100,000 of the population was significantly lower than rates for Canada and the United States in 2009. The table also shows substantially higher prevalence estimates for other countries in our region such as Cambodia, Myanmar (Burma), Thailand and Papua New Guinea.

**Table 2** Estimated HIV prevalence and AIDS incidence in selected countries

Country	HIV prevalence	
	2009 <sup>1</sup>	Rate <sup>2</sup>
<b>AFRICA</b>		
Ethiopia <sup>2,3</sup>	980 000	2 100
Mauritius <sup>2,3</sup>	13 000	1 700
Somalia <sup>2,3</sup>	24 000	500
South Africa <sup>2,3</sup>	5 700 000	18 100
Sudan <sup>2,3</sup>	320 000	1 400
Zambia <sup>2,3</sup>	1 100 000	15 200
Zimbabwe <sup>2,3</sup>	1 300 000	15 300
<b>ASIA PACIFIC</b>		
Australia <sup>5</sup>	20 171	92
Cambodia <sup>2,3</sup>	75 000	800
China <sup>2,3</sup>	700 000	100
India <sup>2,3</sup>	2 400 000	300
Indonesia <sup>2,3</sup>	270 000	200
Japan <sup>2,3</sup>	9 600	<100
Malaysia <sup>2,3</sup>	80 000	500
Myanmar <sup>2,3</sup>	240 000	700
New Zealand <sup>2,3</sup>	1 400	100
Papua New Guinea <sup>2,3</sup>	54 000	1 500
Philippines <sup>2,3</sup>	8 300	<100
Republic of Korea <sup>2,3</sup>	13 000	<100
Thailand <sup>2,3</sup>	610 000	1 400
Vietnam <sup>2,3</sup>	290 000	500
<b>EUROPE</b>		
France <sup>3</sup>	140 000	400
Germany <sup>3</sup>	53 000	100
Italy <sup>3</sup>	150 000	400
Spain <sup>3</sup>	140 000	500
United Kingdom <sup>4,6</sup>	83 000	134
<b>NORTH AMERICA</b>		
Canada <sup>4,6</sup>	65 000	195
United States <sup>3,5</sup>	580 371	275

1 Estimated number of people living with HIV infection.

2 Rate per 100 000 population aged 15–49 years.

3 Estimated HIV prevalence in 2007.

4 Estimated HIV prevalence in 2008. Rate per 100 000 population.

5 Estimated number of people living with diagnosed HIV infection.

6 Estimated number of people living with diagnosed and undiagnosed HIV infection.

Source: HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010

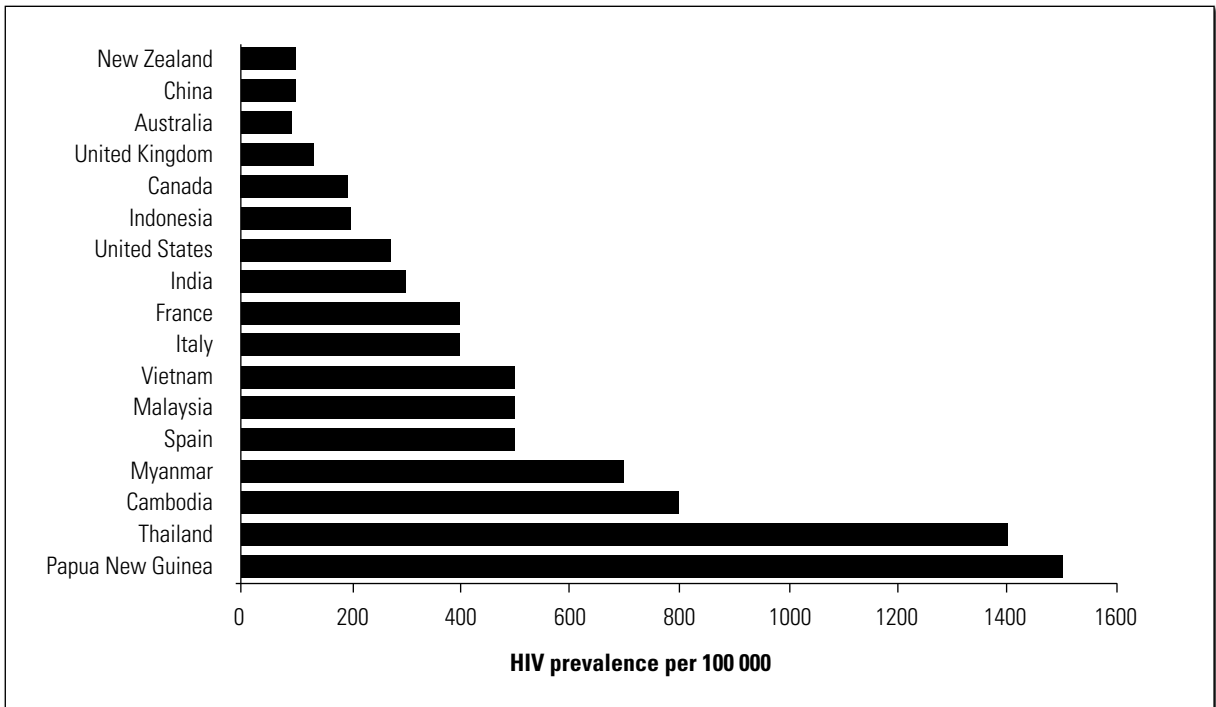


**AUSTRALIA'S EARLY  
RESPONSE TO HIV  
AND AIDS IS WIDELY**

**RECOGNISED AS  
BEING ONE OF THE  
BEST IN THE WORLD.**

Globally, women make just over half of all those living with HIV. In Australia, women made up 9.5 percent of people living with HIV, and 12.8 percent of newly diagnosed HIV infections between 2005 and 2009. That figure is higher among Aboriginal and Torres Strait Islander women, who comprised 19.1 percent of new infections among Aboriginal and Torres Strait Islander people. Almost 60 percent of cases among people from high prevalence countries in 2005–2009 were women.

People living with HIV in Australia who are permanent residents or citizens have universal access to subsidised HIV treatments through Medicare. Overseas, particularly in countries with high HIV prevalence, international efforts to scale-up HIV treatment programs can be slowed by lack of funds, lack of trained health care workers and weak health care systems. (See Figure 3.)



**Figure 3** HIV prevalence in selected countries

Source: *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010*

# AUSTRALIA'S SIXTH NATIONAL HIV STRATEGY

**The *Sixth National HIV Strategy 2010–2013* (the National Strategy) provides the framework for the Australian government's response to HIV. The National Strategy aims to reduce HIV transmission and to minimise the personal and social impact of HIV. Its objectives are to:**

- ❖ reduce the incidence of HIV
- ❖ reduce the risk behaviours associated with the transmission of HIV
- ❖ increase the proportion of people living with HIV on treatments with undetectable viral load
- ❖ decrease the number of people with undiagnosed HIV infection, and
- ❖ improve the quality of life of people living with HIV.

The National Strategy includes five guiding principles which inform government policy on HIV in Australia. The guiding principles state:

- ❖ The transmission of HIV, sexually transmitted infections (STIs) and hepatitis C can be prevented by adopting and maintaining protective behaviours. Vaccination is the most effective means of preventing the transmission of hepatitis B. Vaccination, education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures. Individuals and communities have a mutual responsibility to prevent themselves and others from becoming infected.
- ❖ The *Ottawa Charter for Health Promotion* provides the framework for effective HIV, STI and viral hepatitis health promotion action and facilitates the:
  - active participation of affected communities and individuals, including peer education and community ownership, to increase their influence over the determinants of their health
  - formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights as this protects those who are vulnerable or marginalised, promotes confidence in the system and secures support for initiatives.

VACCINATION,  
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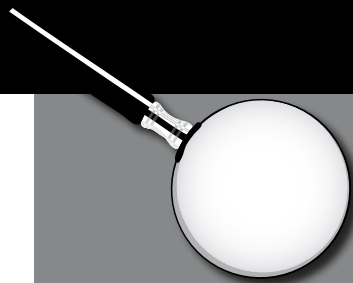
THE HIV PARTNERSHIP:  
RECOGNISING THE  
IMPORTANCE OF A  
MULTI-SECTORAL  
RESPONSE FROM  
GOVERNMENT,  
COMMUNITY, PEOPLE  
LIVING WITH HIV,  
RESEARCHERS AND  
THE FIELDS OF SCIENCE  
AND MEDICINE.

- ❖ Harm reduction principles underpin effective measures to prevent transmission of HIV and viral hepatitis, including through needle and syringe programs (NSPs) and drug treatment programs.
- ❖ People with HIV, STIs and viral hepatitis have a right to participate in the community without experiencing stigma or discrimination, and have the same rights to comprehensive and appropriate health care as other members of the community (including the right to confidential and sensitive handling of personal and medical information).
- ❖ An effective partnership of governments, affected communities, researchers and health professionals is characterised by consultation, cooperative effort, respectful discussion and action to achieve this strategy's goal.
  - **leadership:** strong and visible leadership by the National Government (including bipartisan support), and by all other relative parties
  - **the HIV partnership:** recognising the importance of a multi-sectoral response from government, community, people living with HIV, researchers and the fields of science and medicine
  - **the centrality of people living with HIV:** ensuring policies and programs are informed by the experiences of people with HIV, are responsive to need, and take adequate account of the full range of personal and community effects of policy directions
  - **an enabling environment:** delivering a supportive social, legal and policy environment that encourages people with HIV and affected communities to support and promote education and prevention, respond to education, access voluntary testing and treatment services, and participate actively in all levels of the response
  - **non-partisan response:** ensuring the response does not become inappropriately 'politicised'. The strategy has historically had the bi-partisan support of both major political parties
  - **health promotion and harm minimisation:** including addressing disease prevention, education, social mobilisation and advocacy, with an emphasis on a complete state of wellbeing, and recognising that vulnerabilities can be influenced only by a holistic approach, not just individual behaviours.

Two other essential components of Australia's response to HIV warrant specific mention:

- ❖ the provision of appropriate levels of funding in most instances (via transparent and accountable mechanisms), and
- ❖ the funding and delivery of expert research and surveillance data (developed with communities and service providers), ensuring that policy in response to HIV has been based on a sound evidence base.

The *Sixth National HIV Strategy* identifies seven priority population groups for prevention education and health promotion initiatives: people living with HIV, gay and other men who have sex with men, Aboriginal and Torres Strait Islander peoples, people from (or who travel to) high-prevalence countries, sex workers, people in custodial settings, and people who inject drugs .



The *Sixth National HIV Strategy* is available online at [http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-hiv/\\$File/hiv.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-hiv/$File/hiv.pdf)

The National HIV Strategy endeavours to support the Government to meet its commitments relating to the *Ottawa Charter for Health Promotion* (World Health Organization, 1986), available at [http://www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf), and the *UN General Assembly Declaration of Commitment on HIV/AIDS* (signed 2001), available at <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>



# TRANSMISSION

YOU CANNOT BE INFECTED BY SHAKING SOMEONE'S HANDS, HUGGING, USING THE SAME TOILET, DRINKING FROM THE SAME GLASS, PLAYING SPORTS WITH SOMEONE OR BY BEING EXPOSED TO COUGHING OR SNEEZING BY A PERSON LIVING WITH HIV.

**HIV is not transmitted by day-to-day contact in social settings, schools or in the workplace. You cannot be infected by shaking hands, hugging, using the same toilet, drinking from the same glass, playing sports with someone or by being exposed to coughing or sneezing by a person living with HIV. HIV is not spread by mosquitoes or other biting insects.**

HIV is found in blood, semen, pre-ejaculate, vaginal fluids and breast milk. It may be transmitted through:

- ❖ unprotected penetrative sex (vaginal or anal) with an infected person
- ❖ using contaminated syringes, needles or other sharp instruments
- ❖ blood transfusion with contaminated blood
- ❖ childbirth and breastfeeding, or from an infected mother to her child during pregnancy.

## Safe sex

'Safe' or 'protected' sex involves taking precautions that reduce the potential of transmitting or acquiring sexually transmissible infections including HIV. Different penetrative sexual acts attach different degrees of risk but using condoms correctly every time one has sex is considered safe sex.

## Circumcision

Recent studies suggest that male circumcision reduces the risk of men acquiring HIV through heterosexual sex but it is not completely effective. Circumcised men can become infected and circumcised HIV-positive men can infect their sexual partners.

## The Swiss Statement

The January 2008 issue of the *Bulletin of Swiss Medicine* included a Swiss National AIDS Commission report on the infectiousness of HIV-positive people who adhere to optimally effective antiretroviral therapies. The report, authored by four of Switzerland's foremost HIV experts, included the statement that a person with HIV is not sexually infectious and cannot transmit the virus through heterosexual sexual contact if on antiretroviral therapy resulting in suppression of viral load to a point it cannot be detected. The authors clarified the statement, indicating that it was only valid if:

- ❖ the person infected with HIV consistently adheres with their antiretroviral therapy, the effects of which must be evaluated regularly by their treating physician;

- ❖ the person infected with HIV has a viral load during antiretroviral therapy that is below the limits of detection (blood plasma level <40 copies/ml) and has been so for at least six months (i.e. viraemia is suppressed); and
- ❖ the person infected with HIV has no additional sexually transmissible infection present.

The 'Swiss Statement' made headlines around the world; however, most HIV/AIDS researchers continue to insist that safe sex is the only way to prevent the spread of HIV. For example, UNAIDS and the World Health Organization continue to recommend a comprehensive package of HIV prevention approaches, including correct and consistent use of condoms. The US Centers for Disease Control and Prevention (CDC) continues to underscore its recommendation that sexually active people living with HIV use condoms consistently and correctly with all sex partners.

### **Contaminated syringes, needles or other sharp instruments**

People who inject drugs are at high risk of acquiring HIV because they can inject HIV directly into their bloodstream.

Australia's needle and syringe programs (NSPs) have been highly successful in minimising HIV transmission through injecting drug use. NSPs were introduced before HIV became endemic in Australia's population of injecting drug users, enabling a significant preventive health strategy to be implemented in a population with low rates of HIV infection. *The Return on Investment in Needle and Syringe Programs in Australia* report (Commonwealth Department of Health and Ageing, 2002) indicated that by the year 2000, an estimated 25,000 HIV infections among injecting drug users had been prevented, and that the return on investment (saving the health economy billions of dollars) many times exceeded investment in NSPs (*National HIV Strategy 2005*).

Similar findings were reported in the *Return on Investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia* report (Commonwealth Department of Health and Ageing & NCHECR, 2009), which found that during the decade 2000 to 2009, a further 32,050 HIV infections had been averted, with net financial cost savings exceeding a billion dollars.

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HOWEVER,

AUSTRALIA'S NEEDLE  
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THROUGH INJECTING  
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THE LEVEL OF RISK  
RELATES TO THE  
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OF THE INFECTION,  
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TRANSMISSION,  
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OF EXPOSED  
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SUCCESS OF APPLIED  
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INCLUDING  
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### **HIV transmission in health care settings**

**Health care workers** are at risk of HIV (and other) infection as the result of handling sharp objects that might cut or puncture their skin while treating HIV-positive patients. The level of risk relates to the transmissibility of the infection, the availability of a route of transmission, the susceptibility of exposed people, and the success of applied control measures including 'standard precautions'. Australian medical and associated staff are required to use standard precautions which include:

- ❖ careful handling and disposal of 'sharps' (items that could cause cuts or puncture wounds, including needles, hypodermic needles, scalpel and other blades, knives, infusion sets, saws, broken glass, and nails)
- ❖ hand-washing with soap and water before and after all procedures
- ❖ use of protective barriers such as gloves, gowns, aprons, masks and goggles when in direct contact with blood and other body fluids
- ❖ safe disposal of waste contaminated with blood or body fluids
- ❖ disinfection of instruments and other contaminated equipment
- ❖ proper handling of bedding and clothing stained with blood, diarrhoea or other body fluids.

The *National HIV Testing Policy 2006* states that if a health care worker is occupationally exposed to blood or body fluids (e.g. through needlestick injury), testing should be offered and performed urgently for the purposes of post-exposure prophylaxis (PEP) prescription. PEP refers to the prescription of a short course of antiretroviral drugs following exposure to HIV, to prevent infection. (The *National HIV Testing Policy* is under review at the time of writing. The new policy will be released shortly and published on the Australasian Society for HIV Medicine [ASHM] website at: <http://www.ashm.org.au>).

**Patients** may be at risk of HIV transmission from health care workers, particularly during 'exposure-prone procedures'. In general, health care workers who perform exposure-prone procedures have a professional obligation to know their HIV status, and if HIV-positive not perform them.

### **Piercing and tattooing**

HIV transmission risk exists if non-sterile instruments are used for body piercing or tattooing. Instruments which penetrate the skin must be sterilised and used once, then disposed of or sterilised.

### **Contaminated blood supply**

The National Blood Authority is an Australian Government agency charged with managing Australia's blood supply. The National Blood Authority works to provide an adequate, safe, secure and affordable supply of blood products, blood-related products and services, and to promote the safe and high-quality management of those products. Australian blood products are tested for HIV before they are distributed.

### **Mother-to-child transmission**

Mother-to-child HIV transmission (sometimes called or perinatal or vertical transmission) can occur during pregnancy, during labour or after delivery through breastfeeding. The risk of mother-to-child transmission can be reduced by:

- ❖ treatment with antiretroviral drugs during pregnancy
- ❖ caesarean section
- ❖ avoiding breastfeeding, but only when replacement feeding is acceptable, feasible, affordable, sustainable and safe. If not, exclusive breastfeeding is recommended for the first six months.

While common in the developing world, mother-to-child transmission is rare in Australia.



**THE NATIONAL  
BLOOD AUTHORITY  
WORKS TO PROVIDE  
AN ADEQUATE,  
SAFE, SECURE  
AND AFFORDABLE  
SUPPLY OF BLOOD  
PRODUCTS AND  
SERVICES, AND TO  
PROMOTE THE SAFE  
AND HIGH-QUALITY  
MANAGEMENT OF  
THOSE PRODUCTS.**



Detailed information about infection control procedures in health care settings is available from the **Australian Government National Health and Medical Research Council (NHMRC) website: <http://www.nhmrc.gov.au/node/30290>**

You can find the **National Blood Authority website at <http://www.nba.gov.au>**

# TESTING

HIV TESTING IS GENERALLY RECOMMENDED BECAUSE IDENTIFYING A PERSON IS HIV-POSITIVE MEANS THEY CAN GAIN EARLY ACCESS TO TREATMENT AND SUPPORT, OFTEN INCREASING THEIR QUALITY OF LIFE AND LIFE EXPECTANCY, AND TAKE NECESSARY PRECAUTIONS TO PREVENT TRANSMITTING HIV TO OTHERS.

**HIV infection can only be diagnosed by using an HIV blood test that reveals whether HIV is present. Commonly used HIV tests detect the antibodies produced by the immune system in response to HIV, as it is much easier and cheaper to detect antibodies than to detect the virus itself. Antibodies are produced by the immune system in response to HIV infection, usually taking several weeks to appear, or in rare cases, up to six months (the 'window period'). Unfortunately, HIV is at its most contagious during the window period.**

Most laboratories that test for HIV in Australia (and all of the laboratories that test in areas with higher HIV populations, such as inner Sydney) now use a combined HIV antibody/antigen test. This combination test can pick up infections which occurred as little as 14 days prior to the blood sample being drawn.

HIV testing is generally recommended because identifying HIV infection enables early access to treatment and support, often increasing quality of life and life expectancy of people living with HIV and facilitating their use of necessary precautions to prevent transmitting HIV to others.

HIV testing in Australia is currently guided by the *National HIV Testing Policy 2006* (the 2006 Testing Policy). The *National HIV Testing Policy* is under review at the time of writing and the revised policy is likely to be in force by 2012.

The 2006 Testing Policy outlines six basic principles to inform HIV testing:

- ❖ confidential voluntary testing with informed consent is fundamental to Australia's HIV/AIDS response
- ❖ testing must be of the highest possible standard
- ❖ testing must be of benefit to the person being tested
- ❖ testing must be accessible to all those at risk of HIV infection
- ❖ testing is critical to understanding the epidemiology of HIV infection in the community
- ❖ testing is critical to interruption of transmission.

Under the 2006 Testing Policy, HIV testing must be carried out by a health care practitioner.

## **Confidentiality of HIV test results**

The results of HIV tests are confidential. Medical records remain confidential, and laboratories and state and national databases are given coded information that notifies them of an HIV diagnosis and related data

(such as age, location, mode of transmission), but not the identity of the individual concerned. It is also possible for individuals who do not wish to disclose their name or Medicare number to have 'anonymous' testing.

### **Informed consent**

HIV tests can only be performed with a patient's informed consent, which is typically obtained during pre-test discussion.

### **Pre-test discussion**

Pre-test discussion between the health care practitioner and the patient must occur before HIV testing is done. Specifically, pre-test discussion should provide accurate information about safe practices that are appropriate to the person's gender, culture, behaviour and language, using accredited interpreters where appropriate. The discussion should include:

- ❖ information on how HIV is transmitted (where appropriate)
- ❖ risk assessment and discussion of the reason for testing
- ❖ timing of the risk event and options for post-exposure prophylaxis (PEP)
- ❖ possible desirability of testing for other sexually transmissible infections (STIs)
- ❖ information about confidentiality and privacy
- ❖ information about the testing process including how results are to be provided, the window period, and the difference between HIV and AIDS
- ❖ information about what happens to test results
- ❖ seeking informed consent for the test to be conducted
- ❖ assessment of the person's preparedness to be tested and assurance that the person wishes to proceed with the test
- ❖ information about what a negative or positive result means
- ❖ assessment of support mechanisms while waiting for the test result and/or if the result is positive.

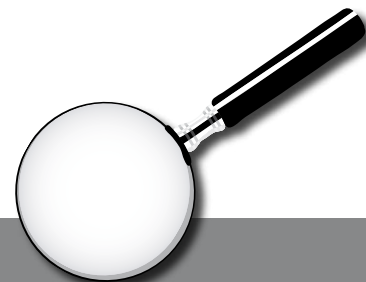
### **Test results and post-test discussion**

Positive test results must be given in person with post-test discussion to follow. Post-test discussion is required whether the diagnosis is positive or negative. Post-test discussion provides the opportunity to discuss the patient's health, possible referrals and prevention issues.

The Futures 6 report found that of the approximately 1,100 people surveyed:

- ❖ 25.1 percent tested for HIV because they became ill
- ❖ 16.9 percent tested as part of routine health screening
- ❖ 12.3 percent tested because of a particular risk episode
- ❖ 10.4 percent tested because they were a member of a risk group
- ❖ 2.9 percent were tested without their knowledge.

**HIV TESTS CAN ONLY  
BE PERFORMED  
WITH A PATIENT'S  
INFORMED CONSENT,  
WHICH IS TYPICALLY  
OBTAINED DURING  
PRE-TEST DISCUSSION.**



*The National HIV Testing Policy* is available on the **Australian Government Department of Health and Ageing website** at [http://www.health.gov.au/internet/main/Publishing.nsf/Content/F4F093E1E22A7478CA256F1900050FC7/\\$File/hiv-testing-policy-2006.pdf](http://www.health.gov.au/internet/main/Publishing.nsf/Content/F4F093E1E22A7478CA256F1900050FC7/$File/hiv-testing-policy-2006.pdf)

## TREATMENT

HIV IS DIFFICULT TO TREAT BECAUSE IT QUICKLY ADAPTS TO WHATEVER MEDICINES ARE BEING TAKEN AND IS ABLE TO MUTATE TO CIRCUMVENT EACH MEDICINE. COMBINATION ANTI-RETROVIRAL THERAPY, WHICH TYPICALLY INVOLVES TAKING AT LEAST THREE DRUGS AT THE SAME TIME, MAKES IT HARDER FOR THE VIRUS TO ADAPT AND BECOME RESISTANT.

**There is currently no cure for HIV, and best estimates put the likelihood of a vaccine or cure decades away. However, the development of effective treatments has radically changed the meaning of an HIV diagnosis. In the early 1980s, people living with HIV were expected to live only a few years but the development and distribution of antiretroviral therapies (ART) means most people in Australia diagnosed with HIV can expect to live longer, healthier lives.**

### **Combination antiretroviral therapy**

Antiretroviral drugs are used in the treatment and prevention of HIV infection. They work against HIV by stopping or interfering with the reproduction of the virus in the body. If virus reproduction is stopped, the body's immune cells live longer and provide the body protection from infections.

HIV is difficult to treat because it quickly adapts to whatever medicines are being taken and is able to mutate to circumvent each medicine. Combination antiretroviral therapy, which typically involves taking at least three drugs at the same time, makes it harder for the virus to adapt and become resistant. 'Highly Active Antiretroviral Therapy' (HAART) is another term used to describe a combination of three or more anti-HIV drugs.

The Futures 6 Report found that of those people with HIV surveyed 79.6 percent were currently using ART and 85.0 percent had used ART at some time.

Taking the medicines every day at the right time and in the right way keeps the correct levels of medications in the body, which makes it very hard for the virus to become resistant. Treatment adherence is vital for effective HIV management, and it is one of the ongoing challenges faced by people with HIV and their treating doctors.

ART can also reduce the risk of mother to child transmission. In most high-income countries, the rate of HIV transmission to babies has been reduced to less than 1 percent by ART in combination with caesarean section (instead of vaginal birth) and 'replacement'/formula bottle feeding (instead of breastfeeding).

### **Side effects and toxicities**

While treatments have had a significant impact on disease progression, these same treatments are complex and their associated toxicities produce a wide range and varying degrees of side effects in different people. They

frequently result in episodic illnesses and co-morbidities with greater immediate impact than the actual HIV infection. Some produce side effects such as nausea, vomiting or headaches but some side effects are so severe that treatment must be altered or stopped. Some specific ART medicines cause longer term changes in body shape and the redistribution of fat within the body (lipodystrophy).

The Futures 6 Report found that of those people with HIV surveyed, 39.1 percent of those currently taking ART reported that they experienced difficulties taking them of which the major problems were:

- ❖ 19.2 percent side effects
- ❖ 20.2 percent remembering to take the drugs on time
- ❖ 15.0 percent transporting medication
- ❖ 13.1 percent taking medication in public
- ❖ 11.5 percent organising meals around the drugs
- ❖ 8.2 percent taking large numbers of tablets.

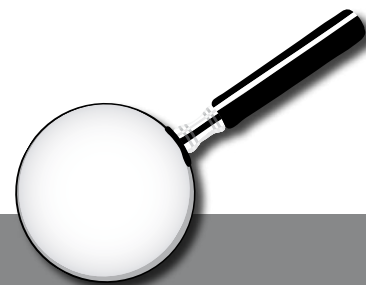
Side effects from ART remain a significant concern for those on treatment, with 19.2 percent reporting that they experienced side effects. The most commonly reported side effects were diarrhoea, nausea and fatigue.

### **Post-exposure prophylaxis (PEP)**

Post-exposure prophylaxis (PEP) refers to a set of actions aimed at preventing infection in a person who may have been exposed to HIV infection. PEP may include first aid care, counselling and risk assessment, HIV testing following informed consent and, depending on the risk assessment, the provision of a short course (28 days) of antiretroviral drugs with follow-up and support. Research suggests that if medication is initiated quickly after someone has been exposed to HIV, HIV infection (or seroconversion) may be averted. PEP should be made available as soon as possible and no later than 72 hours after exposure, and then be given for 28 days without interruption.

### **Transmitting HIV while on antiretroviral therapy**

Taking antiretroviral therapy does not guarantee the prevention of HIV transmission to sexual partners, infants or persons sharing unsafe injecting equipment (see 'Swiss Statement' on page 26). Usually antiretrovirals will keep HIV at a very low or undetectable level which may reduce transmission risk but the virus remains present, and there is no agreement to date about the particular 'threshold' at which HIV cannot be transmitted. Other factors that may increase the risk of transmitting HIV to others while on ART include poor adherence to treatment, presence of other illnesses, and taking other medicines that interfere with ART.



For more information on post-exposure prophylaxis, see the **World Health Organisation website at** <http://www.who.int/hiv/topics/prophylaxis/en>

# PREVENTION

**Australia's HIV prevention efforts have achieved significant results, with HIV far less prevalent in Australia than in many comparable settings. (For more comparative data, see 'Australia in the Global Context' on page 20.)**

There have been significant efforts to develop health promotion programs linked to measurable outcomes so that successive efforts are improved. In brief, Australian HIV prevention and health promotion principles are in line with those summarised by Baxter and McCallum (1998):

- ❖ Education designed and delivered by peers is likely to be more effective than education developed and delivered by other 'external' agencies – especially in marginalised communities suspicious of government and its operations
- ❖ Sustained behaviour change on a wide scale is more achievable through a programmatic focus on influencing social and community norms and beliefs, rather than by a focus on changing individual responses
- ❖ Education programs should involve the community in discussion and debate about the range and nature of measures it could take to reduce the impact of the epidemic
- ❖ HIV-positive people should be involved in all phases of program design, from initial concept through development to content and delivery
- ❖ Education should be 'sex positive'
- ❖ Education should be 'sexuality positive'
- ❖ Language, images and processes used should be those already existing in the community involved or generated by that community
- ❖ Language and images used should be direct, explicit, understandable and simple
- ❖ Campaigns should target high-risk behaviours rather than high-risk groups
- ❖ Resources and information need to be made available to assist communities coping with change
- ❖ The objective of information programs is to provide people from affected communities with sufficient information and support to make their own safe decisions rather than providing a prescriptive set of rules

AUSTRALIA'S HIV PREVENTION EFFORTS HAVE ACHIEVED SIGNIFICANT RESULTS, WITH HIV FAR LESS PREVALENT IN AUSTRALIA THAN IN MANY COMPARABLE SETTINGS.

THERE HAVE BEEN SIGNIFICANT EFFORTS TO DEVELOP HEALTH PROMOTION PROGRAMS LINKED TO MEASURABLE OUTCOMES SO THAT SUCCESSIVE EFFORTS ARE IMPROVED.

1 'Experience from Australia' in Anne Malcolm and Gary Dowsett *Partners in prevention: International case studies of effective health promotion practice in HIV/AIDS*, UNAIDS, 1998.

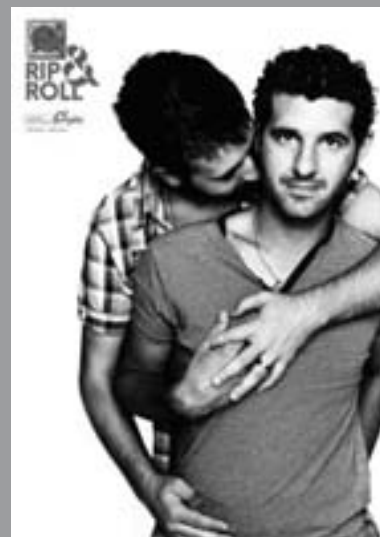
- ❖ Education programs should take great care to share equally the responsibility for preventing new infections between those infected, those not infected, and those unaware of their HIV status
- ❖ Education programs should be vigorous, continuous and have the capacity to adapt flexibly to changes in the epidemic and to changes within communities
- ❖ Education program design should be supported by an active, reflexive social research program
- ❖ These principles need to be endorsed and supported by the political and community leadership.

### **Harm reduction**

The principle of harm reduction has directly informed Australia's response to HIV, and has delivered clear results. Harm reduction can encompass a variety of strategies, such as needle and syringe exchange programs, peer education about safer drug use practices and drug treatment programs. Harm reduction strategies are not intended to condone practices such as drug use but rather to acknowledge that drug use does occur and the need to minimise harms that results from it. The principle of harm minimisation supports access to necessary and proven technologies, such as new and safer injecting equipment, condoms, and any other interventions shown to be effective in preventing HIV transmission. The success of Australia's needle and syringe programs has greatly limited the potential impact of HIV. Similarly, condoms have been demonstrated to be the cheapest, most readily accessible, safe and practical way to prevent sexual transmission of HIV and some other sexually transmitted infections (STIs).

### **Needle and syringe programs**

As suggested above, one of the most dramatic factors contributing to Australia's success in HIV prevention has been the success of needle and syringe programs (NSPs) in preventing HIV among people who inject drugs. NSPs are believed to have prevented some 32,000 cases of HIV infection in Australia in the last decade – and to have generated health based savings that have paid for the program many times over (NCHECR, *Return on Investment 2*, 2009). Despite assertions to the contrary, there is no evidence that NSPs increase injecting drug use. In fact, NSPs refer clients into drug treatment services, and drug use can actually decrease among people who inject drugs attending an NSP (World Health Organisation, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users*, World Health Organization 2004, p12.).



### **Prevention campaigns**

The 2010 'Rip & Roll' campaign was developed by Healthy Communities as a social marketing campaign to reinforce condom use among gay men.

Even though the material complied with Australian advertising standards, it was temporarily removed by Adshel – the company responsible for the campaign's outdoor visibility – after a series of complaints from the Australian Christian Lobby (ACL). With tens of thousands of people protesting the decision via social media, the ACL's Wendy Francis conceded on ABC Radio that she was behind the campaign to remove the ads.

Adshel immediately reinstated the campaign, saying: "It has now become clear that Adshel has been the target of a coordinated ACL campaign. This has led us to review our decision to remove the campaign and we will therefore reinstate the campaign with immediate effect."



### Prevention campaigns

AFAO's **Proud to be Black, Proud to be Gay** is a series of posters portraying Aboriginal and Torres Strait Islander gay men in a fun, strong and confident light, representing positive role models for the Aboriginal and Torres Strait Islander gay community.

The poster series identifies these men as bearers of an important message; encouraging each other to protect themselves against HIV and sexually transmitted infections, to wear condoms, to talk to each other about these issues and by doing so, also educating their own people and communities.

HIV prevention among people who inject drugs has not, however, been limited to NSPs. Needle and syringe programs need to be understood and reported in the context of prevention work that includes peer education on safer injecting practices, blood awareness, safe sex practices and drug treatment options including pharmacotherapy treatment and other harm reduction strategies.

### Peer education

Peer education has been a cornerstone of effective HIV prevention education. Peers are effective educators because they understand the culture and language of a group and can be accepted by its members. Peer education has been effective among gay men. Sex worker organisations have also been very successful through their employment of current and or past sex workers as peer educators. Peer educators staff some needle and syringe exchange programs, providing a means for connecting with injecting drug users and disseminating prevention and treatment information to people who are often stigmatised, marginalised and difficult to reach. In short, peer-based education is likely to be more effective than education developed and delivered by other 'external' agencies, especially in marginalised communities.

### PrEP (Pre-exposure prophylaxis)

Research is underway to identify whether pre-exposure prophylaxis (PrEP) may be an additional tool to reduce the risk of HIV transmission. PrEP describes HIV-negative people at risk of HIV infection taking antiretroviral medications to reduce that risk. While PrEP sounds good in theory, it poses many challenges in practice. Firstly, scientists are still trialling different drugs and the frequency of dose required to establish which may be most effective. Secondly, educators remain concerned that exaggerated belief in PrEP as an HIV prevention tool may undermine other established HIV prevention practices, encouraging individuals to take greater risks.

Two recent trials have produced very different results. The first, among women in sub-Saharan Africa, was stopped before its scheduled completion data as an interim report found comparable rates of HIV transmission among those taking PrEP and those not taking PrEP. Another trial undertaken in multiple sites recently found that PrEP had reduced HIV-transmission risk among men who have sex with men and transgender women, although PrEP did not reduce risk completely. Further trials are ongoing.

## LEGAL REGULATION

### Public health

Public health legislation in each state underpins the role of government in regulating public health and responding to disease. HIV is a notifiable disease in all Australian jurisdictions, meaning that medical practitioners must notify health authorities when an HIV diagnosis is made.

Public health legislation in each state also allows health authorities to manage people with HIV (and other notifiable diseases such as tuberculosis) who are at risk of infecting others. This management typically involves a series of interventions, beginning with counselling and escalating to imposition of a public health order and even confinement if necessary. (See also 'Confidentiality in HIV test results' on page 30.)

### Discrimination

Discrimination based on HIV infection is unlawful throughout Australia. HIV is covered by both federal and state/territory legislation. Federal law (the *Disability Discrimination Act 1992*) not only protects people living with HIV but also people believed to have HIV, and those who associate with them. The history of the development of anti-discrimination legislation makes it clear that the definition of 'associate' is intended to include homosexual as well as heterosexual partners.

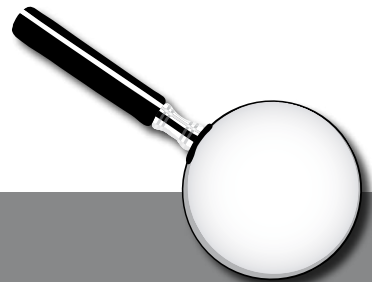
State and territory anti-discrimination Acts make it unlawful to discriminate on the grounds of 'disability' or 'impairment', including HIV infection. In the ACT and NSW it is also illegal to vilify a person with HIV. In Tasmania, it is unlawful to incite hatred on the grounds of disability (including HIV).

### Criminal prosecution of HIV transmission

Australia is experiencing an increase in the number of people being prosecuted for offences involving the transmission of HIV, or exposing others to HIV infection.

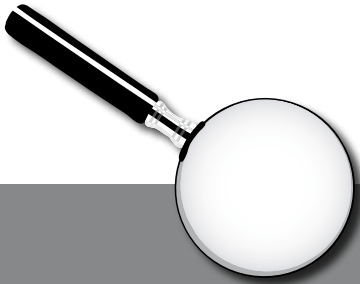
Each state and territory has different laws under which people may be prosecuted for transmitting or exposing others to HIV. Regardless of the merits of individual cases, criminal prosecution of people for exposure or

DISCRIMINATION  
BASED ON HIV  
INFECTION IS  
UNLAWFUL  
THROUGHOUT  
AUSTRALIA. HIV IS  
COVERED BY BOTH  
FEDERAL AND  
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LEGISLATION.



For more information see the **Australian Human Rights Commission's website at <http://humanrights.gov.au>**

There are a number of valuable websites with quality information about criminal prosecutions involving HIV transmission or exposure, including <http://www.avert.org/criminal-transmission.htm> and <http://www.aidsmap.com>



There are a number of valuable websites with quality information about criminal prosecutions involving HIV transmission or exposure. For example, see:

<http://www.afao.org.au>

<http://www.avert.org/criminal-transmission.htm>

<http://www.aidsmap.com>

[http://www.edwinjbernard.com/my\\_blog\\_criminal\\_hiv\\_transm.html](http://www.edwinjbernard.com/my_blog_criminal_hiv_transm.html)

transmission of HIV is considered by some commentators to be problematic because prosecutions:

- ❖ do not reduce HIV transmission risk
- ❖ single out HIV as worse than other infectious diseases
- ❖ attribute blame to individual accused: a message that runs counter to public health mutual responsibility messages
- ❖ ignore the fact that failure to disclose HIV status is not extraordinary
- ❖ reduce trust in health care practitioners, which may affect individual's treatment options as well as transmission risk
- ❖ increase stigma against people living with HIV
- ❖ increase the number of people living with HIV in Australian prisons
- ❖ are unacceptably arbitrary.

HIV policy commentators argue that it is generally preferable to manage people whose behaviour places others at risk of HIV infection under Australia's public health system, which includes legal mechanisms mandating safe behaviours or even detention. Criminal prosecutions tend to stigmatise people living with HIV and this stigmatisation may discourage people who engage in high risk behaviours from engaging with the health system.



# PRINCIPLES FOR REPORTING ON HIV AND AIDS

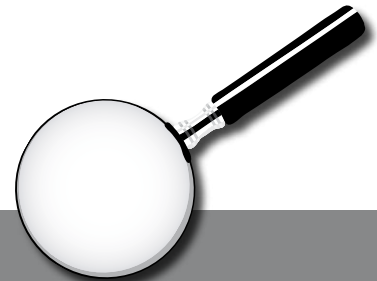
**The *Media Alliance Code of Ethics* sets out standards by which journalists can assess their reportage:**

*Respect for truth and the public's right to information are fundamental principles of journalism. Journalists describe society to itself. They convey information, ideas and opinions, a privileged role. They search, disclose, record, question, entertain, suggest and remember. They inform citizens and animate democracy. They give a practical form to freedom of expression. Many journalists work in private enterprise, but all have these public responsibilities. They scrutinise power, but also exercise it, and should be accountable. Accountability engenders trust. Without trust, journalists do not fulfil their public responsibilities. Alliance members engaged in journalism commit themselves to:*

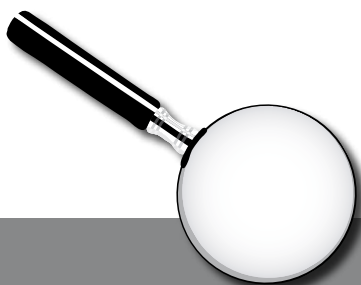
- *Honesty*
- *Fairness*
- *Independence*
- *Respect for the rights of others.*

The African Journ-AIDS website includes a set of principles for reporting on HIV. These principles are equally applicable for journalists in Australia:

1. Accuracy is critical, since important personal and policy decisions may be influenced by media reports. Journalists should be particularly careful to get scientific and statistical information right. Facts should be painstakingly checked, using credible sources to interpret information, verify facts and make statistics and science accessible and relevant to wide audiences. Sources should be named as often as possible. Stories should be written in context.
2. Misconceptions should be debunked, and any claims of cures or treatments should be reported with due care. Journalists should look at all stories critically.
3. Clarity means being prepared to discuss sex, cultural practices and other sensitive issues respectfully but openly. Care should be taken to



Full text is available at  
<http://www.alliance.org.au/media-alliance-code-of-ethics>



The full text of these principles is available through the **African Journ-AIDS website** at [http://www.journaids.org/index.php/media\\_toolkit/ethics\\_reporting\\_on\\_hivaids/basic\\_principles\\_in\\_covering\\_hivaids](http://www.journaids.org/index.php/media_toolkit/ethics_reporting_on_hivaids/basic_principles_in_covering_hivaids)

**UNAIDS and the Kaiser Foundation** have produced a guide for journalists: *The Media and HIV: Making a Difference*. It is available at [http://data.unaids.org/publications/irc-pub06/jc1000-media\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc1000-media_en.pdf)

**The International Federation of Journalists** also has a media guide: *HIV/AIDS Media Guide – IFJ media guide and research report on the media's reporting of HIV/AIDS* at <http://www.ifj.org/assets/docs/117/252/83d8475-9cb28fc.pdf>

- ensure language, cultural norms and traditional practices relating to, for example, inheritance and sex are understood and accurately reported.
4. Balance means giving due weight to the story, and covering all aspects, including medical, social, political, economic, and other issues. Balance also means highlighting positive stories where appropriate, without underplaying the fact that HIV and AIDS is a serious crisis.
  5. Journalists should hold all decision makers to account in their handling of the pandemic, from government to the pharmaceutical industry and advocacy groups. They should be engaged with, but not captive to, any interest group.
  6. Journalists should ensure that the voices and images of people living with and affected by HIV and AIDS are heard and seen (with each person's consent). The human face of the pandemic should be shown. They should take care that the voices heard are diverse, and include those of women and men, vulnerable and marginalised people.
  7. Journalists should respect the rights of people with HIV and AIDS. Vulnerable people should be treated with particular care. Journalists should seek informed consent before intruding on anyone's privacy. They should seek to understand the possible consequences for individuals who participate in their report, and to ensure those individuals are clear about the consequences. Only in cases of overwhelming public interest can somebody's HIV status be reported against their wishes.
  8. Particular care should be taken in dealing with children. They experience the most extreme consequences of the epidemic, and their rights to privacy should be afforded even greater protection. They should only be identified if the public interest is overwhelming, and then only if no harm to them is foreseeable and they and any parents or guardians have given informed consent. Children have the right to participate in decisions affecting their lives. They also have the right to be heard, and journalists should ensure that the particular concerns they face are covered.
  9. Discrimination, prejudice and stigma are very harmful, and journalists should avoid fuelling them. Particular care should be taken not to use language or images that reinforce stereotypes.





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