

Building on success 2

*Towards a National Strategy
for HIV/AIDS Health Promotion
for Gay and Other
Homosexually Active Men*

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A note on terminology

Gay men and other homosexually active men

Gay men' refers to homosexually active men who self identify as gay or are attached to the gay community, or both. 'Other homosexually active men' is used to describe homosexually active men who neither describe themselves as gay nor are attached to the gay community.

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

This document is based upon a review of HIV/AIDS education programs for gay and other homosexually active men conducted by the National Centre for Health Promotion. In this document all references to 'the Review' are referring to that review unless otherwise stated.

Health education and health promotion

Health education is defined as any combination of learning experiences which are designed to facilitate voluntary actions conducive to health.²

Health promotion is the combination of education and environmental supports for action and conditions of living which are conducive to health.³

Executive summary

The HIV epidemic in Australia has had its greatest impact on gay men. Of those who have died from AIDS more than 89 per cent were gay or other homosexually active men. Of those who have been diagnosed with AIDS more than 88 per cent are gay or other homosexually active men. Of those who have tested positive to the virus (where exposure category is known), more than 80 per cent are gay or other homosexually men.⁴

Although there has been a dramatic decline in the incidence of HIV infection from the peak rate in 1984 to a comparatively low rate of infection over the last decade it remains of concern that new HIV infections continue to occur in Australia. Each year since 1993 approximately 600 new diagnoses of HIV infection amongst gay and other homosexually active men have been reported.⁵ There have also been approximately 200 diagnoses of newly acquired HIV infection.⁶

Altogether, since the first case of HIV was diagnosed in 1983, there have been 16,030 diagnoses (following adjustment for multiple reporting) of HIV infection in Australia to 31 December 1997. There have been 5,540 deaths following AIDS.⁷ It is estimated that there are currently more than 10,000 people living with HIV in Australia.

A recent review of gay and other homosexually active men's HIV/AIDS education in Australia (hereafter referred to as 'the Review') found that:⁸

- Australia has been very successful in containing the HIV/AIDS epidemic over the last decade;
- there has been a high volume of educational activity across the nation, addressing different target groups within the gay men's community in particular, and using a range of educational (and other) methods;
- there are high levels of literacy (about HIV/AIDS and safer sexual practice) among gay men and in high levels of safer sexual practice;
- effective partnerships and structures have been developed at national, State/Territory and at community levels to design and deliver effective HIV/AIDS education.

The Review also found:

A changing context

- the waning of the sense of crisis among gay men in relation to their risk of HIV/AIDS and changes in their reactions to the epidemic has necessitated changes in the content and methods of educational programs aimed at minimising the risk of transmission of the virus within gay men's communities;
- the availability of new treatments for people living with HIV has meant the need for renewed effort to ensure compliance with treatment regimens so that they have maximum effect on the health and quality of life of people living with HIV;

Variability in the quality, reach and effectiveness of interventions

- the methods used to date to educate gay and other homosexually active men about HIV/AIDS and its transmission, about safer sexual practice, and about living with HIV/AIDS, have been successful, but interest in the issues is waning among gay men;

- there is ongoing need for health promotion to assist young, newly sexually active men (including gay men) to adopt safer sexual practices;
- there has been no systematic evaluation of the quality or impact of interventions at local and State/Territory levels and no systematic development of a body of evidence of effectiveness;

Changes in the policy environment and infrastructure support for effective action

- the introduction of broadbanded bilateral funding agreements between the Commonwealth and the States and Territories has changed the focus of accountability from process (what is being delivered) to outcomes (what has been achieved);
- the research that has played an essential role in the educational response to the epidemic among gay men has been focused, largely, on macro-level monitoring of knowledge and behaviours (particularly sexual practice) across the population and not sufficiently on the quality and impact of interventions at local level;
- workforce development strategies have not kept pace with the growing need for evidence-based practice.

The recommendations that follow, therefore, have been developed to:

- maintain the policies, programs, and infrastructure that have been responsible for success to date;
- respond to the changing epidemic;
- respond to the changing policy environment
- address evident shortcomings in relation to leadership, direction, methods, monitoring and surveillance, research and evaluation, and workforce development.

Recommendations

To ensure continuing national leadership and direction

It will be necessary to:

- *reaffirm the partnership among key stakeholders*
- *provide direction for the next phase of education and health promotion for gay and other homosexually active men*
- *achieve a more cohesive, comprehensive, efficient national response to the epidemic*

It is recommended that:

1. The Commonwealth Department of Health and Family Services engages the partnership and develop a fourth National HIV/AIDS Strategy that:
 - a) reaffirms that gay men are the group at greatest risk of HIV infection and AIDS, and hence, must be a priority target group for education and health promotion;
 - b) reaffirms that people living with HIV/AIDS are the focus of prevention and education strategies that address their own specific health needs;
 - c) reaffirms the necessity to ensure that gay men continue to be actively engaged in the design, delivery and evaluation of all health promotion (including education) designed to control the spread of the virus;
 - d) reaffirms the need to ensure equity of access to health education and promotion programs and to ensure equity of outcomes;
 - e) broadens the education and prevention program to become the health promotion program, with consequent broadening of the objectives of the program and the strategies used to achieve these. This will include the need to develop performance indicators (or outcome indicators) that reflect the full range of outcomes of health promotion action;
 - f) outlines the roles and responsibilities of each level of jurisdiction – Commonwealth, State/Territory, local government, and community agency – in the control of HIV/AIDS with particular reference to gay and other homosexually active men.

To continue a cohesive, national approach

It is recommended that

2. The Commonwealth Department of Health and Family Services continue to make signature of the bilateral Public Health Outcome Funding Agreements contingent upon the States'/Territories' endorsement of the most recent National HIV/AIDS Strategy and the development of State/Territory strategic plans [as outlined according to the criteria in Recommendation 5].

3. The ANCARD/IGCARD Evaluation and Monitoring Working Party develop a set of valid, verifiable, reliable performance indicators to use to measure progress in reducing the incidence of HIV/AIDS and related diseases among gay and other homosexually active men and in improving the quality of life of gay men living with HIV/AIDS. These should then guide the specification of the outcomes to which the States/Territories and the Commonwealth Department of Health and Family Services are committed through the Public Health Outcome Funding Agreements. (Examples of performance indicators are included in Appendix Two).
4. ANCARD monitor and report on progress in each of the States and Territories in relation to the performance indicators in the Public Health Outcome Funding Agreements.

To develop state/territory leadership and direction

It is recommended that:

5. The Public Health Outcome Funding Agreements commit the State/Territory health authorities to collaborate with community-based organisations to develop statewide strategic plans for health promotion among gay and other homosexually active men, to prevent the spread of HIV/AIDS and related diseases (particularly hepatitis) and to improve health and quality of life.

The Plans should include:

- outcomes/levels of performance to be achieved
 - priority target groups
 - program objectives
 - strategies or methods of intervention
 - assignment of roles and responsibilities of each of the organisations responsible for program delivery
 - resources
 - time required.
6. The Public Health Outcome Funding Agreements include a performance indicator that requires the State/Territory health authorities to develop performance agreements with community-based organisations based on the strategic plans. The agreements should include delineation of the roles and responsibilities of each partner and clear definition of lines of accountability for action, achievements, and expenditure.
 7. The strategic plans developed by the State/Territory health authorities and community agencies incorporate support for the implementation of programs for Aboriginal and Torres Strait Islander gay and other homosexually active men⁹ over sufficient time and with sufficient resources to enable the achievement of the desired outcomes, at individual, community, and population levels.
 8. The State/Territory health authorities and community agencies support the role of health care professionals in the delivery of education and information to gay and other homosexually active men, particularly those men who are HIV positive.

To improve the quality and effectiveness of health promotion interventions

Current data show only limited risk of HIV infection among other homosexually active men.¹⁰ These men do not constitute a homogenous group, making it difficult to communicate directly with them. Rather, the use of environmental strategies such as safe sex policies at venues or settings in which men have sex with men are likely to be more effective in reaching and influencing the behaviour of other homosexually active men.

No other target groups should be given priority until there is clear evidence of significant risk of infection (or potential risk) or unless specific local conditions apply. Criteria that can be used to assist in assessing levels of risk are outlined in Appendix Three.

It is recommended that:

9. The following target groups be given priority:
 - a) gay men
 - b) gay and other homosexually active men living with HIV
 - c) gay and other homosexually active Aboriginal and Torres Strait Island men
 - d) young men, including young gay men, who are newly sexually active
10. Organisations responsible for the design and delivery of health promotion programs including State/Territory health authorities and community organisations, extend their HIV/AIDS health promotion programs to address other, related communicable diseases only when there is a clearly-identified risk to their target populations.

To build evidence of effectiveness

The new outcomes focus for public health that is being required by the new Public Health Outcomes Funding Agreements means that it is now urgent to develop evidence of effectiveness in HIV/AIDS health promotion for gay men and other homosexually active men.. This is not a simple task. Concerns about the focus of research and the research methods used in ‘effectiveness’ studies are shared across the whole range of contemporary health promotion practice. These concerns are not confined to the HIV/AIDS area.^{11 12 13}

The hierarchy outlined in Appendix One is an example of the ‘levels’ of evidence that have been used to develop clinical guidelines. However, it is clear that considerable work is now needed to develop a hierarchy that is more appropriate for health promotion. The first step is to identify the mix of health promotion strategies or methods that are most likely to be effective for a given population or setting. The second step is to apply the most appropriate research methods to assess the impact and outcomes. In order to stimulate immediate action on these urgent matters

It is recommended that

11. The Commonwealth Department of Health and Family Services in collaboration with the partners responsible for the implementation of the National HIV/AIDS Strategy:
 - a) form a consensus group to develop a nationally agreed framework for the evaluation of the quality, implementation and achievements of HIV/AIDS health promotion programs at national, State/Territory and local levels, specifying types of evaluation needed and appropriate research methods;

- b) develop criteria to assess the quality of evidence of effectiveness of HIV/AIDS health promotion for gay and other homosexually active men.

To ensure implementation of effective practice

Fundamentally, good health promotion practice is based on:

- *good knowledge of the target audience*
- *good knowledge of the context or environment within which the target audience lives and works*
- *good knowledge of the constraints and resources available for intervention.*

Different groups within the gay community require different types of intervention to achieve different outcomes. For example, for people living with HIV/AIDS, compliance with treatment regimens is likely to be a major program. For newly sexually active men, development of safer sexual practice will be important. For gay-community-attached men, developing the knowledge, skills and lifestyles required to maintain good sexual health, including safer sexual practice, will be the focus of programs. In addition, the environments that influence the behaviours and lifestyles of gay men and other homosexually active men, will influence the content and methods used by specific programs.

It is recommended that

12. The health needs of target groups be the driving force in determining health promotion program direction and content.
13. Programs use a comprehensive range of methods, aimed at addressing each of the determinants of the health of population groups, including environmental and organisational determinants.
14. The benchmarks outlined in Table One (page 16) be adopted by all organisations responsible for program delivery as current measures of the quality of an HIV/AIDS health promotion program for gay and other homosexually active men. These benchmarks should be revised and updated regularly.
15. AFAO establish an expert group, comprised of educators and researchers from within and beyond the HIV/AIDS sector, to use the criteria developed by the consensus group in Recommendation 11, to regularly review, update, and disseminate the evidence of effectiveness to each member of the partnership.
16. The ANCARD Education Sub-Committee develop guidelines for the preparation and use of sexually explicit resources as a component of interventions. The guidelines should recommend the formative evaluation of the resources to ensure that they are culturally appropriate and credible to the target population before full production and distribution.
17. Where issues require a national, coordinated response, the Commonwealth Department of Health and Family Services continue to take a leadership role in developing and implementing programs. Examples of areas where such action is appropriate include programs to reduce the stigma and discrimination experienced by gay men and others who express their sexuality in different (i.e. other than heterosexual) ways; school based programs on sexual health and safer sexual practice; or compliance and uptake of treatments.

To improve the dissemination and application of ‘effective practice’

As evidence of the effectiveness of health promotion interventions is built, it is important to ensure that there are systems in place to ensure the systematic implementation of effective practice across the whole of the affected population. The dissemination (including implementation) of effective practice is an issue of growing interest in the contemporary health promotion arena, and improving the understanding of processes that contribute to the effective dissemination of better practice is an issue of high priority for the future.

It is recommended that:

18. The Commonwealth Department of Health and Family Services establish a national project to identify effective mechanisms to ensure the dissemination (including the implementation) of research findings in HIV/AIDS health promotion policy and practice.

To sustain capacity to design, deliver, and evaluate HIV/AIDS health promotion programs

The Australian response to the HIV/AIDS epidemic has included the establishment of a significant level of infrastructure support to ensure the design, delivery, and evaluation of effective education programs for gay men and other homosexually active men. The Review confirmed the need to sustain this capacity, and to refine or strengthen it in some areas.

Develop benchmarks of capacity for program design, delivery and evaluation

It is recommended that :

19. ANCARD/IGCARD in partnership with AFAO, review and revise the following benchmarks for the minimum level of infrastructure required by community agencies and State/Territory health authorities for HIV/AIDS health promotion for gay and other homosexually active men:
 - a) organisational policy supporting health promotion as a major focus of the work of the agency;
 - b) access to epidemiological and population-wide data on the behaviours and knowledge of gay and other homosexually active men, including those who are HIV positive;
 - c) access to information on supportive policies, environments, and services (or the lack thereof) that influence the sexual practice and sexual health of gay and other homosexually active men;
 - d) a trained, well supervised workforce with skills in research, program design, delivery, and evaluation. This may mean a group that includes people with different strengths in each of these.
 - e) a workforce development policy and strategy;
 - f) a research and evaluation strategy focused on identifying effective health promotion interventions and disseminating findings;
 - g) funding to support program implementation and evaluation.

The Public Health Outcome Funding Agreements will be renegotiated at regular intervals. It is important that the capacity of the State/Territory health authorities and community agencies to design, deliver and evaluate HIV/AIDS health promotion programs for gay and other homosexually active men and for HIV positive men, is considered as a performance indicator in each of these Agreements.

It is recommended that:

20. ANCARD/IGCARD in partnership with AFAO, report regularly* on the capacity of State/Territory health authorities and AIDS Councils using the benchmarks agreed to through the process outlined in Recommendation 19.

To extend capacity for intervention and evaluation research

It is recommended that:

21. The National Centre in HIV Social Research extend its mechanisms for collaboration between researchers and educators to establish research priorities and to design and conduct research.

To improve national monitoring of the risk of HIV infection it is recommended that:

22. The National Centre in HIV Epidemiology and Clinical Research improve national monitoring and surveillance of the risk of HIV infection posed to:
 - a) other homosexually active men and
 - b) people from non-English-speaking backgrounds.

To ensure a national approach to workforce development and training it is recommended that:

23. The Commonwealth Department of Health and Family Services establish an expert group † to oversee the implementation of the recommendations of the National Training Agenda for HIV/AIDS Educators.

* Regularly, here, means linking the reviews to the period covered by each of the Public Health Outcome Funding Agreements. The findings of the reviews would then be used to develop the performance indicators in the new agreements.

† The expert group should include representatives of government, community organisations, experts in training and education.

Table 1: Benchmarks for effective health promotion interventions^{14 15}

Effective	Not effective
Well planned programs that	Poorly planned programs that
<ul style="list-style-type: none"> • clearly define outcomes or objectives based on analysis of needs, context, and contributing factors^{16 17} • clearly define target populations or organisations¹⁸ (eg by age, race, risk behaviour, culture, peer and social group) 	<ul style="list-style-type: none"> • do not have clearly defined outcomes or objectives • do not have clearly defined target populations
<ul style="list-style-type: none"> • tailor the intervention strategies (education, facilitation, advocacy) and methods (e.g. mass media, small groups) to ensure a rational fit between program activities and program objectives or outcomes¹⁹ 	<ul style="list-style-type: none"> • do not tailor the message for different population groups • give ambiguous, vague, or inappropriate messages
<ul style="list-style-type: none"> • adopt a multifaceted, or comprehensive approach including building personal skills, developing social support, building supportive environments, implementing healthy public policy, and ensuring appropriate services^{20 21} 	<ul style="list-style-type: none"> • use a single strategy, such as education, to achieve population-wide behaviour change
<ul style="list-style-type: none"> • use multiple strategies that link program components <ul style="list-style-type: none"> – a community organising strategy – a community development strategy – a communications (or media) strategy – a social marketing strategy – a group empowerment strategy – a self-help, self-care strategy²² 	

Effective	Not effective
Well planned programs that	Poorly planned programs that
<ul style="list-style-type: none"> use sound methods, including sound educational methods^{23 24} 	<ul style="list-style-type: none"> use poor quality materials deliver programs using inappropriate methods
<ul style="list-style-type: none"> focus on changing the physical and social environments that determine individuals' and communities' capacity to change.^{25 26 27} 	
<ul style="list-style-type: none"> have sufficient resources to allow long-term, incremental intervention related to each of the levels of outcome (health promotion, intermediate, and health outcomes)²⁸ 	<ul style="list-style-type: none"> attempt to achieve objectives or outcomes with insufficient resources, including insufficient time
<ul style="list-style-type: none"> evaluate appropriately to ensure program quality, and to assess impact, and outcome^{29 30} 	<ul style="list-style-type: none"> do not evaluate at any level
Programs that use effective processes for planning and delivery, including	Programs that ignore the importance of process in planning and delivery
<p>Programs that are 'for and by' the target populations and</p> <ul style="list-style-type: none"> use 'natural leaders' among peers are developed for peers by peers are carried out or led by peers^{31 32} 	<p>Programs that:</p> <ul style="list-style-type: none"> are devised by 'experts' or professionals who are not familiar with the people whom they are trying to reach are developed from the 'top down', rather than from the 'bottom-up' function with a 'do to', rather than a 'do with' orientation or approach
<p>Programs that</p> <ul style="list-style-type: none"> use language at the literacy level of the targeted population ensure that the cultural and social context is appropriate 'ring true' to people's experiences³³ 	<p>Programs that are not personal or user friendly</p>

Effective	Not effective
Well planned programs that	Poorly planned programs that
<p>Programs that</p> <ul style="list-style-type: none"> • ensure that group process is as important as the content³⁴ • provide group support for individuals in the initiation and maintenance of behaviour change. <ul style="list-style-type: none"> – group provides context and opportunities to learn and practice – personal sharing in group leads to personal and group transformation – transformation of group lays groundwork for broader changes in community norms in behaviour³⁵ 	<p>Programs that fail to reinforce maintenance of safe behaviours and send messages that are judgemental, moralistic or attempt to instil fear</p>
<p>Programs that</p> <ul style="list-style-type: none"> • enhance individual self-esteem • enable people to develop the skills they need to, for example, implement change in personal relationships³⁶ • enhance participants' self-efficacy³⁷ 	
<p>Programs that reach people where they live, where they work, and where they go</p>	

1. Introduction

The HIV epidemic in Australia has had its greatest impact on gay men. Of those who have died from AIDS more than 89 per cent were gay or other homosexually active men. Of those who have been diagnosed with AIDS more than 88 per cent are gay or other homosexually active men. Of those who have tested positive to the virus (where exposure category is known), more than 80 per cent are gay or other homosexually men.³⁸

Although there has been a dramatic decline in the incidence of HIV infection from the peak rate in 1984 to a comparatively low rate of infection it remains of concern that new HIV infections continue to occur in Australia. Each year since 1993 approximately 600 new diagnoses of HIV infection amongst gay and other homosexually active men have been reported.³⁹ There have also been approximately 200 diagnoses of newly acquired HIV infection.⁴⁰

Altogether, since the first case of HIV was diagnosed in 1983, there have been 16,030 diagnoses (following adjustment for multiple reporting) of HIV infection in Australia to 31 December 1997. There have been 5,540 deaths following AIDS.⁴¹ It is estimated that more than 10,000 people are living with HIV in Australia.

This Document recommends actions that:

- build on our success;
- respond to the changing epidemic;
- respond to the changing policy environment.

Building on success

Australia is regarded internationally as one of the countries that has been most successful in controlling the spread of HIV. Compared with many other countries the rates of transmission of the virus are very low and the much-feared epidemic appears to have been largely contained.

However despite our success there is no room for complacency. HIV/AIDS still remains a very real threat to the health of gay and other homosexually active men. The Review reaffirmed the need for the continuation of concerted national action to control and further reduce the incidence of HIV infection. The Review also confirmed that additional action is required to ensure that the health and quality of life of those who have contracted the virus are maintained at the highest possible level.

Responding to the changing epidemic

Education programs now need to take into account the changing nature of the Australian epidemic. There is strong evidence to suggest that gay and other homosexually active men are now responding differently to the epidemic than when it first emerged. For many gay men the sense of crisis has waned, making them less eager to respond to education and more willing to adopt a variety of strategies to deal with HIV and safe sex.

Additionally there have been enormous advances in science. Combination anti-retrovirals are proving to be beneficial for many people living with HIV. As a result there has been a dramatic increase in their use. As understanding of the immune system and treatment of HIV infection increases it will continue to have an impact on gay and other homosexually active men.

Responding to the changing policy environment: leadership, direction and resources

The political support and administrative structures that have been operating since 1983 have been critical in providing strong leadership and direction for education programs. However recent changes in the Commonwealth/State funding arrangements for a range of public health programs, including HIV/AIDS, will lead to changes in the ways in which HIV/AIDS health promotion programs are funded and organised at State/Territory levels.

In this environment, while there are some opportunities for improved national coordination and approaches to public health, there may also be a potential loss in terms of cohesion, leadership and resources.

Summary

This document proposes steps to be taken by the major agencies responsible for HIV/AIDS health promotion for gay men and other homosexually active men. They are intended to ensure that Australia has the capacity to meet the challenges of the future.

1.1 Background

The third National HIV/AIDS Strategy recommended that a national Gay Men's Education Strategy should be developed following a national assessment of the effectiveness of education programs for gay men.⁴² A review of HIV/AIDS education programs for gay and other homosexually active men was conducted between November 1997 and April 1998 by the National Centre for Health Promotion, the University of Sydney.

The Review used a variety of methods:

- critical examination of published and accessible unpublished literature on gay men's HIV/AIDS education to identify factors related to effectiveness and 'best practice' in the field;
- critical examination of the literature on effectiveness and best practice in health promotion and health education, to identify key factors influencing success or failure;
- key stakeholder interviews with members of the partnership;
- publication of a discussion paper to canvas issues and ideas and to ensure a wide range of individuals and organisations contributed;
- consultation meetings with key stakeholders in the capital city of each State and Territory;
- public consultation meetings in the capital city of each State and Territory;
- written submissions from individuals and organisations.

This document is based upon the findings of that Review.

2. Objectives and principles

2.1 Objectives

This document recommends actions to:

1. enhance the quality and effectiveness of the HIV/AIDS health promotion programs for gay and other homosexually active men in Australia;
2. enhance the quality and effectiveness of HIV/AIDS health promotion programs for HIV positive gay and other homosexually active men in Australia;
3. strengthen the infrastructure support for effective HIV/AIDS health promotion programs for gay and other homosexually active men in Australia.

2.2 Principles

The following principles for education and prevention programs are from the third National HIV/AIDS Strategy.⁴³ They remain at the core of the response to HIV/AIDS.

- Education and prevention programs for established, emerging or potential epidemics in specific communities are best delivered by the communities involved, in partnership with governments, health professionals and researchers.
- The participation of HIV-positive people is central to any HIV prevention and education program. HIV-positive and HIV-negative people should be regarded as partners in HIV prevention education and HIV health maintenance.
- People with HIV/AIDS and gay men and their communities must remain central to the planning, delivery and evaluation of HIV/AIDS programs, services and policies.
- Where there is a clear and direct relationship between HIV/AIDS preventive strategies and strategies directed at communicable and sexually transmissible diseases, education and prevention programs should reflect this.
- Integration of HIV/AIDS services must not dilute or make irrelevant HIV/AIDS programs to their target populations.
- HIV-positive people have specific health promotion needs.
- Education and prevention initiatives must take account of diversities in cultural and linguistic backgrounds, gender, age, sexual orientation, disability and geographical location.
- Educational material designed to aid prevention of HIV must be presented in such a way as to have maximum effect on intended target groups, including groups best reached by the use of more direct educational messages.
- Residents of correctional and other residential institutions should have similar access to education and prevention initiatives as the rest of the community.

- A supportive legal and policy environment must complement education and prevention strategies for HIV, STDs and related communicable diseases.
- Community awareness efforts in connection with discrimination and Australia's policy approach to HIV/AIDS must be maintained.
- All health care workers, carers, and educators should have access to appropriate training in HIV and infection-control procedures.

The Review highlighted several additional principles that are required to focus and guide future HIV/AIDS health promotion for gay and other homosexually active men:

- There is a need to use direct, explicit materials to support education programs where these are culturally appropriate and enhance the credibility of the message.
- Funding must be tied to priority issues or groups.
- There is a need for national leadership and for a national approach to establishing priorities, goals, and policy. The design and delivery of local programs must be in response to the needs and circumstances of local populations.

3. Responding to a changing epidemic

Education programs for gay and other homosexually active men need to be adapted in response to a changing social and political context and, in particular, changes in scientific understanding of HIV and changing patterns of responses to HIV by gay men.

It is also important that a strategy is developed on the basis of what has already been achieved.

Australian social research on gay and other homosexually active men has indicated that:⁴⁴

- Most gay and other homosexually active men engage in protected anal intercourse with casual partners;
- A significant proportion of gay men in regular relationships practice unprotected anal intercourse with a regular partner, however, in some circumstances, the practice may not present a risk of HIV transmission;
- The practice of needle sharing is rare;
- Levels of HIV antibody testing amongst gay men remains high;
- Knowledge of HIV transmission remains very high.

Further detailed analysis is available from the National Centre in HIV Social Research⁴⁵ and is included in the Review report.⁴⁶ Overall the research indicates that a great deal has been achieved already in terms of knowledge and sustained practice of safe sex and safe injecting. The challenge remains to ensure that these achievements can not only be sustained but improved to ensure a further reduction in new HIV infections.

Living in a world with HIV

In the early 1980s there was only limited knowledge available about HIV and its transmission. This, combined with an increasing number of deaths and illness, and growing media hysteria about homosexuals and AIDS, meant that there was a sense of crisis and fear among gay men.⁴⁷

It was in these circumstances that education activities began. These took place in the belief that a dramatic change in the sexual behaviours of gay men would be required for a short period only. In addition, rapid advances in knowledge about both HIV and the immune system led to widespread belief that a 'cure' would be found. The success of AZT in treating HIV infection in the late 1980s further promoted this belief. However by the early 1990s it had been recognised that AZT was not as effective as first hoped. There were few treatments available that seemed likely to result in HIV infection becoming a chronic, manageable illness

As it became evident that there was not going to be a miracle 'cure' gay men slowly learned to live with HIV. The early sense of crisis disappeared, largely. This does not mean that gay men are no longer concerned about HIV and its impact on their community. Nor have gay men stopped viewing it as a serious health threat. However it does mean that HIV no longer engulfs most gay men's lives as it once did.⁴⁸

Changing responses to HIV/AIDS and safe sex

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

In short, gay men’s responses to HIV have changed. Gay men are no longer adopting a single strategy to deal with HIV and negotiating safe sex.⁴⁹ Instead, they have been adopting increasingly sophisticated safer sex practices, often termed ‘negotiated safety’. The term ‘negotiated safety’ was coined in 1993 to describe the practice by gay men in regular relationships who had negotiated not to use condoms in their relationships. This was occurring when both had tested HIV negative, were aware of each other’s status, and had negotiated a clear and unambiguous agreement about the nature of their sexual practice both within and outside of the relationship, such that any sexual practice outside their relationship was safe.⁵⁰

However, subsequent research found that ‘poor’ negotiation of unprotected anal intercourse within regular relationships was a significant factor amongst those gay men who had recently sero-converted.⁵¹ Many men who were attempting to negotiate safe sexual practice with their partners did not have the negotiation skills required and were possibly placing themselves or their partner at risk.

As a result safe sex was redefined to include not using condoms in particular contexts and education programs changed to assist men to develop the skills needed to minimise the risk posed to their health and that of others.⁵²

Impact of new combination treatments

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

Combination anti-retrovirals are proving to be beneficial for many people living with HIV, and there has been a dramatic increase in their use.⁵³ HIV-positive people now need education programs that provide them with accessible, up-to-date information on combination treatments and that support them in complying with the stringent treatment regimes. The success of new treatments has led to increasing speculation that HIV is becoming a chronic, manageable illness.⁵⁴

There is considerable debate about the potential impact of new combination treatments on gay men’s safe sex behaviour.^{55 56} It will be necessary for researchers and educators to identify and adapt to this impact, with particular emphasis on improving the health and quality of life of men living with HIV/AIDS.

Gay men living with HIV/AIDS

The early national response to HIV/AIDS saw the development of four Programs to combat the epidemic. These were the Education and Prevention Program, the Treatment and Care Program, the Research Program, and the International Assistance and Co-operation Program. The Education and Prevention Program aimed to raise awareness of HIV/AIDS across the whole population, and to promote the development of new community norms (in relation to safe sex) within populations at risk.⁵⁷ Many agencies responsible for education and prevention established structures and programs that reflected the priorities. As a consequence, the needs of gay and other homosexually active men living with HIV/AIDS have not been given adequate attention, partially as a result of the organisational structures that were established to manage the earlier phases of the epidemic.

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

Summary

- Although the early sense of crisis has waned HIV/AIDS remains a serious and ongoing health threat for gay and other homosexually active men.
- There is widespread knowledge of HIV/AIDS and means of transmission among gay men. However, this knowledge is not automatically followed by behaviour change.
- Gay men are responding to the need to adopt long-term behaviours to reduce their risk of HIV infection (or that of others) using an increasingly diverse range of 'safe sex' behaviours.
- New combination treatments will continue to have a significant impact upon the health of gay and other homosexually active men living with HIV/AIDS and potentially on the commitment to safe sex by gay and other homosexually active men.
- Increasing recognition of the specific needs of gay and other homosexually active men living with HIV/AIDS

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

Target audiences are no longer as receptive to simple messages such as 'condoms every time'.

- Provision of basic information on routes of transmission, while still important for the newly sexually active, cannot be the sole focus of education programs. Other factors that influence the adoption and maintenance of safe sex behaviours must be addressed.
- Programs will need to include a variety of objectives and use a combination of strategies.
- Programs will need to be flexible and responsive to the changing environment, and will have to operate in a climate of uncertainty.
- Programs will need to address the specific needs of gay and other homosexually active men living with HIV/AIDS.

4. Responding to a changing policy environment: the need for a fourth national HIV/AIDS strategy

The political support and administrative structures that have developed to direct and implement the Programs outlined in the three National HIV/AIDS Strategies have provided strong leadership and direction for the education program. There has also been the commitment of significant resources to education for gay and other homosexually active men.

Although political support for maintaining the effects of the programs remains relatively strong, the administrative structures governing the allocation of resources and program management are changing. Late in 1996 the National Public Health Partnership was established with a brief to:

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

One of the major steps taken through the Partnership has been that of reorganising the funding arrangements for public health action between the Commonwealth and the States and Territories. Instead of a series of specific purpose payments linked to ‘vertical’ programs such as the HIV/AIDS Program, the National Women’s Health Program, and the National Drug Strategy, funding is now being ‘broadbanded’. Through a series of bilateral agreements between the Commonwealth and each of the States and Territories, the money that had been allocated separately is now in a single band. The States and Territories must now account for their expenditure in terms of their ‘performance’ in relation to the indicators that have been included in the new Public Health Outcomes Funding Agreements.

The first round of Public Health Outcome Funding Agreements has been completed with almost all the States and Territories having signed.

In this new environment there is no ring-fenced allocation of resources for HIV/AIDS education in general, nor specifically for education for gay men and other homosexually active men. Within each State and Territory a considerable proportion of the funds for public health programs will now be allocated on the basis of the perceived capacity of organisations and programs to achieve the outcomes that have been included in the Agreements.

The Review identified several potential risks posed by the new funding arrangements and the focus on the achievement of outcomes. The risks identified were:

- the potential loss of the national cohesion that has been achieved through the National HIV/AIDS Strategies, as each of the States and Territories negotiates with the Commonwealth separately to define its own performance indicators;

- the potential loss of the leadership that has been provided by the Commonwealth Department of Health and Family Services. This has assisted in working toward a consistent level of activity across the nation and providing a mechanism to enable the performance of the individual States and Territories to be benchmarked against that of the others;
- the use of inappropriate indicators in the absence of nationally agreed valid, reliable indicators to be used to indicate progress resulting from effective health promotion;
- the potential for the States and Territories to overlook the need for community organisations to participate actively in the development of valid, verifiable, and reliable performance indicators;
- the potential loss of resources for programs targeting the environments, behaviours, services, and programs that influence the sexual health of gay and other homosexually active men, including those who are living with HIV/AIDS, with a resultant reduction in the volume and intensity of activity.

Despite these concerns the Review found a high level of support for action to improve national coordination and for the new approaches to public health funding, program delivery and accountability. It was recognised that opportunities will arise from the new arrangements.

Some of the opportunities suggested were:

- development of strategic partnerships with groups or areas within the health sector working to achieve similar goals, such as:
 - the men’s health programs now developing in several States and Territories; or
 - the suicide prevention programs across the nation that will need to address the special needs of gay men, especially younger gay men;
- development of strategic partnerships with groups or organisations outside the health sector, such as:
 - departments of school education (with respect to improving school environments to ensure acceptance of sexual diversity, and to further developing sexual health education for school students).
- greater flexibility for the States and Territories to take account of local context.

In addition to the strategic concerns and opportunities that were identified in relation to the changed policy and funding environment, the Review also pointed to the need to build the technical evidence that can be used to argue that health promotion represents a sound investment that contributes to the achievement of significant improvements in the health of populations.

(Recommendations 2, 3, 4, 5, 11, 17)

4.1 Roles and responsibilities

The extent to which the recommendations in this document are implemented (and achieve the intended outcomes) will depend on cooperation among and within a wide range of sectors of Australian society. The third National HIV/AIDS Strategy outlined the roles and responsibilities of the partners in Australia’s response to HIV/AIDS. In summary the roles are as follows:

- The Commonwealth Government will continue to provide leadership and coordination for national education programs, research, monitoring and surveillance as it has throughout the epidemic. Since 1991 the Commonwealth Department of Health and Family Services has reduced its role in direct service delivery for gay and other homosexually active men and has adopted a more strategic leadership role in education.⁵⁸ The Commonwealth works closely with a range of community and health care bodies and provides funding to a number of national community and professional organisations. Research and development projects have also been commissioned from academic bodies and private organisations.
- The Australian National Council on AIDS and Related Diseases (ANCARD) is the Commonwealth Government's principal advisory body on AIDS. Its main role is to provide advice to the Commonwealth Minister for Health on all matters related to the achievement of the Strategy's goals including identifying emerging issues and monitoring and anticipating changes in the epidemic.
- The Intergovernmental Committee on AIDS and Related Diseases (IGCARD) provides a forum for Commonwealth, State and Territory liaison and coordination on policy, finance, programs and implementation of initiatives related to HIV/AIDS.
- State and Territory Governments have responsibility for providing leadership at their level of jurisdiction. This includes establishing an appropriate policy framework and developing, delivering and evaluating a range of services, including education. State and Territory governments primarily fund community organisations to develop and deliver education programs for gay and other homosexually active men. However some government health authorities do provide education programs directly to these groups. Together with non-government organisations, the States and Territories also operate needle and syringe exchange programs.
- AIDS Councils are the community based organisations in States and Territories responsible for the majority of the HIV/AIDS education programs for gay and other homosexually active men. However a range of other HIV/AIDS specific, gay and lesbian, and general health and youth organisations do receive some funding for HIV/AIDS education. AIDS Councils focus primarily on three areas of work – education and prevention, care and support for people living with HIV, and advocacy and policy development.
- The Australian Federation of AIDS Organisations (AFAO) is the peak organisation representing State and Territory AIDS Councils, the National Association of People with HIV/AIDS, the Australian Intravenous League, and the Scarlet Alliance. It plays a central role in representing the people affected by HIV, coordinating the efforts of non-government organisations, contributing to the development of national policies, programs and strategies and development of a number education initiatives. AFAO has, through the Gay Education Strategies (GES) and Positive Information and Education (PIE) Projects established in 1994, played an increasing role in developing educational resources and in enhancing the capacity of its member organisations to respond to the epidemic.

The Public Health Outcome Funding Agreements mean that it will be necessary to redefine the roles and responsibilities of each member of the partnership identified in the third National HIV/AIDS Strategy. Each State and Territory will now be free to allocate a proportion of its public health funding wherever it is likely to achieve the most effective outcomes – across a range of issues and population groups.

The roles and responsibilities outlined, above, therefore, reflect a policy environment that had adopted a national approach to HIV/AIDS education, and that supported this with specific funding. This document is being developed at a time when the role of the National Public Health Partnership in setting national direction for specific areas such as HIV/AIDS is uncertain.

This document has, therefore, selected from the third National Strategy, the roles and responsibilities that must be preserved if the quality, effectiveness and efficiency of HIV/AIDS education for gay and other homosexually active men is to be strengthened.

Funding for HIV/AIDS education for gay and other homosexually active men is administered by the State/Territory health authorities. In most cases this has involved the development of agreements with the AIDS Councils (and other community-based organisations) that give responsibility for program delivery to the community-based organisations. The Review found that this was the full extent of the action taken by the health authorities in some States and Territories. In others, a much greater level of coordinated action is occurring.

There has not been sufficient time to assess the implications of the Public Health Outcome Funding Agreements for the allocation of funds by the States and Territories. Nor has there been sufficient time for the States and Territories to revise their performance agreements with the agencies responsible for delivering the 'outcomes' to which they (the States and Territories) are committed through the bilateral funding agreements.

State and Territory health authorities will need to collaborate with community-based organisations if they are to achieve the outcomes to which they are committed through the Public Health Funding Agreements. This will require the development of Statewide strategic plans that outline:

- outcomes/levels of performance to be achieved
- priority target groups
- program objectives
- strategies or methods of intervention
- roles and responsibilities of each of the organisations, including government health authorities, and community organisations
- resources
- time required.

It will also require agreement on

- capacity available or required by each of the responsible organisations (including government). This would include capacity for workforce development, research and evaluation;
- level of resources available and committed;
- reporting on inputs, including financial information.

(Recommendations 5, 19, 30)

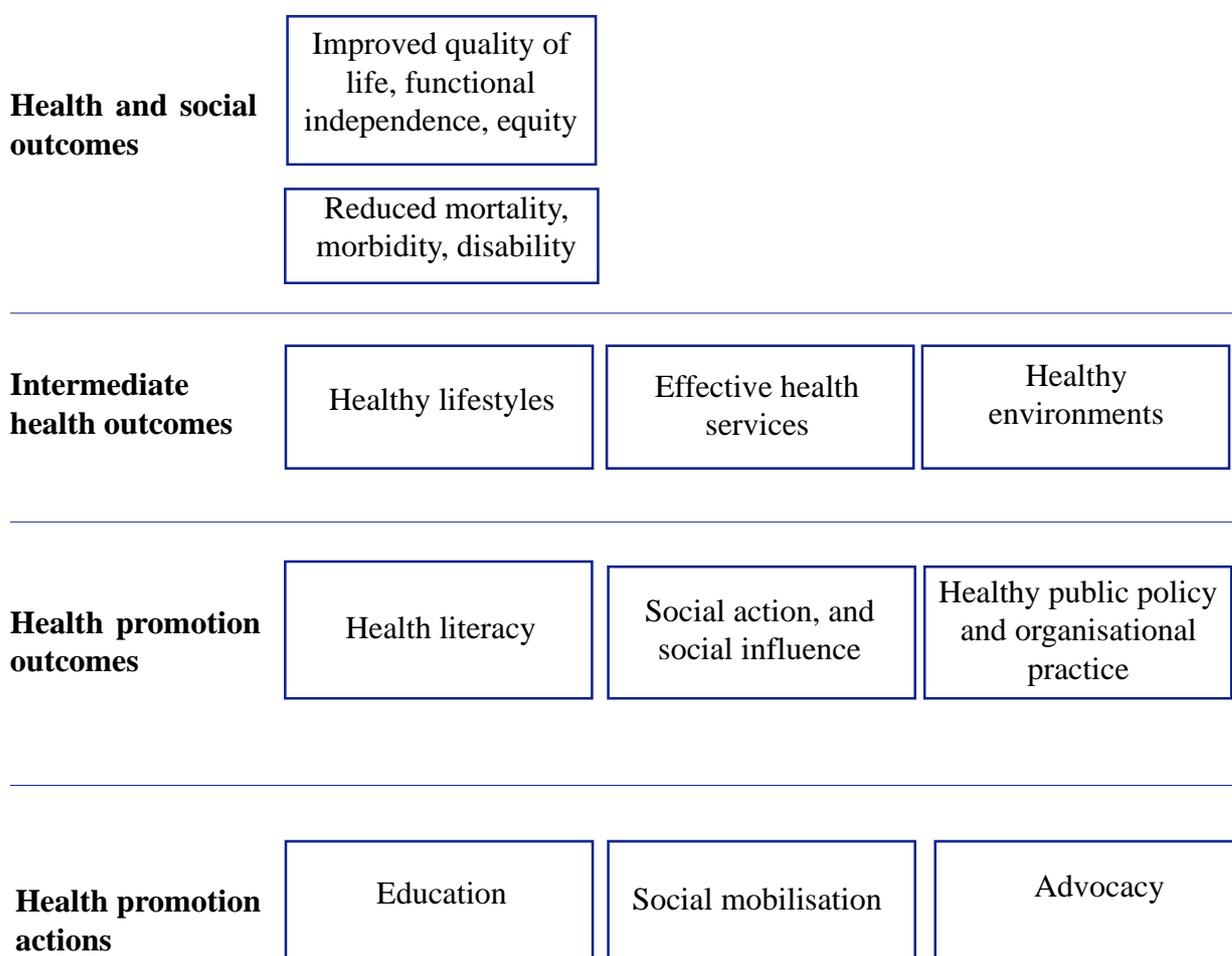
5. From education to health promotion

5.1 Health promotion and health outcomes

The emphasis on the achievement of outcomes that is required by the new Public Health Outcome Funding Agreements reinforces the need for clarity about the outcomes that can and should be expected of health promotion in general, and health education in particular. The Review identified a framework (see Figure 1) that identifies the two ‘levels’ of outcome that precede, the achievement of health outcomes.

The framework also identifies the different types of activity that are needed in order to influence each of the determinants of health and social outcomes. It places education within the wider range of actions that are used in health promotion and highlights the fact that the outcomes of education activities are measured most directly by their effect on the health literacy of individuals and communities.

Figure 1 A conceptual model for health promotion and health outcomes⁵⁹



Three *health promotion actions* are represented by the model

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

Through these activities a range of outcomes is achieved.

- *Health promotion outcomes* are the most immediate changes resulting from health promotion activity. They are changes in the personal, social and environmental factors that can be modified to influence the determinants of the health of populations and individuals.
- *Health literacy* is the most direct outcome of education activities. Health literacy reflects the knowledge and skills of individuals and populations, and their attitudes and beliefs in relation to different issues and behaviours. The outcomes of education might be measured in terms of changes to knowledge and skills, motivation and self confidence. Improved health literacy could also be measured in terms of a community's capacity to identify health problems, and to arrive at and implement solutions.^{60 61 62 63}
- *Intermediate health outcomes* represent the determinants of health and social outcomes. They are, often, the result of the achievement of health promotion outcomes. For example, the gay men's community organisations were able to mobilise support and resources to provide education programs and diagnostic and treatment services that, in turn, influenced the lifestyles of gay men and health services available to them. Another example of a change in public policy that, in turn, influenced the environment in which homosexually active men lived and worked was the introduction of the Disability and Discrimination Act 1992. This influenced the likelihood of gay men seeking and then acting on new knowledge and skills they may have received through educational interventions.
- *Health and social outcomes* are measured by changes in mortality, morbidity or levels of dysfunction on one hand, or more positively, by improvements in equity, and/or in the perceived quality of life of individuals and communities. In relation to HIV/AIDS, examples include reductions in the incidence of infection with HIV, and improvements in the quality of life of people living with AIDS.

5.2 Placing HIV/AIDS education in the context of contemporary health promotion

The Review confirmed the success of Australia's cumulative response to the HIV/AIDS epidemic. Although the terms of reference confined the Review to an assessment of the effectiveness and efficiency of the educational response, a range of additional activities was identified in the course of the Review. The Review confirmed that, although education is a powerful tool to use to bring about changes in the knowledge, attitudes, skill, and sometimes, behaviours, of individuals and communities, it is not sufficient, on its own. It will be necessary, in the future, to ensure that there is continuing action to change (or support the continuation of) the policies, environments, and services that also determine the sexual health of gay and other homosexually active men. Education must remain a central component of the nation's response – but it will require increasing support from additional strategies if its full effect is to be achieved.

The Review confirmed that there is need both for technical capacity to design effective programs and services for the target populations (and the environments that influence their lives), and for organisational capacity to define need, to develop and deliver programs, to identify and obtain the necessary resources, and to evaluate appropriately to ensure the quality of programs and to measure their effectiveness.

The infrastructure and programs that have been established in Australia were built during a crisis. This was entirely appropriate for the time but the Review confirmed the need to identify actions that are now needed to ensure that Australia continues to strengthen its capacity to meet the new challenges arising in the gay men's community and in the wider public health policy environment.

The recommendations presented in this document are intended to guide action to strengthen the technical capacity of the individuals and organisations responsible for reducing the incidence of HIV infection among gay and other homosexually active men, and for minimising harm associated with the virus. This includes establishing national policy supporting the wider range of actions encompassed by health promotion, while retaining education as a central component of these.

(Recommendation 1)

6. Priority target groups

On the basis of the epidemiological evidence and social research, and evidence of the feasibility of effective health promotion intervention, the following are the highest priority target groups identified by the Review that preceded the development of this document:

- Gay men
- Gay and other homosexually active men living with HIV
- Gay and other homosexually active Aboriginal and Torres Strait Island men
- Young men, including young gay men, who are newly sexually active

The third National HIV/AIDS Strategy prioritised education and prevention programs for homosexually active men.⁶⁴ The Review confirmed that gay men remain a high priority. This document has, however, made a further distinction between gay and other homosexually active men.

Gay men, particularly gay men attached to inner-city communities, continue to be at greatest risk of HIV infection. Gay men living in suburban or rural areas are also important target groups, but the Review found that a range of education programs is already in place to reach these men. These programs are often overlooked because they tend to use education methods that are less visible, although more appropriate for the local context. The types of programs depend on the geography of each state, resources available and population distributions, and the Review found no justification for an increased focus on these men. Agencies will need to continue to review their own priority target groups according to local factors and research.

The Review confirmed that gay and other homosexually active men living with HIV also have particular needs that must be addressed. The Positive Information and Education Consultation Report on the information and education needs of people living with HIV/AIDS should be used to develop the content of health education programs to address the needs of this group.⁶⁵

(Recommendation 9)

The third National HIV/AIDS Strategy identified Aboriginal people and Torres Strait Island people as priority populations for education and prevention programs, with particular reference to the needs of homosexually active men. The Strategy expressed concern about the potential for an HIV/AIDS epidemic among these communities, given high rates of sexually transmitted diseases. For these reasons, the education programs that are currently being developed with and in Indigenous communities must continue to be implemented and supported. The National Indigenous Gay and Transgender Project Consultation Report provided a comprehensive assessment of the needs of Indigenous Gay and Transgender people.⁶⁶ The Indigenous Gay and Transgender Sexual Health Strategy⁶⁷ that was based on the findings of that consultation should be used in developing education programs.

(Recommendation 7)

A range of programs currently targets other homosexually active men. The evidence suggests that other homosexually active men are much less greater risk of HIV infection than gay men.

However it is important that measurement of the risk of HIV infection posed to other homosexually active men should be improved by ensuring that epidemiological surveillance differentiates between gay and other homosexually active men. Current social research on the knowledge and sexual practice of other homosexually active men, and on appropriate educational methods to reach these men, appears adequate.

(Recommendations 9 and 22)

Although young gay and other homosexually active men are not, from the evidence available, at high risk of HIV infection, it is important that specific action is taken to ensure that their risk remains low. Various initiatives have already been taken to ensure that HIV/AIDS education occurs in schools, but the Review identified the need for these to be more inclusive of sexual health, and for wider action to ensure that the development of young people's sexuality occurs in environments that are accepting of sexual diversity.

(Recommendation 9)

There is limited information about the risk of HIV infection among gay and other homosexually active men from non-English speaking backgrounds. It is not clear whether existing health promotion programs are providing members of these groups with the information and services they need. Nor is it clear whether the rates of incidence of HIV infection, their sexual health, or their health literacy in relation to HIV/AIDS are similar to (or better than) those that apply to the Australian born population. Research being undertaken by the National Centre in HIV Social Research may assist in further understanding the needs of people from non-English speaking backgrounds, and it is clear that national data on the needs of these groups would be of great benefit in planning health promotion programs.

Reports from The HIV Services Access Project, the Assessment of the Information Needs of People with HIV from Culturally and Linguistically Diverse Backgrounds, and HIV/AIDS and HCV Education for People from Diverse Cultural and Linguistic Backgrounds (draft) are three documents that have explored many of these issues in more depth.^{68 69 70} These should be used when developing programs for people from non-English speaking backgrounds.

(Recommendations 1 and 22)

7. Content

The Review identified several issues that are currently of concern in relation to the sexual health of gay and other homosexually active men. Furthermore, the scientific understanding of the virus and of treatments is developing quickly, adding to the range of ‘content’ issues that must be addressed if health promotion programs are to succeed.

Analysis of current issues confirms the need for education to be included within a more comprehensive set of strategies if it is to be possible to reach all members of the priority target groups and to influence each of the factors that determines their sexual health (including their knowledge and skills).

Rather than specifying issues, therefore, this document has recommended actions to strengthen the technical capacity of the organisations (including government health authorities) to identify priority issues, and to develop programs that will be effective in addressing these.

In summary, to be effective, health promotion programs for gay and other homosexually active men:

- must address the different needs of different target groups, including people living with HIV/AIDS;
- must include education that does more than provide information on routes of transmission of HIV, although this is still important for the newly sexually active. Other, more complex issues that influence the adoption and maintenance of safe behaviours must be addressed;
- must integrate education into programs that use a comprehensive range of strategies to change the environments, policies, and services that, in addition to knowledge and skills, determine the sexual health and sexual behaviours of gay and other homosexually active men;
- must acknowledge the changing and different relationships of gay men to the epidemic. Education programs will need to reflect the reality of gay men’s lives and the place of HIV within their lives.

Programs will need to be flexible and responsive to rapid changes in the environments in which they are working. Above all, it will be necessary to develop integrated, comprehensive responses that aim to achieve a range of outcomes – health promotion, intermediate, and health outcomes. Action will be required at national, State/Territory and local government levels.

(Recommendations 2 and 5)

Antiviral drug compliance was identified as a key content issue by the Review. The importance of optimal dosing, timing and diet mean that combination therapy programs are often difficult and intrusive. All combinations require complete compliance. Compliance is, therefore, not only a key issue in promoting the health and well being of people living with HIV, but is also potentially a central issue in the prevention of further HIV transmission.

(Recommendation 12)

The third National HIV/AIDS Strategy refers to the need to explore the overlap between hepatitis C and HIV/AIDS efforts. Throughout Australia HIV/AIDS agencies are incorporating hepatitis C into existing services when this is needed to address local factors or needs. Services for injecting drug users, for example, often include education and information about hepatitis C in their HIV/AIDS education programs.

Hepatitis C is transmitted via infected blood. The main transmission pathway for Hepatitis C is through sharing of contaminated equipment by injecting drug users. Sexual transmission of hepatitis C is rare.⁷¹ Given this it appears to be appropriate that existing health promotion programs for gay and other homosexually active men who inject drugs incorporate prevention and education message about hepatitis C.

The third National HIV/AIDS Strategy also refers to the need to explore the overlap between HIV/AIDS and other communicable diseases. HIV/AIDS health promotion programs currently incorporate other communicable diseases differently, depending upon locally-defined needs. For example many small group work education programs incorporate a focus on other diseases; print media campaigns have sporadically addressed the prevention of STDs and hepatitides; programs for HIV positive gay men frequently incorporate a focus on other STDs and blood borne viruses and on ways in which these may compromise the health of people living with HIV/AIDS.

Deciding on whether to include education (and other strategies) to address other related communicable diseases in current HIV/AIDS health promotion programs should remain the responsibility of individual agencies. They can take account of local factors. Incorporating other communicable diseases must not decrease the focus on HIV/AIDS and must ensure that gay and other homosexually active men's adherence to safe sex behaviours is not compromised by a plethora of competing health prevention messages. Although some sexually transmitted diseases are risk markers for HIV these should be targeted only if they meet the criteria outlined in Appendix 2.

However there appears to be a high rate of prevalence of hepatitis A among gay men and both hepatitis A and B can have serious consequences for the health of gay men. Immunisation should be promoted.

(Recommendation 10)

The second and third National HIV/AIDS Strategies each attempted to refocus the seemingly narrow emphasis of education programs on preventing HIV/AIDS to the wider issue of promoting sexual health. The Review found that many HIV/AIDS health promotion programs are already addressing the issue of safe sex within a broader sexual health context. This has been founded on knowledge that programs are more likely to succeed if they address other factors that impact upon safe sex practice, and if they address clients' expressed needs.

However there has been only limited national policy developed in the area of sexual health leaving educators without clear guidance as to goals and expected actions. The evaluation of the second Strategy recommended clarifying what was meant by broader sexual health – an issue of importance given the absence of a national sexual health strategic plan.⁷² Clarification of a definition of sexual health and its implications for HIV/AIDS health promotion is still needed.

8. Methods of intervention

The Review found that a wide range of educational methods has been used to inform, educate, and assist gay and other homosexually active men to develop their knowledge, learn new skills, and to change their sexual practice, and, among injecting drug users, to change their injecting practices.

Group work has been the centrepiece of education, usually peer led, with a high level of relevance to the participants. This has been supported by the use of a wide range of printed materials and by the use of the mass media (paid and unpaid). Public forums and outreach programs have also been utilised to reach wider audiences.

These have been supported by policies and legislation that have influenced the wider environments within which the education is occurring. Anti-discrimination legislation, the introduction of needle exchange programs, the legislation ensuring confidentiality of people undergoing HIV testing are just some of the other activities that have been essential components of the success of Australia's response to the epidemic. Further policy development and implementation is needed to support the educational response.

Each of educational methods employed by programs has been in response to expressed needs and has relied on the commitment of gay men's communities. It is essential that gay men, including gay men living with HIV continue to be actively involved in every aspect of program development, delivery and evaluation.

(Recommendation 1)

The Review found that the comprehensive mix of educational methods used to date has resulted in the achievement of relatively high levels of health literacy in relation to HIV/AIDS among gay men. This mix has included face-to-face and mediated methods of communication and interaction.

The Review identified the need for the educational mix to be supplemented by the wider range of strategies that are recommended in contemporary health promotion practice and are justified on the basis of available evidence.

In light of the different needs of different target groups in different settings and environments, it is important that the methods employed to achieve the desired outcomes are appropriate to the task. It is impossible to specify the most appropriate mix of methods for all target groups, geographical areas, and issues.

The Review pointed to the need to increase the intensity and scale of initiatives to achieve the changes in environments, services, organisations and policies that will be necessary to assure the sexual health of gay and other homosexually active men, including those who are HIV positive. This may mean that some activities are discontinued and that a narrower set of priorities is established with greater resources allocated to these.

(Recommendation 13)

The Review identified some opportunities for intersectoral and intrasectoral collaboration that may offer the chance to ‘reach’ groups of gay and other homosexually active men in schools and health care settings. It will be important to investigate these opportunities and to develop and evaluate some pilot programs to assess their effectiveness in relation to HIV/AIDS, and sexual health more broadly.

One example might be the development of a partnership with the Health Promoting Schools movement. The emphasis of that movement on developing healthy school communities offers the opportunity to develop policies and programs to influence the acceptance of diverse sexual preferences for example, in addition to working to improve the more traditional curriculum-based approaches to education.

While there is a need to achieve a better balance between the systematic implementation of proven methods across the population it is also necessary to encourage the development of innovative practice.⁷³

The principles that guide this document (and the third National Strategy) refer to the need for ‘direct educational’ messages and for ‘culturally-specific’ education programs. However, the use of sexually explicit or sex positive education materials continues to provoke debate and concern. There is extensive evidence from the health promotion field more generally, that programs, including printed and audiovisual resources, are significantly more likely to be effective if they are culturally appropriate and relevant to their target audiences. The Review supported the need for the use of direct, explicit materials to support education programs where these are culturally appropriate and enhance the credibility of the message.

(Recommendations 12 and 16)

Health promotion programs need to ensure that, particularly in relation to programs for HIV-positive gay men and other homosexually active men, health care professionals are involved in the design, delivery and evaluation. This is to ensure that health care professionals are supported in their role as educators and kept up to date on current interventions.

(Recommendation 8)

9. Infrastructure

Infrastructure⁷⁴ refers to the systems for policy development, monitoring and surveillance, research and evaluation, workforce development and program delivery that direct and support action to promote, protect, and maintain health.

The Review confirmed the findings of the second national HIV/AIDS Strategy that the development of an effective infrastructure to design, deliver, and evaluate the range of interventions required to control and combat the HIV/AIDS epidemic has been a major contribution to the success of Australia's initiatives.⁷⁵

The early bilateral political support for a comprehensive program of action was essential to the subsequent success of efforts to control the spread of the virus. This support, resulting largely from the advocacy and initiatives of the gay men's community, led to the establishment of research, treatment, education, and international assistance & cooperation programs. The Education and Prevention Program has have been able to define needs, develop services, deliver programs, and measure progress.

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

The limited evidence available appears to confirm that this infrastructure support is one of the factors that distinguishes the Australian response from that of many other developed nations. The following sections take the specific elements of the infrastructure support, and identifies issues and actions in relation to each.

9.1 Capacity for program delivery

The State and Territory health authorities and the State/Territory AIDS Councils have developed considerable infrastructure to design and deliver education programs at State/Territory, regional and local levels. There has been relatively clear delineation of roles and responsibilities and the Review did not identify many areas in which there has been duplication of roles.

The new policy and funding environment, however, will mean that it is important to identify the essential components of infrastructure needed to deliver effective health promotion programs to reduce the incidence of HIV/AIDS and to minimise harm associated with the virus among gay and other homosexually active men. It will also mean identifying areas in which combined actions by the health authorities and the community-based organisations are necessary, each contributing different components.

The Review identified elements of the capacity required by community-based agencies responsible for designing, delivering, and evaluating educational (and other) activities. These are:

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

- a trained, well supervised workforce with skills in program design, delivery, and evaluation. This may mean a group that includes people with different strengths in each of these. It also means ensuring staff have access to the tools and materials they need for on-going professional development;
- funds to support program implementation, including venue hire, printing, travel, or payment for educators, for example.

Specialist skills should be available at the State/Territory level to which the community-based organisations have ready access. Some of these have been made available through AFAO and the Gay Education Strategy (GES) – now the (ANET) project. These include:

- access to special expertise in public health advocacy, print and audiovisual resource production; social marketing, policy development, and outcome evaluation;
- access to high-level advice on research and evaluation, and to regular updates on the scientific advances in the field.

(Recommendations 19 and 20)

9.2 Research and evaluation

The Australian response to the HIV/AIDS epidemic has been underpinned by a strong research capacity. The National Centre in HIV Epidemiology and Clinical Research and the National Centre in HIV Social Research have provided the comprehensive epidemiological, behavioural and social data that have been the basic building blocks for health education. This research effort must be maintained.

However, although there has been extensive macro-level evaluation that has measured the cumulative effects of the range of educational (and other preventive) activities at national level, there has only been limited evaluation of individual programs. The Review identified an urgent need for a conceptually sound evidence base for health promotion in relation to HIV/AIDS in particular. This evidence should be developed in light of concerns about the focus and methods of ‘effectiveness’ studies that are shared across the whole range of contemporary health promotion practice.^{76 77}

The Review highlighted the need for careful consideration of the purposes of evaluation of health promotion programs and of the research methods used. Measuring changes in any characteristic or behaviour (resulting from the cumulative effects of many different interventions) across a whole population is very different from measuring changes in the characteristics of the people, communities or environments that have been the target of specific interventions.

The effectiveness of specific health promotion interventions (such as education, for example) can be measured only in terms of the ‘outcomes’ it is reasonable to expect. That is, education is best measured in terms of its contribution to improved health literacy; advocacy is more likely to result in organisational and policy changes. But changes in behaviours across populations are the result of the combined effect of improved health literacy, and changes in the environments and services that determine behaviours.

It is usually impossible to identify single strategies that have brought about sustained changes in the health of populations – comprehensive programs using each of the five strategies outlined in the Ottawa Charter for health promotion are considered to be the most effective in improving the health of populations.^{78 79}

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

The implications for evaluation are that different types of evaluation measure different levels of effect. Each measures different end points, using different criteria for success. In all, the Review highlighted the need to shift from macro-monitoring of indicators across the population towards a more substantial focus on program evaluation with a view to building the evidence of effectiveness, evidence of ‘what works’?

(Recommendations 11 and 19)

Not all programs or projects should be evaluated at the same level of intensity, nor use the same research methods. For example, there will be a need for policy research in addition to social, behavioural and epidemiological research, and it will be necessary to develop criteria and a more appropriate hierarchy to assess the ‘quality of evidence’ in health promotion in this area.

The Review found that most organisations delivering HIV/AIDS education programs had not developed an evaluation strategy. It will also be necessary to ensure that the culture of organisations delivering programs views evaluation as an essential component of their work programs. The Review pointed to the need for performance agreements between funding bodies and organisations responsible for program delivery to include conditions that require evaluation as a condition of funding. Additionally evaluation requires specific research skills. Many HIV/AIDS educators have not received training in evaluation methods appropriate to their level of their work.

(Recommendations 23 and 6)

A range of mechanisms is already in place to disseminate research findings and to assist practitioners to adapt their practice in light of the findings. The current mechanisms have been effective in ensuring that emerging trends in the safe sex practices of gay and other homosexually active men and in their knowledge and attitudes have been quickly identified. This has ensured that educational programs have been adapted to suit community needs.

(Recommendation 18)

A process is also required to regularly review the evidence on effectiveness and to identify the elements of ‘best practice’ for health promotion interventions to promote the health of gay and other homosexually active men, including those who are HIV positive. An effective system to disseminate the Review and to ensure that effective practice is taken up, systematically, across the country must be established.

(Recommendations 11 and 23)

The National Centre in HIV Social Research and HIV/AIDS educators already work collaboratively to ensure that research findings are translated into practice. However, the Review found that there is a need for educators to be actively engage in establishing the research agenda, and for a more effective balance to be achieved between investigator driven and policy driven research in this area.

(Recommendation 21)

9.3 Training and workforce development

A skilled and knowledgeable workforce is an essential element of an effective infrastructure for improving health. This document focuses on the needs of workers whose primary role is education, particularly those working in community-based agencies. The Review highlighted the fact that there has been no systematic training offered for this group. The urgency of the initial crisis left little time for training other than that necessary for educators to have the latest facts about HIV, its modes of transmission, and about methods to prevent or limit transmission. More recently there has been concern expressed that training in health promotion/health education is likely to result in reduced opportunities for peer educators to engage in this work.

However the Review highlighted the need for the more systematic development of the skills of the HIV/AIDS education workforce. The tasks of designing, implementing, and, in particular, evaluating health education/promotion programs have become more complex. As the epidemic is no longer characterised by a sense of crisis demands for better performance and outcomes are increasing. Educators will need to have high levels of knowledge and skills if they are to achieve the outcomes that will be required under the new funding arrangements.

Professionalisation of the work does not mean that peers cannot continue to be involved in education. The strength of the Australian response to HIV/AIDS has been attributed to the central involvement of affected groups in planning, designing and implementing health promotion activities. The Review confirmed the need to maintain this high level of involvement. However, the Review also confirmed the need for appropriate levels of training to ensure that educational and health promotion interventions are effective.

Educators require training to develop knowledge and skills in:

- content issues relevant to HIV/AIDS, other STDs, and sexual health;
- the design, delivery and evaluation of effective health education and, in some cases, health promotion programs. [Note: Not all educators require the wider health promotion knowledge and skills. However, it is important that there be a core group who do have these skills in addition to those required for effective education.]
- more specialised skills in research and evaluation are required by a smaller educators.

The wider issue of workforce development also requires attention. The Review found that many community based organisations, in particular, have high levels of turnover amongst their education staff. Some of the reasons for this included lack of career development opportunities, better remuneration in other organisations, and burn out. These are not training issues but require the attention of managers and administrators to ensure that a skilled education workforce is providing the education and, where necessary, implementing other health promotion strategies. In turn, this requires the development of a more strategic, planned approach to workforce development and training for staff.

Managers need to ensure that they provide their workforce with access to a full range of training and educational opportunities. These include:

- on-the-job training
- regular supervision, linked with performance appraisal
- access to short courses to update content knowledge

- access to short courses to develop technical knowledge and skills (in this case, in program development, delivery and evaluation)
- access to formal education

The National Training Agenda for HIV/AIDS Educators report was a comprehensive review of the training needs of HIV/AIDS educators and included recommendations to improve the training.⁸⁰ This Review confirmed that there is widespread support for adoption of the national training agenda. Specific priorities were identified, including:

- establishment of a system to formally accredit educators' experience;
- promoting access to existing university courses and other relevant training courses;
- development of systematic national training on priority content-specific issues;
- expansion of the national Gay Educators Conferences to incorporate additional training opportunities;
- systematic, formal learning opportunities within the workplace (including an increased focus on critical reflection and becoming learning organisations)

(Recommendation 7)

Appendix 1 – Quality of evidence ratings

Quality of evidence ratings⁸¹

- I Evidence obtained from a systematic review of all relevant randomised controlled trials
- II Evidence obtained from at least one properly-designed randomised controlled trial
- III-1 Evidence obtained from well-designed controlled trials without randomisation
- III-2 Evidence obtained from well-designed cohort or case control analytic studies, preferably from more than one centre or research group
- III-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.
- IV Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Appendix 2 – Examples of performance indicators

Examples of performance indicators

The following performance indicators are suggestions that should be reviewed and discussed when developing and agreeing upon national indicators.

Health outcomes

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

Intermediate outcomes

Behaviours/risk factors

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

Health services

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

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

Environments

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

Health promotion outcomes

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

Indicators of input

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

Indicators of capacity

For example, AIDS Councils need:

- organisational policy supporting health promotion as a major focus of the work of the agency;
- access to epidemiological and population-wide data on the behaviours and knowledge of gay and other homosexually active men, including those who are HIV positive;
- access to information on supportive policies, environments, and services (or the lack thereof) that influence the sexual practice and sexual health of gay and other homosexually active men;
- a trained, well supervised workforce with skills in research, program design, delivery, and evaluation. This may mean a group that includes people with different strengths in each of these.
- a workforce development policy and strategy;
- a research and evaluation strategy;
- funding to support program implementation and evaluation.

Appendix 3 – Criteria

Criteria to use to assist in deciding on the need to broaden HIV/AIDS education and health promotion programs to include a focus on other communicable diseases

- prevalence of other communicable diseases among gay and other homosexually active men
- severity of other communicable diseases, particularly among gay and other homosexually active men who are HIV positive
- availability of alternative avenues for delivering programs and services to address related communicable diseases
- resources available
- community support for action and concerns of agency clients
- competing priorities for the expenditure of limited resources – is this the most efficient way in which to use resources
- ensuring that the focus on HIV/AIDS and the needs of gay and other homosexually active men can be maintained.

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